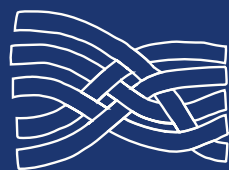


Who owns the health system?

HOW PUBLIC FUNDING IS
DRIVING PRIVATE PROFIT



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AOTEAROA**

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Executive Summary

While New Zealanders largely support having a public health system, today almost half of all public health spending takes place in the private sector. **80% of the increase in public health spending over the last three years has been funnelled into the private sector.** And, while the private health sector remains a mix of both corporate and not-for-profit structures, we are witnessing increasing corporate consolidation across key sectors including general practice, home and community support services, pathology and imaging services, elective surgeries and aged residential care. Public funding is crucial to this expansion, as it provides a stable and scalable revenue base.

The privatisation of healthcare has traditionally been characterised as a *creeping* phenomenon, long-considered a growing threat to the sustainability of health funding and service delivery in Aotearoa New Zealand. The pace of privatisation is no longer a creep; privatisation has bolted. **Almost half of public health spending – 46.4% in 2024/25 – is now being consumed by the private sector.** A growing share of public spending is being

channelled to privately owned service providers that increasingly operate under commercial ownership structures. These structures are legally and contractually obligated to prioritise shareholder returns, creating incentives that can conflict with the delivery of high-quality, accessible, and equitable health services.

In many cases, public funding now flows to healthcare providers controlled by asset managers, pension funds, private equity funds, and multinational corporations. There is a real concern that public health dollars are now being used to service financial obligations such as debt repayments, investor yields, corporate acquisitions, and portfolio growth. In some instances, the entry and expansion of private providers has been a response to the failings of government officials and policymakers who have underfunded or undermined public service capacity for financial or ideological reasons. Regardless of how we got here, the growing extraction of profits and financial costs from publicly funded health services and from Aotearoa New Zealand raises fundamental questions about efficiency, accountability and value for money.



WHO OWNS THE HEALTH SYSTEM? HOW PUBLIC FUNDING IS DRIVING PRIVATE PROFIT

This report documents the scale of public expenditure within the the emerging private health system. It maps ownership within those services, and identifies some of the gateways through which public money flows into the private health system. Each case study documents how consolidation, market power

and debt-funded acquisitions are reshaping our health system. It shows evidence of state-backed profitability in key parts of the health system and describes multinational tax and ownership structures that are designed to maximise private returns. The case studies detailed in this report are:



General practice



Private hospitals (elective surgery and procedural treatments)



Diagnostic, imaging and radiology



Aged residential care



Home and community support services

New Zealand faces significant healthcare challenges. These include persistent health inequities, uneven access to health services, significant growth in noncommunicable disease and patient comorbidity, a growing and ageing population, and a lopsided approach to funding and delivering primary and acute

care. If we are to meet these challenges, policymakers must pay closer attention not only to how much money is spent on health, but also to who receives that money, who owns the organisations involved and whether scarce healthcare funding is being reinvested in care or extracted from the system and the country.

Privatisation and outsourcing have often been justified by pointing to mounting public sector debt levels as a handbrake against investment in new facilities and public capacity. And yet increasingly we are seeing private providers borrowing heavily to increase their capacity and establish strong market positions, much of which, it appears, is being driven by public spending. In effect, we are exchanging low-cost transparent and accountable public borrowings for much higher cost private debt that is more difficult to monitor. From 2020 to 2025, liabilities in the health care and social assistance sector (including borrowings) have increased 243%.¹

As a result, we are left with a health system in which the public carries the ultimate responsibility for care, while increasingly

concentrated private providers dictate essential capacity. Highly leveraged firms are vulnerable to rising interest rates and economic downturns and may respond by reducing staffing levels or increasing charges. Financial distress or the risk of default could threaten service continuity in sectors that have become dependent on a handful of providers. Private investors are unaccountable to Aotearoa New Zealand's public, and ultimately the provision of publicly funded health care remains the responsibility of the government regardless.

Unless these challenges are addressed, increasing health expenditure may do as much to sustain financial returns and corporate expansion as it does to sustain the healthcare system itself.



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HEADLINE FINDINGS



GENERAL PRACTICE

- Public funding now accounts for 55% of general practice revenue, up from below 50% in the last two years.
- Corporate ownership has risen from 14% of practices in 2022 to an estimated 25% in 2026, following TPG's acquisition of Tāmaki Health and Tend's purchase of The Doctors.
- The debt-funded Tāmaki Health deal appears to be structured through the Cayman Islands, borrowed at roughly double current public borrowing rates.



PRIVATE HOSPITALS

- Publicly funded elective surgeries have grown by 93% in four years to more than a billion dollars in 2024/25.
- Public funding makes up an estimated 45.3% of private hospital revenue, up from 35.1% five years ago.
- Three entities control 70% of the private hospital market (by bed count).



DIAGNOSTICS, IMAGING AND RADIOLOGY SERVICES

- Public funding accounts for an estimated 65% of sector revenue, with community laboratory almost entirely contracted out.
- Awanui Labs holds an estimated 75% of the laboratory market and handles 98% of referrals.
- Debt-funded private equity roll-up RHCNZ delivers more than a third of radiology services.



AGED RESIDENTIAL CARE

- Public funding accounts for an estimated 76% of aged residential care revenue, yet almost all facilities are privately owned.
- The Big Six alone received \$627.3 million HNZ funding in the latest year for which data is available.
- Two of the Big Six providers have been ‘taken private’ by offshore private investors.



HOME AND COMMUNITY SUPPORT SERVICES

- An estimated 94% of Home and Community Support Services revenue comes from public sources.
- The largest provider in the sector – NZ Health Group – paid a \$32.6 million dividend in 2025 and has just been acquired by Fisher Funds and Direct Capital.
- In 2023, Access Community Health was sold to Australian private equity fund Anchorage Capital Partners.

RECOMMENDATIONS

1

Recognise and resource a public health system that allows for tino rangatiratanga and mana motuhake of hauora Māori as an obligation under te Tiriti o Waitangi.

2

Commit to a plan that ensures new health spending goes toward building public sector capacity and not to private sector profit.

3

Commit to a plan that ensures all workers in the health system are paid fairly and equitably for their work, with world-leading terms and conditions.

Turn the tide on health privatisation and build the foundations for an equitable, accessible, high-quality public health system by:

- 4** Requiring that all private providers receiving over \$5 million in public health funding per year publish financial statements that clearly disclose the scale of public funding received and evidence of how both operational and workforce funding is utilised to fulfil contract requirements.
- 5** Introducing measures to better monitor corporate tax payments from all domestic and international entities that receive public funding for health services to ensure compliance, transparency, and accountability.
- 6** Introducing a public interest test for the private acquisition of publicly funded health providers, with conditions limiting acquisition debt and profit extraction.
- 7** Building public capacity in funded sector health services by directly building infrastructure, employing workforce and delivering services that have historically been outsourced to the private sector. This requires long-term workforce and service planning to rebuild public capacity in line with the needs of a growing and ageing population.
- 8** Requiring all funded sector and private sector providers receiving public funding for delivery of public health services to report quarterly workforce staffing numbers, skill mix and quality outcomes for all occupation groups to enable scrutiny and encourage accountability.
- 9** Linking funding for private providers of public health services to robust monitoring of service delivery and patient outcomes and hold providers accountable for the delivery of key public health system goals and objectives.

Introduction

Ownership in the health system matters. It matters for patients. It matters for health workers. It matters for Aotearoa. Ownership, broadly put, decides who gets to choose who and in what quantity someone benefits from public assets, public infrastructure and public services. The underlying promise of the public health system is that if you get ill, have an accident, need an operation or have a baby – the public system is there for you. That promise has never been realised equitably amongst New Zealanders, particularly for Māori for whom the health system has consistently delivered poorer outcomes and barriers to access, to and through the full spectrum of health services from preventive to tertiary care. The health system must give full effect to te Tiriti o Waitangi by translating its guarantees into its structure, culture and daily practice. When we privatise or outsource health services, we surrender that obligation.

Healthcare in Aotearoa New Zealand is delivered through a mix of four main ownership models. At one end of the spectrum are **publicly owned and operated services**, such as the 86 Te Whatu Ora Health New Zealand owned and

managed public hospitals. Private provision encompasses a range of ownership models and should not necessarily be considered synonymous with for-profit delivery. **Not-for-profit** community and NGO service providers, like Plunket and Hospice, may receive funding from a mix of public and private sources. Not all organisational structures outside of the public health system produce the same issues, there will be many not-for-profit entities operating in Aotearoa truly acting as NGOs with all funds going out the door to support New Zealanders. **For-profit providers** may range from a single rural GP practice to a large-integrated hospital under highly leveraged offshore private equity ownership. The fourth ownership model is **Māori-owned health services**, often kaupapa Māori service providers that are owned and governed by Māori and deliver a wide range of health and social services throughout the motu. Many operate as charitable or community trusts, while others may incorporate commercial activities to support broader social and economic objectives.

Debates over ownership and delivery are taking place alongside the significant challenge of



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how to fund an equitable, accessible, high-quality health system to provide care for a growing, ageing and increasingly unequal society in Aotearoa New Zealand. The over-65 population, which receives healthcare at five times the rate of the under-65 population,² is currently growing six times faster than the under-65 population.³ Access and capacity constraints mean unmet need is increasing across all population groups.⁴ Long-standing health inequities persist, with Māori, Pacific peoples, those on lower incomes and those with disabilities experiencing disproportionately high rates of preventable illness and chronic diseases. Barriers to primary and preventative care can place stress on more expensive hospital and acute services that further stretch the health system.

There is often excessive emphasis on the place of clinical intervention in health outcomes, when this makes up only 20% of the determinants of ill health.⁵ The conditions in which a person is born, grows up, lives, learns, works and ages within their broader cultural, social, physical and economic context are far greater drivers of their health status. This means poverty, high unemployment, substandard housing and unequal access to education have both direct and indirect impacts on people's health and can be cumulative over their lifetime. Failing to address these socioeconomic factors contributes to higher acuity, increased ambulatory sensitive hospitalisations and ultimately more costly healthcare delivery.

The quality and availability of health services are inconsistent across regions, in part due to the failure of responsive investment in health services based on population change, demographic change, and health disparities from the failure of private providers to deliver health services in less densely populated locations.⁶ The result is longer wait-times for various health services, lengthy, costly and disruptive travel arrangements to access health care or unmet need.⁷ These conditions often escalate to higher acuity and, therefore, costly treatment or worse outcomes such as preventable increases in years lived with disability or premature death.⁸

Health expenditure is expected to rise from 7% of GDP today to around 10% in 2065, and the ratio of working-age people to retirees is projected to fall from 4:1 today to 2:1 over the same period.⁹ Rising costs are falling on fewer shoulders. Spending is already failing to keep up. Successive governments have pointed to arbitrary fiscal guidelines to justify real per capita cuts in health spending, but patients and health workers report the system is already under severe stress based on current need, let alone the rapid escalation expected in future decades. Tax reform will need to play a role, but identifying systemic efficiencies can improve the quality of healthcare being delivered now, and in the future, to ensure public money makes its way to frontline services.

This is particularly relevant given the striking growth of private sector health provision, much of it supported by public funding. From primary care and aged care to diagnostics, specialist services, pharmaceuticals, laboratories, and support services, private firms with increasingly sophisticated corporate structures are playing a growing role in the delivery of healthcare in Aotearoa New Zealand. The unions that commissioned this report are concerned that increasing health privatisation may be diverting resources away from frontline care towards shareholder returns, financial engineering and market consolidation.

This report explores the emerging private ownership of New Zealand's health system, tracking the flow of earnings generated from healthcare expenditure. It finds substantial earnings being extracted from sectors that are dependent on public funding and essential public services, including primary care, radiology, pathology, outsourced elective surgeries, aged care and community support services. It documents growing market consolidation, the expansion of both domestic and international corporate healthcare groups, the increasing role of private equity ownership, and the use of complex leveraged buyouts that appear to reduce taxable profit.

Every dollar of profit is one that could have been used to fund accessible, safe, high-quality health care in the public system. This report documents the disproportionate growth of the

private system, and how public funds appear to be supporting that expansion. Directing resources into debt servicing, investor returns, and corporate consolidation comes at the expense of safe staffing levels, wages, training, equipment, infrastructure, service expansion and patient care, and in other jurisdictions has been linked to reduced competition, rising costs and increasing market power.

The report details numerous instances of 'leveraged buyouts,' in which a private equity investor uses debt to finance an acquisition. The debt is saddled onto the acquired company, with finance costs often consuming the bulk of taxable income, leaving tax authorities or workers looking to bargain a fair wage increase out in the cold. Leveraged buyouts are occurring in the primary care, radiology, pathology, and private hospital sectors and demonstrate the need for greater oversight and regulation.

New Zealand's growing and ageing population and stark health inequalities means the country cannot afford waste, duplication or inefficient allocation of scarce healthcare resources. Over coming decades, taxpayers and workers will be asked to contribute more to sustain the health system. In return, they have a right to expect that healthcare funding is being used as effectively as possible. Understanding who owns the health sector, who profits from it, and whether those profits contribute to or undermine the system's long-term sustainability is central to the future of healthcare in New Zealand.

Public spending on health

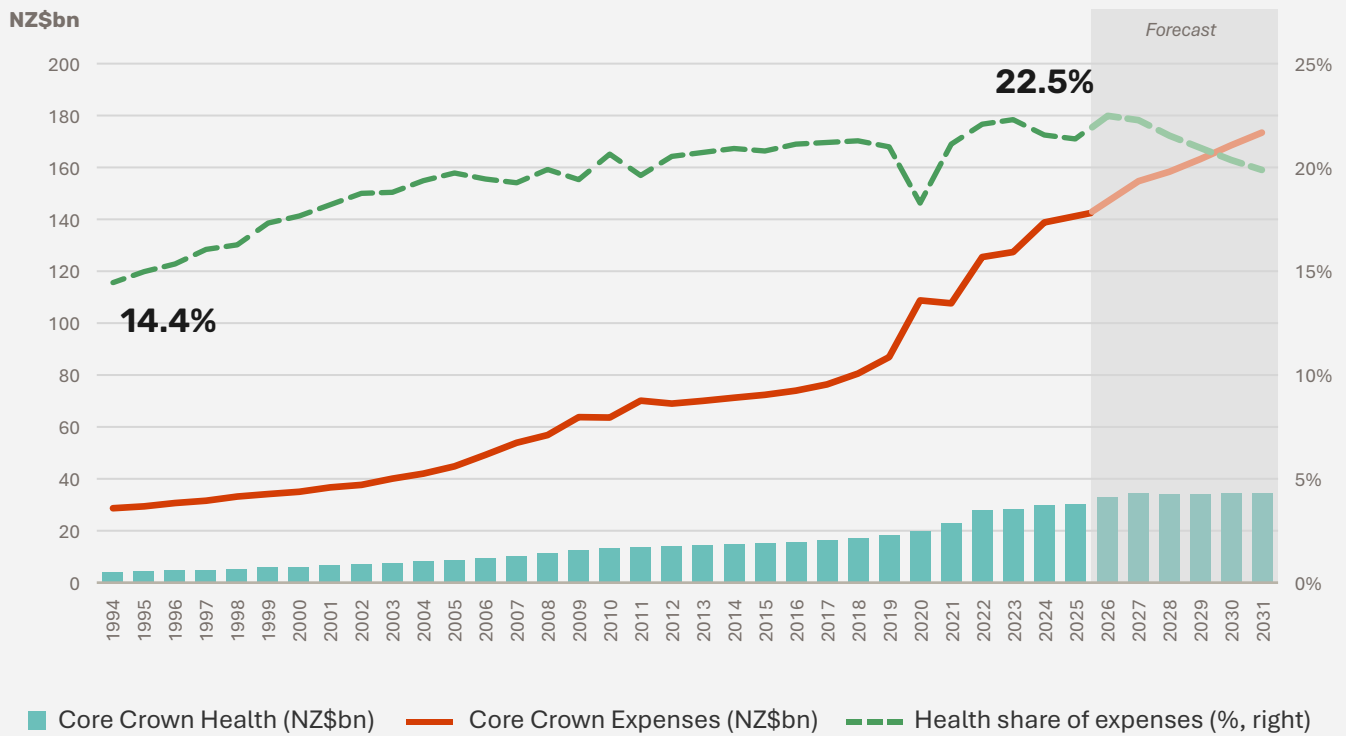


The share of public funds going into health spending has steadily increased over recent decades in Aotearoa New Zealand, a common experience amongst advanced economies. This reflects both the increasing care needs of our growing and ageing population, as well as the increasing breadth of available health services. Treasury measures public health spending with a figure called ‘Core Crown health spending,’ which includes operating funding across the Health appropriation (‘Vote Health’), disability support services and health payments to ACC.¹⁰ Three decades ago in 1994/95, Core Crown health spending for the country’s 3.7 million people was \$4.4 billion, or \$9.1 billion in today’s money.¹¹ This accounted for 14.4% of the \$28.5 billion in ‘Core Crown expenses’ that year.¹²

Three decades later in 2024/25, Core Crown health spending was six times higher in nominal terms, at \$30.3 billion. This included notable increases during the pandemic (9% in 2019/20 and 15% in 2020/22) and during the cost-of-living crisis period (22% in 2021/22). Even when adjusted for the 55% increase in population over these three decades, plus the 138% increase in inflation, we can see in Figure 1 that the health share of Core Crown spending has risen quite steadily over the period, peaking at 22.5% in 2025/26. Over that period, the under-65 population has grown by 37.9%, while the over-65 population – who receive a much greater share of health resources – increased three times faster, at 116.8%.

Figure 1 | Core Crown Health spending

Fiscal Time Series 1972–2025, PREFU 2026 expense tables



The Pre-election Economic and Fiscal Update included projections for Core Crown health spending out to 2031. On a nominal basis, that data suggests Core Crown health spending will rise 3% in 2026/27 and then flatline over the remaining forecast period.¹³ The orange line in Figure 2 inflation-adjusts these figures to June 2026 dollars.¹⁴ In real terms, this shows Core Crown health spending to peak in 2026/27 and then decline by 8% out to June 2031. The blue bars in Figure 3 adjust for projected population

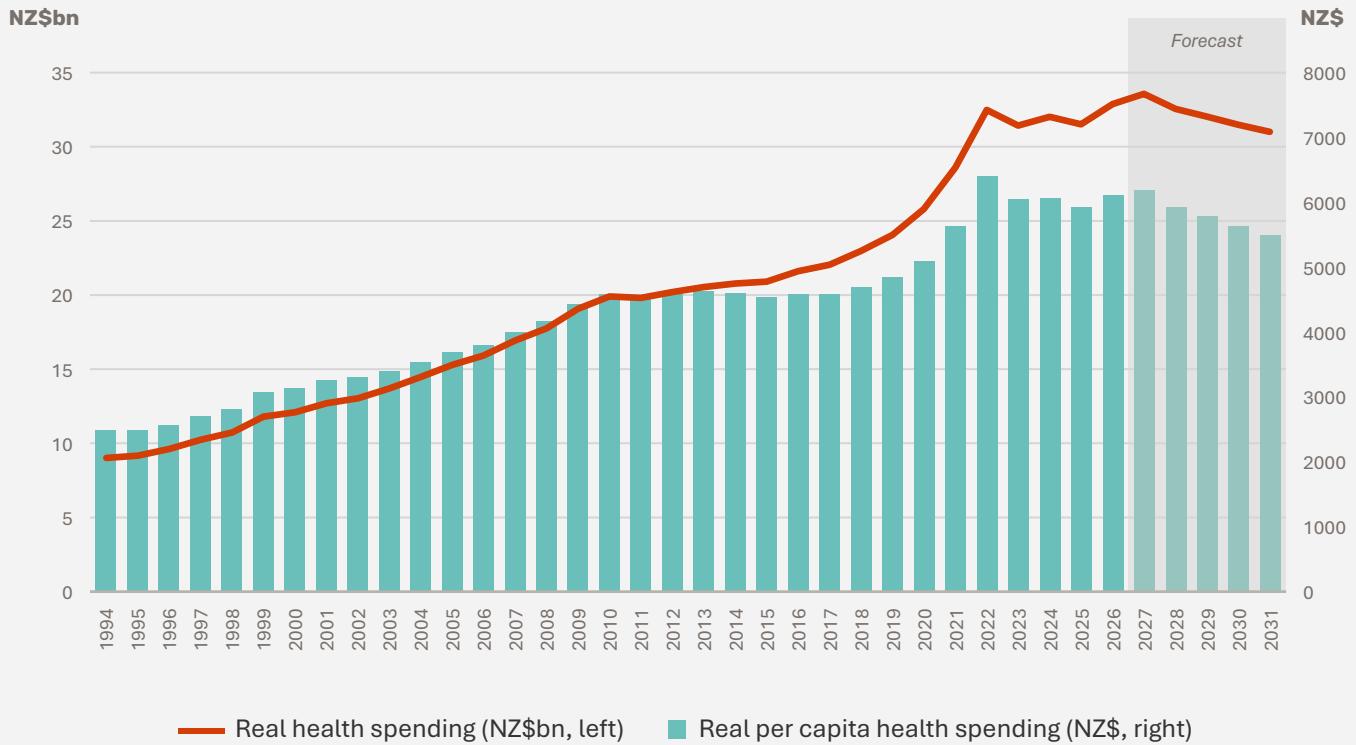
growth, suggesting a real per capita public health spending cut of 9% from 2026 to 2031. This baseline projection excludes unallocated future operating allowances, and at Election 2026 both major parties' fiscal plans commit more than half of their \$2.4 billion allowances to health.¹⁵ Whether these increases to health funding are sufficient to sustain real per capita health spending – let alone demographic pressure and health inequities – remains to be seen.



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Figure 2 | Real Per capita health spending (June 26 dollars)

Fiscal Time Series 1972-2025, PREFU 26 expense tables, DPE065AA, RBNZ MPS



We should be mindful about putting too much weight in these projections. The fast-growing over-65 population is a reliable voting bloc, and limited attention to the social determinants of health¹⁶ mean that demand for healthcare is likely to continue to grow. Furthermore, these figures don't touch on the question of who will deliver that healthcare. If an increasing proportion of publicly funded healthcare is delivered by profit-oriented private providers, expenditure growth could grow faster still.

THE GROWTH OF PRIVATE HEALTH CARE PROVISION

The growing share of private provision documented in this report has its roots in the 1993 Bolger Government health reforms that aimed to liberalise the healthcare sector. Since 1938, public hospital care in New Zealand had been free at the point of use under an integrated model where the government both financed and delivered healthcare services. In 1988,

businessman Alan Gibbs, a merchant banker who had chaired the newly-corporatised Forestcorp, published a report commissioned by government called ‘Unshackling the hospitals.’ It argued that public hospitals were an inefficient public monopoly that needed to separate the role of funding from service delivery.¹⁷

This view crystallised in the 1991 ‘Green and White Paper,’ which imagined “a type of quasi-market through the splitting of the roles of purchasers (buyers) and providers (sellers)” where public and private sellers would “compete to provide services in return for a share of these public funds.”¹⁸ The resulting 1993 reforms converted Area Health Boards into ‘Crown Health Enterprises’ (CHEs) with commercial mandates, competing for contracts from the newly established Regional Health Authorities.¹⁹

The CHEs, however, soon found that contracting was expensive, and the underlying commercial logic had proved politically contentious. From 1996, the internal competitive market was wound back, and in 2001 the hospital providers were replaced by 21 ‘District Health Boards’ (DHBs) that both managed funding and delivered hospital healthcare services.²⁰ DHBs would continue to hold funding and contract out for primary care services, but the tight budgetary constraints still squeezed resources. Non-clinical services like cleaning, catering, laundry and

security were outsourced to a mix of local and multinational contractors, and community pathology was tendered out to private laboratories.

These constraints tightened again through the 2010s, as fiscal restraint and underinvestment capped public healthcare capacity. Meanwhile the growth of private surgical facilities, fuelled by private health insurance, built out a parallel system to circumvent the growing delays of the public system. Waiting lists grew, and DHBs began to use that same private capacity to meet their own wait time targets. The pandemic deepened that dependence: planned care was proactively delayed to shore up capacity, and outsourcing became a standard tool to work through the growing backlog, an increasingly default response for scaling up healthcare delivery.

PUBLICLY FUNDED, PRIVATELY DELIVERED

Today, a growing share of the country’s total health expenditure from all sources is now delivered outside direct public provision. The establishment of Te Whatu Ora Health New Zealand (HNZ) in 2022 as a consolidated public health entity has centralised financial reporting that was previously difficult to track the extent of outsourcing across the former 20 DHBs. It is now possible to calculate a sector-



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wide total. HNZ's total expenditure reached \$29 billion in 2024/25, up 9% over the last three years (this includes \$476 million in ACC contract revenue).²¹ HNZ's largest single expense line is 'personnel costs,' which has been flat for the last three years at slightly below \$12 billion.²² Adding in roughly half a billion dollars a year in 'outsourced personnel'²³ brings the labour share of HNZ spending to 42.6% in 2024/25, down from 45.6% in 2022/23.

Figure 3 | HNZ funding to the private sector

Health NZ financial statements

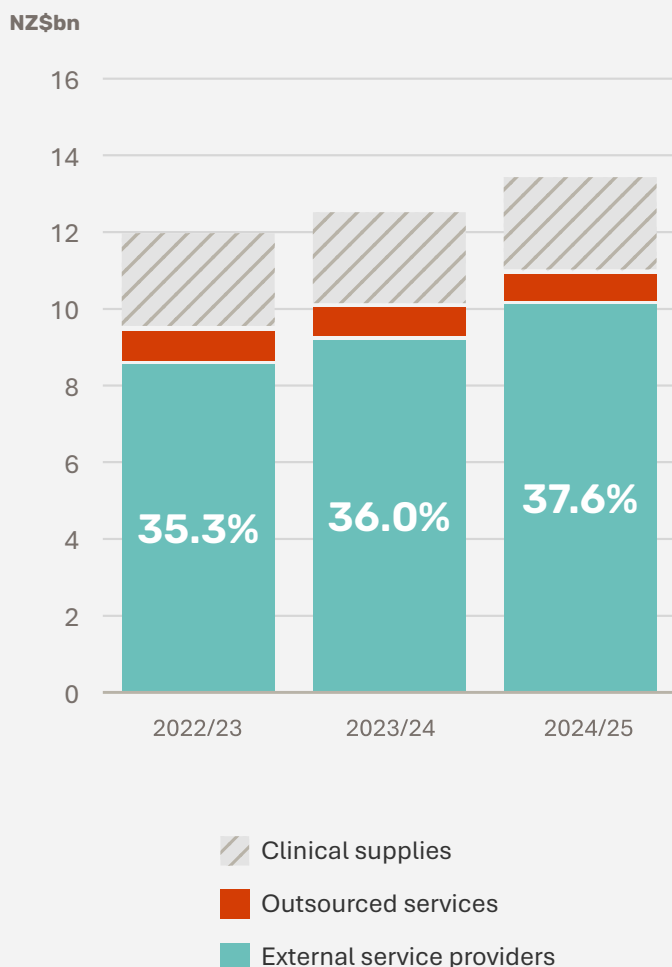


Figure 3 shows HNZ spending in the private sector. Spending on 'external service providers' (the blue bars) and 'outsourced services' (the orange bars) together increased from 35.3% of HNZ spending in 2022/23 (\$9.4 billion) to 37.6% in 2024/25 (\$10.9 billion).²⁴ The shaded bars of the graph include 'clinical supplies,' which are necessarily purchased from private sector providers; their inclusion increases HNZ's private sector spend from 37.6% in 2024/25 to 46.3%. Clinical Supplies cannot be readily disaggregated from payments to external service providers and therefore cannot be cleanly excluded from the calculation.

This figure includes outsourced non-health services, such as security, catering, laundry, information technology, software licenses and so forth.²⁵ These services are part of the cost of running a health system, and many have been progressively outsourced over time. In August 2026, for example, HNZ proposed spending as much as \$100 million on a new contract for hospital security services.²⁶ These ancillary services are likely also contracted out in the private healthcare sector.

The public health system includes the 'funded sector,' where services are publicly funded but privately delivered. These services are categorised within the Vote Health appropriation 'Delivering primary, community, public and population health services' which totalled \$9.1 billion in 2024/25, or 31% of total health funding.²⁷ The services funded through this appropriation are predominantly delivered

through private and non-governmental providers, including general practices, community pharmacies, aged care facilities, and NGOs.²⁸ Some of these providers may also receive funding from other public sources, such as the Ministry of Social Development or Whaikaha the Ministry of Disabled People.

Increasingly, we are also seeing publicly funded and planned hospital and specialist services being delivered in the private sector. HNZ's spend on "outsourcing planned care" had already reached \$317 million by 2023,²⁹ and a commissioned report noted that this is driven by "higher prices being paid in tandem with increased volumes."³⁰ The Coalition Government's 'Elective Boost' policy aimed to expand the use of the private sector, ostensibly reducing the elective surgery waitlist.³¹ Issues have arisen with the inflated expense, inequities in who and what procedures are outsourced to private hospitals and ³² loss of accountability over our public health system.³³ There is scant evidence of any meaningful cost benefit analysis by HNZ on the outsourcing strategy, and poor understanding of the financial impacts on the organisation.

Private sector providers are also playing an increasing role in specialist sectors like radiology and pathology. These services have a direct line of sight to the outsourcing of planned care, with private diagnostics increasingly forming part of the same referral and treatment pathways as private surgical hospitals. On top of an existing \$40 million annual contract for

community radiology, HNZ spent an additional \$100.6 million outsourcing 169,276 medical imaging scans to private providers in the year to 28 February 2025.³⁴

Additional publicly funded healthcare comes through the Accidental Compensation Corporation (ACC), New Zealand's 'no-fault' national workplace and accident insurer, which is funded by levies paid by employers, employees and motorists.³⁵ The vast majority of this funding is paid to private sector healthcare providers, and HNZ's accounts clearly delineate public expenditure as 'ACC contract revenue'.³⁶ A proportion of ACC spending also funds workers' time off work ('weekly compensation'). ACC funding towards medical treatment, social rehabilitation, vocational rehabilitation, hospital treatment, dental treatment and elective surgery totaled \$4.4 billion in 2024/25.³⁷ Subtracting ACC contract revenue from this gives an ACC private spending total of \$3.9 billion in 2024/25.

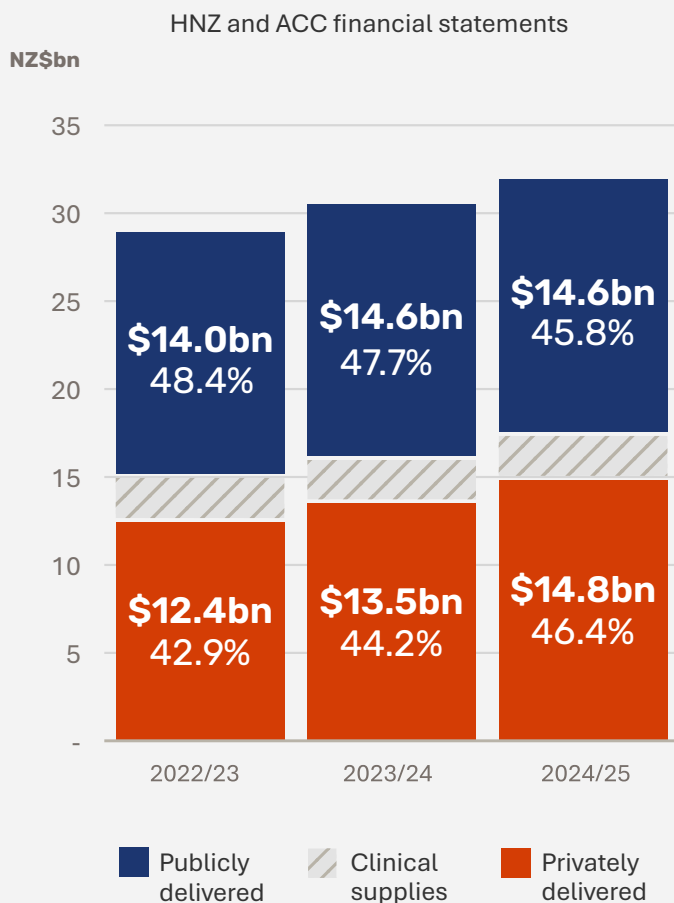
Adding these ACC figures to the HNZ figures above, the total for publicly funded privately delivered healthcare reaches \$14.8 billion in 2024/25 (\$17.2 billion if clinical supplies are included). In 2024/25 this accounted for 46.4% of combined HNZ and ACC spending, which reached \$31.9 billion, see Figure 4.³⁸ The \$14.8 billion combined HNZ and ACC figure is up by \$2.4 billion from 2022/23, with private sector providers consuming 80% of the increase in public spending over that period.



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Public sector spending totals can be further calculated by subtracting this combined public to private health total and the clinical supplies figure from our total public spending figure. **In 2024/25, this figure came to \$14.6 billion, 45.8% of the total public health spending figure, and now less than the privately delivered total.** While ‘publicly funded, privately delivered’ calculations likely overcount the total (due to the inclusion of clinical supplies), the trend here is clear: private delivery is scaling up, while growth in public delivery has stopped.

Figure 4 | Publicly funded health by sector



THE PRIVATE HEALTHCARE SECTOR

Alongside the \$14.8 billion HNZ and ACC spent in the private healthcare sector in 2024/25, private spending on private healthcare is growing. This includes the growth of insurance-funded private health spending,³⁹ out-of-pocket costs borne by the consumer, and other ancillary costs or charges. The Stats NZ Annual Enterprise Survey (AES) measures the total revenue of the ‘healthcare and social assistance’ industry at \$32.7 billion in 2024/25, up \$2.1 billion in the last year and more than doubling over the last decade.⁴⁰

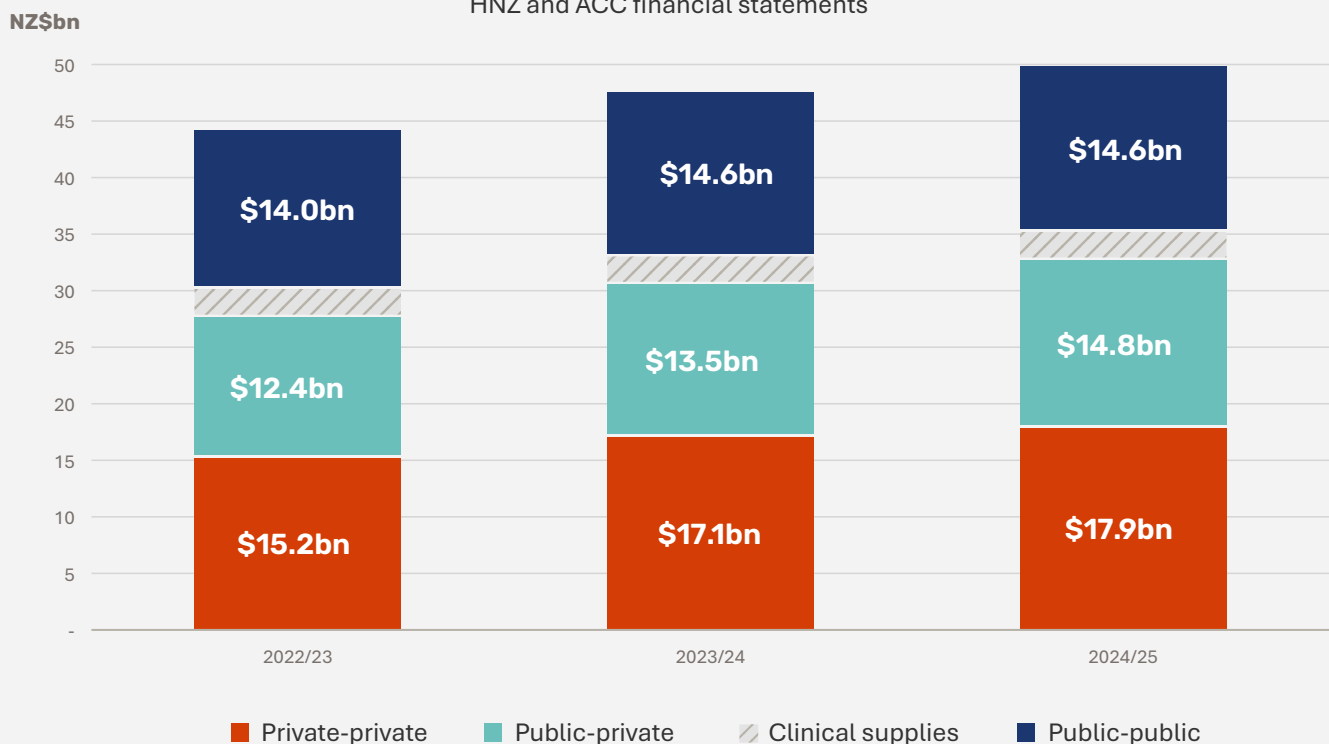
This total includes the ‘publicly funded, privately delivered’ spending total calculated in the previous section, and therefore we can estimate that privately funded privately delivered healthcare totalled a further \$17.9 billion in 2024/25. This is the fastest growing segment of health spending, up more than \$2.6 billion since 2022/23. Total spending on healthcare reached \$49.8 billion, up almost \$5.7 billion over the last two years. Privately delivered healthcare accounts for 89% of this increase.

Based on this analysis, it appears that public funding is providing a stable and expanding revenue base for private sector healthcare providers and investors to scale up their capacity.⁴¹ Although privately funded private healthcare is the fastest growing segment overall, public funding is unlocking additional

private spending on privately delivered healthcare (e.g. a patient receiving publicly funded but privately delivered elective surgery may purchase upgrades or follow-up services).

In this way, public funding is creating demand for private healthcare and underwriting its expansion, while spending growth on publicly delivered care is comparatively glacial.

Figure 5 | The public-private health mix
HNZ and ACC financial statements



The increasing share of publicly funded privately delivered care raises questions about the extent to which public funding is underwriting profitability, and whether the public is getting the most out of rising public health spending. AES data for healthcare and social assistance includes a profit measure, ‘surplus before income tax,’⁴² which reached a record \$4.5 billion in 2024/25, a 14% margin on

total sector income (\$32.7 billion). This figure is misleadingly high, because it also includes contractor income, which is recorded in the AES as service fee income. Contracting is common in highly specialised (generally well-paid) parts of the health sector, and some sub-sectors will have relatively high shares of contractor income within their surplus before income tax figures.

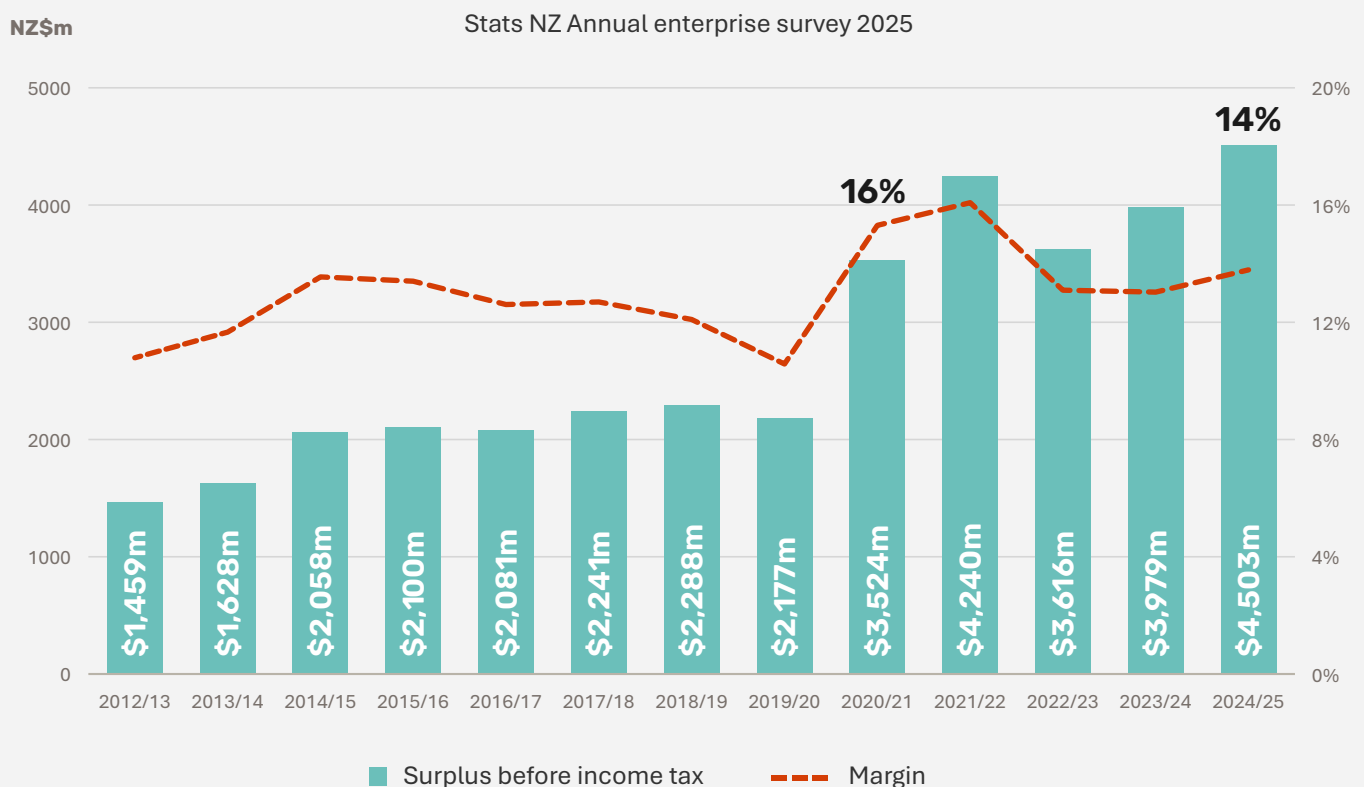


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Nonetheless, the scale of surplus before income tax is substantial. Between 2019/20 to 2021/22 surplus before income tax nearly doubled, from \$2.3 billion to \$4.2 billion. While it may account for some of the increase, it is unlikely that changes in contractor income alone is responsible for this increase, with surplus before income tax margins hitting 16%

in 2021/22, at the height of the pandemic when health spending surged.⁴³ **In other words, taxable profit from the healthcare and social assistance sector almost doubled over this period. In 2024/25 pre-tax profit for the healthcare and social assistance sector reached \$4.5 billion.**

Figure 6 | Healthcare and social assistance profit



Through the following case studies we will use publicly available data from government and corporate data sources to attempt to provide a more complete picture of five key health sub-sectors: general practice, hospitals and elective surgeries, specialist medical services

(diagnostic and imaging), aged residential care and home and community support services. Not all private provisions carries the same risks, but the shift towards increasing corporate ownership, particularly private equity-backed, do present risks to the publicly funded system.

These transactions are often debt-financed, creating a claim on future healthcare revenues and creating possible revenue streams for other investors while reducing taxable income. At private finance rates, this borrowing is inherently more costly than public borrowing. Consolidation can help absorb that cost, and large corporate groups in turn increase the public funder's reliance on a small number of large providers. At the same time, complex offshore ownership structures stretch from Singapore to the Cayman Islands, Luxembourg and the Bahamas. We are concerned these structures may be drawing resources away from frontline delivery and into financial returns.

HAUORA MĀORI FUNDING

Despite guarantees set out in Te Tiriti o Waitangi, there are persistent, unfair, and unjust differences in health outcomes for Māori compared with non-Māori in New Zealand. This Māori health inequity is an outcome of colonisation and the alienation of whenua, which left Māori communities disproportionately exposed to poverty and substandard housing. Ongoing actions (such as the Tohunga Suppression Act 1907, which criminalised traditional healing practices) and inaction (such as inadequate responses when Māori were disproportionately

impacted by introduced diseases, such as the 1918 influenza pandemic, and insufficient monitoring and accountability across the health system) mean the inequities continue today. At 75.8 years, Māori life expectancy lags the 82.8 year life expectancy of pākehā.⁴⁴ Māori adults are 50% more likely to have diabetes than non-Māori and have heart disease rates twice as high as non-Māori, while Māori women experience lung cancer at three times the rate of non-Māori.⁴⁵

These persistent disparities have shaped policy, as iwi, hapū and Māori communities have sought to establish tino rangatiratanga within health. Broadly speaking, advocacy by Māori for a more effective health system can be traced to the very establishment of the health system. The 1970s marked an era described as “the beginning of a sea change in Crown-Māori relations.”⁴⁶ Māori collectives and individuals sought more involvement in policy and agenda setting, and eventually in the direct provision of services, with the aim of improving whānau outcomes and wellbeing.

Although the ‘purchaser-provider’ health sector reforms of the 1990s opened up space for Māori health entities to deliver culturally centred health and care services that were ‘by Māori, for Māori,’ several Māori groups had already begun to establish community health clinics. The reforms, in the words of Professor Mason Durie, “simply allowed plans and programmes



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in place to find new expression.” This included moving into providing mainstream services and securing primary health care contracts.

Māori health organisations operate in a variety of ways. In addition to being funded through mainstream service contracts (like primary health care and mental health services) there is some dedicated funding for Māori health services. One of these, ‘Hauora Māori’ was formalised as a specific budget appropriation within Vote Health by the Clark government in 1999, with funds managed by the Ministry of Health and DHBs. Whānau Ora was established in 2010 as a funded programme and administered by Te Puni Kōkiri (Vote Māori Development) with support from the Ministries of Health and Social Development.⁴⁷ In 2014, it moved to an NGO-commissioning model – through this programme providers were able to supplement or support existing service contracts with funding to implement family-centred, whānau ora approaches using, for example, whānau ora navigators.

Māori-owned health services are defined by the Ministry of Health as suppliers of services that are owned and governed by Māori and are providing health and disability services primarily but not exclusively for Māori.⁴⁸ Accurately tracking the number of Māori health providers is difficult because of changes in organisational ownership and structures through mergers, acquisitions, closures, the

use of subsidiaries and training names, and the volatility of funding cycles which sees some providers not receiving funding every financial year.

The Ministry of Health reported there were around 370 Māori health providers in 2024/25, which is 50 more than reported in the 2023/24 year. The increase in providers is made up of new providers identified through new Health New Zealand contracts.⁴⁹ Funding to Māori health providers has increased from \$585 million in 2020/21 to \$1.1 billion in 2024/25, an 87% increase, driven by a \$201 million increase in Hauora Māori services and \$157.5 million in mental health services.⁵⁰ While these increases are significant, the Hauora Māori budget is still only 4.2% of Vote Health, down from 4.4% in the previous year. In a review of Budget 2026, Dr Bill Rosenberg and Dr Jacqueline Cumming outlined that Hauora Māori services needed an additional \$669 million in funding per year, that underfunded Māori PHOs should receive a further \$611 million (following the primary health care findings in WAI 2575) and that \$435.7 million was needed to fund comprehensive Hauora Māori Services.⁵¹

Health and wellbeing are inextricably linked to Te Tiriti o Waitangi, where article two guarantees Māori tino rangatiranga over taonga like health, while article three guarantees Māori the same rights and

privileges as non-Māori, including the right to equal health.⁵² The Crown has a responsibility to provide equitable public services, including health services. At the same time, Māori exercise enduring authority over matters affecting their health and wellbeing. These dynamics are being examined in the Waitangi Tribunal's Wai 2575 Health Services and Outcomes Kaupapa Inquiry, which in its first stage (looking into primary health care) highlighted the persistence of significant health inequities and underscored the crucial role of Māori in the design, governance and delivery of healthcare in Aotearoa. Kaupapa Māori health providers are targeting these inequities, delivering culturally-grounded care and demonstrating how Māori-led models of health sovereignty can transform public services. These models centre whānau outcomes and long-term wellbeing, providing an important alternative to Western healthcare models.⁵³

Ngāti Hine Health Trust in Te Tai Tokerau exemplifies these approaches, operating well beyond the traditional clinical silos by combining primary care, community outreach and holistic wellbeing initiatives to address deep-seated health inequities. Te Puia Hospital is the only iwi-owned hospital

and represents an important high-water mark of health sovereignty. Owned by the Ngāti Porou Hauora Trust, the hospital is publicly contracted to deliver primary care, aged residential care, emergency care and general capacity, but is underwritten by Ngāti Porou iwi which can target its own health care objectives. In Rotorua, Ngāti Whakaeue has launched a papakāinga model of aged care. Located on the existing Manawa Gardens papakāinga, kaumātua are supported to age in place on ancestral land, formalising and supporting unpaid whānau carers that were already filling gaps in the public health system.

In 2018, Ngāti Whātua Ōrākei inked a deal with insurer nib New Zealand to provide free universal private health insurance for members of the hapū, with all premiums and excess payables met by the hapū. "This is not about snubbing any of the public health system" said Ngāti Whātua Ōrākei chairperson Marama Royal, which continues to play a major role in providing services.⁵⁴ Tumu whakarae Tom Irvine said the scheme differs from employer-paid insurance schemes by covering pre-existing conditions, and is therefore focused on early identification and long-term investment in hauora.⁵⁵



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IWI CAPITAL AND PRIVATE HEALTHCARE

The examples above can be characterised as Māori (iwi, hapū, community) responses to addressing Māori health need and aspirations by providing (or in the case of Ngāti Whatua example, funding) services. However, there are other examples about Māori investment in the business of health. While these could still be for larger Māori development goals, they are removed from a singular focus on improving and increasing health care provision for Māori. Iwi and Māori investment firms are acquiring growing stakes in primary care, diagnostics and health infrastructure. These investors are mandated to grow and protect an intergenerational asset base and are taking equity positions within the for-profit healthcare system.

Iwi co-investment vehicle Te Pūia Tāpapa has co-invested \$94 million in large-scale Aotearoa New Zealand businesses and assets. Its investment approach “is different to a typical New Zealand private equity fund,” focusing on “generational investment periods of 15-20 years.”⁵⁶ It is a preferred partner of the NZ Super Fund, and in 2020 it acquired a 4% stake in pathology market leader Awanui in a leveraged buyout deal alongside the Super Fund and the

Ontario Teachers’ Pension Plan. In 2022, Te Pūia Tāpapa acquired a 5% stake in Evolution Healthcare which delivers private surgical and specialist healthcare services alongside the Queensland government investment vehicle and pension fund Australian Retirement Trust.

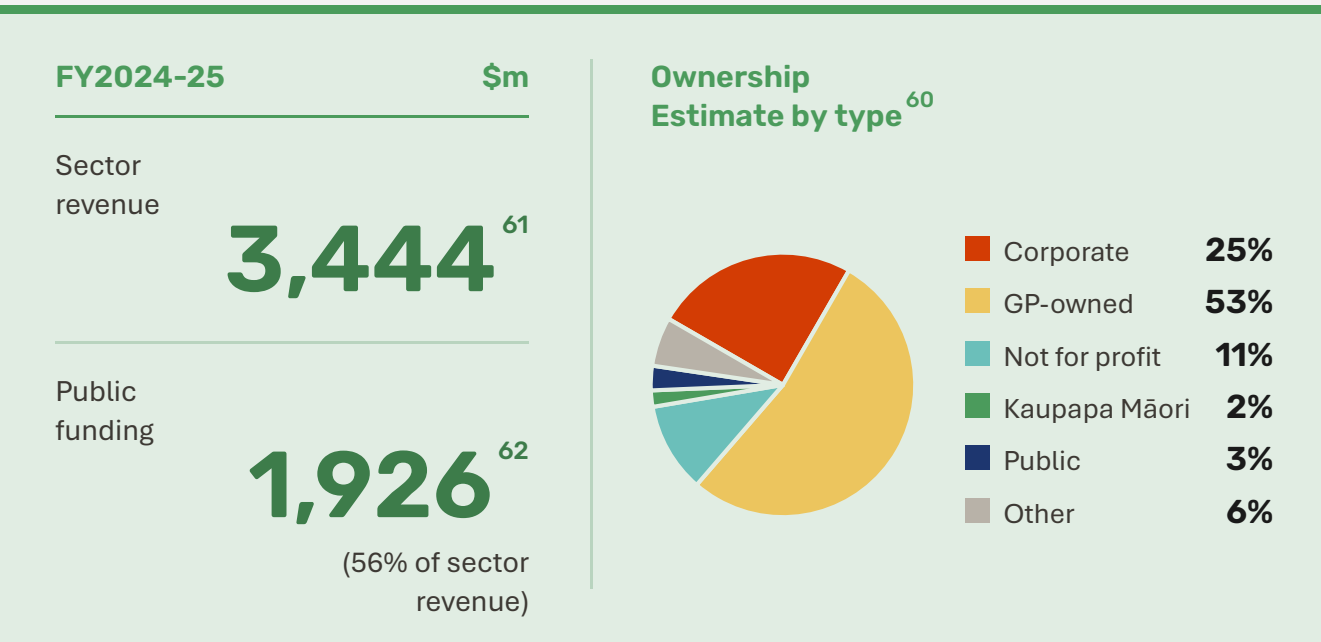
In September 2024, Ngāi Tahu Holdings acquired a 0.8% stake in emerging telehealth and general practice provider Tend as part of its “New Economy to support innovative and sustainable business through the motu” said Ngāi Tahu Holdings Chief Executive Todd Moyle.⁵⁷ A year later, Ahuahu Group, the commercial arm of Te Nehenehenui Trust acquired a 0.88% stake, and in February 2026 Ngāti Whātua Ōrākei took a similar 0.88% stake. In a subsequent transaction, iwi capital backed Tend to acquire Green Cross Health’s 65 ‘The Doctors’ clinics. Ngāi Tahu’s stake jumped to 24.7%, while Ngāti Whātua’s climbed to 2.43%.⁵⁸ Ngati Porou’s Nāti growth fund also acquired an undisclosed shareholding, with their spokespeople noting that “For whānau living on the East Coast, distance, limited local services, severe weather and disruption to transport networks can make getting to a medical centre difficult.”⁵⁹ That \$270 million takeover deal will create the largest single primary care provider in the country with 10% share of the primary care market based on enrolled population.

General Practice



HEADLINE FINDINGS

1. Public funding now accounts for 55% of general practice revenue, up from below 50% in the last two years.
2. Corporate ownership has risen from 14% of practices in 2022 to an estimated 25% in 2026, following TPG's acquisition of Tāmaki Health and Tend's purchase of The Doctors.
3. The debt-funded Tāmaki Health deal appears to be structured through the Cayman Islands, borrowed at roughly double current public borrowing rates.



Primary care is a completely outsourced part of the health system by design. Unlike, for example, the National Health Service in the United Kingdom, here in Aotearoa New Zealand our primary care system, specifically our general practice services have generally never been publicly owned. It was a carve out

in the 1938 Social Security Act, the legislation that established the free and universal public health system in Aotearoa, to protect the private interests, income and autonomy of doctors who could continue to directly charge patient fees for services. Instead of a fully state-funded, free GP service, the Government



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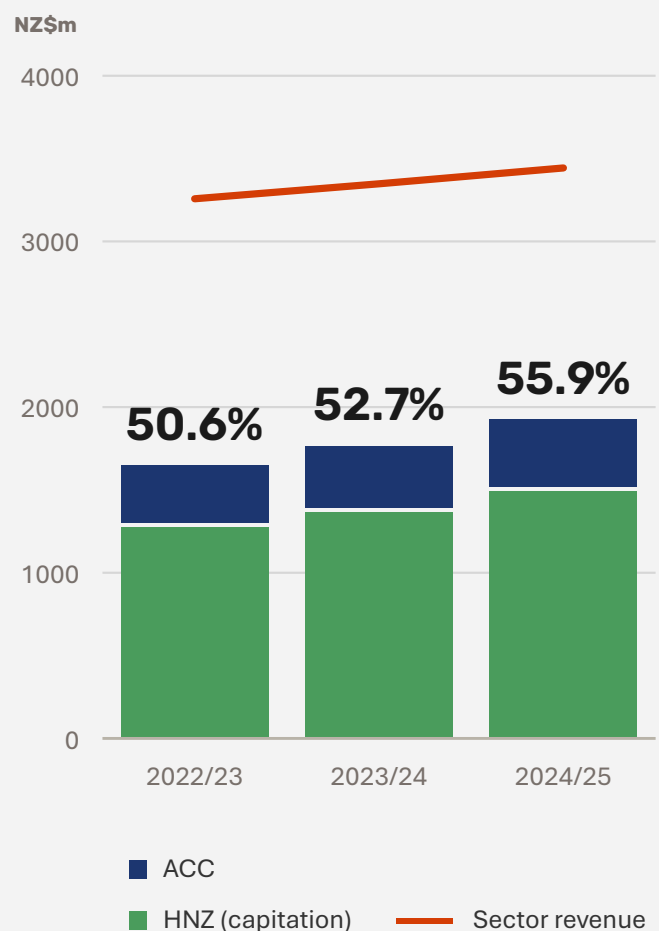
introduced a **fee-for-service subsidy system** in 1941 that allowed doctors to receive government funding while still charging patient fees on top of public money.⁶³

The development of general practice entirely within the private sector paved the way for barriers to access, prevention and early intervention of health issues, and inequities in health outcomes ever since. It has also paved the way for the wave of corporate consolidation that we are seeing today. Primary care receives substantial public funding but is privately delivered.⁶⁴ Public funding comes from HNZ through ‘capitation payments’ and ACC funding for injury-related consultation and treatment. Capitation payments are the primary component, set according to age, gender and deprivation criteria of the enrolled population on the provider’s books. These payments are made by HNZ to Primary Health Organisations (PHOs), who then distribute funding to general practices. In 2024/25, there were 956 general practices in Aotearoa, making up the vast majority of primary care service delivery in the country. 2022 data suggests 3% of general practice is public, comprised largely of university services (student health) and 1% DHB-ownership.⁶⁵

Capitation funding paid by HNZ makes up the largest share of general practice medical services revenue, with the general practice funding appropriation reaching \$1.489 billion in 2024/25.⁶⁶ ACC also provides public funding for injury-related consultations and

procedures at general practices. In 2024, for example, 34.9% of ACC claims were lodged in general practice, while another 17.1% were lodged in urgent care.⁶⁷ While ACC does not present this figure in its annual reports, we estimate it totals around \$400 million in 2024.⁶⁸ Figure 7 shows the HNZ and ACC components of public funding to the general practice sector as a share of total sector revenue, which we estimate has reached 54.9% in 2024/25. This proportion has increased meaningfully since 2022/23, when it was still less than 50%.

Figure 7 | General practice medical services



There is likely to also be an element of third party and commercial revenue in the mix for the general practice sector, as well as a small amount of revenue from contracts with iwi and charitable trusts. Out of pocket expenses – patient co-payments – make up the remainder of revenue. In 2022, Max Rashbrooke estimated the cost of removing GP fees, effectively quantifying the cost of co-payments at \$744 million to \$1 billion.⁶⁹ We have not calculated an exact figure, however, it likely sits around 35-40% of sector revenue.

Corporate ownership in the general practice sector has risen sharply in recent years, up from 14% of practices in 2022⁷⁰ to an estimated quarter of practices in 2026.⁷¹ Two transactions involving the three largest companies have materially increased consolidation in the sector. Both transactions involve classic private equity roll-up strategies, in which an investor acquires numerous providers in a market to achieve a dominant position.⁷² New Zealand may be sleepwalking into the same problems in health that it has faced with banks, petrol stations and supermarkets. It is essential we deal with these potential issues now, rather than wait for a crisis in consolidation, affordability and access later.

TPG ACQUIRES TAMAKI HEALTH

In March 2026, US private equity giant TPG closed a deal to acquire Tāmaki Health’s 51 GP and urgent care clinics across the country with more than enrolled 350,000 patients for a reported \$450m.⁷³ Tāmaki Health was already under private equity ownership, with Australian fund Mercury Capital acquiring 49.44% of shares in 2017. Mercury executed a buy-and-build strategy to consolidate its market share and in April 2022 paid \$77 million to acquire a further 50% of shares, increasing its position to 98.99%.⁷⁴ Tāmaki Health have not published financial statements over this period, but the difference in sale prices between the 2022 and 2026 transactions suggest the firm’s value almost tripled over four years.

The vast majority of shares (95%) in the ultimate NZ holding company are owned by Singaporean ‘TECA Lorient SG Pte Limited’.⁷⁵ TECA stands for ‘TPG Emerging Capital Asia’, and US filings notes that TECA “targets control-oriented transactions” and invests “in profitable companies benefitting from regional tailwinds.”⁷⁶ There is limited public information on the transaction, but the Overseas Investment Office shows ownership going from 72% NZ ownership to just 5%.⁷⁷ In a subsequent transaction on 31 July, a related subsidiary called ‘TECA SF Pte. Ltd’



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sold “indirect interests” in “up to 50% of the shares in New Zealand healthcare business ETHC Group Limited” (Tamaki Health) to Dutch pension fund ABP.⁷⁸ US disclosure for TPG from 2025 lists a similarly named subsidiary – TECA Finance (AUD), L. P. – registered in the Cayman Islands,⁷⁹ suggesting that above the Singapore holding companies, the ownership chain may run through one of the world’s most notorious tax havens.

Law firm Kirkland and Ellis advised TPG on debt financing for the acquisition,⁸⁰ and the deal appears to be a ‘leveraged buyout.’ This means the transaction is funded by debt taken on by the acquired company itself. Blackrock-owned fund HPS Corporate Lending Fund lists \$105 million in senior secured debt to Tāmaki Health Group at an interest rate of 9.65%,⁸¹ roughly double the current long-term rate of sovereign borrowing. This would suggest annual finance costs of \$10.15 million per year on this tranche of debt alone. The total debt-to-equity mix on the transaction is not publicly reported, but a relatively conservative 50:50 mix on a \$450 million transaction at similar interest rates would incur annual finance costs of almost \$22 million.⁸² This may mean that a substantial proportion of capitation funding is effectively pre-committed to paying interest payments, drawing resources away from frontline care. If interest costs reflect the cost of acquiring a profitable business, it raises questions about the role of public funding supporting private

finance arrangements, and whether greater efficiencies could be achieved through direct public provision.

TPG investments in healthcare in other parts of the world have raised concerns, with human rights concerns emerging at the Evercare Group in Kenya, including aggressive billing practices, detention of patients with unpaid medical debts and aggressive cost-cutting measures.⁸³

TEND ACQUISITION OF GREEN CROSS MEDICAL

In June 2026, emerging telehealth provider Tend Health entered into an agreement to acquire Green Cross Health’s ‘The Doctors’ network for \$270m, comprising 65 clinics and 400,000+ patients. **This will increase the Tend network to 90+ clinics and around 10% of the enrolled population, making it the largest general practice and online telehealth provider in the country.**⁸⁴

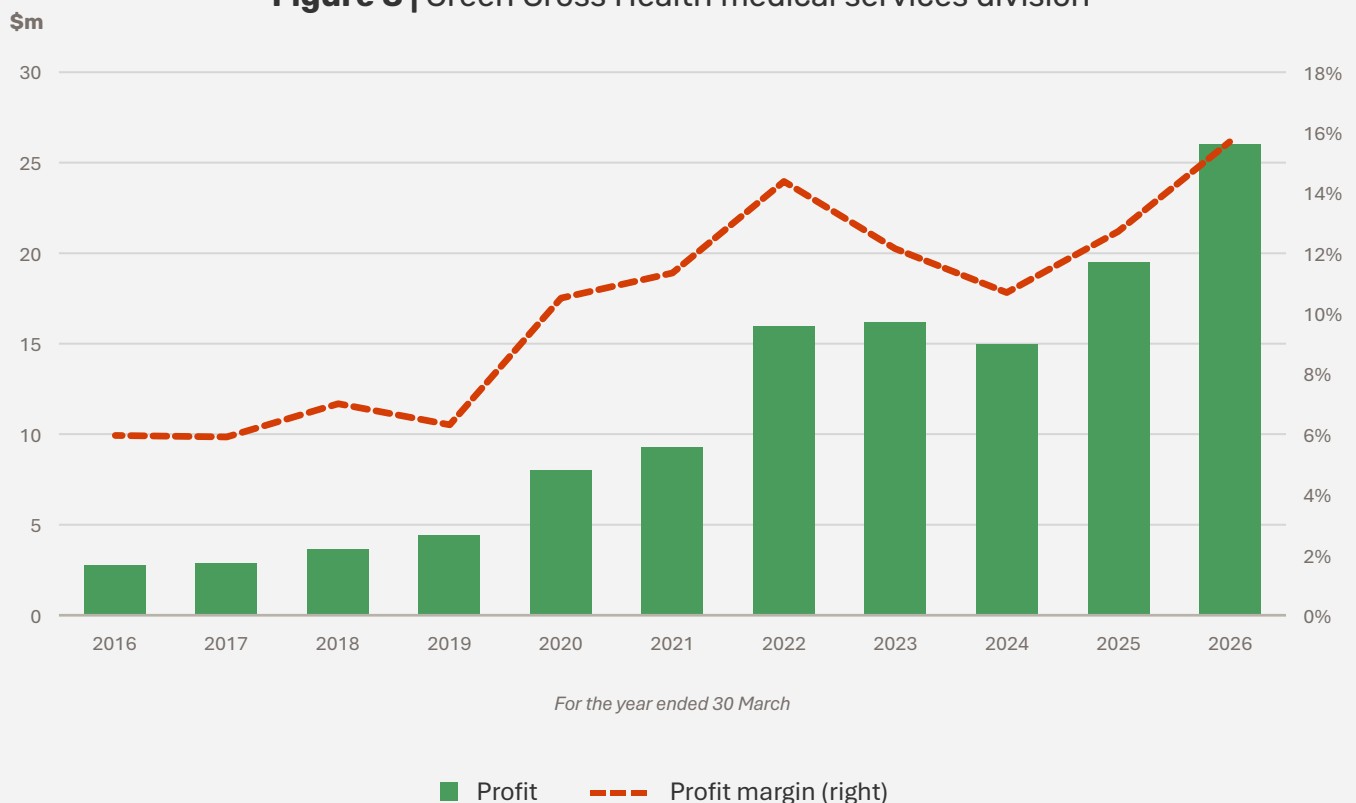
Green Cross Health evolved from the 2009 merger of Life Pharmacy and Unichem to form Pharmacybrands.⁸⁵ In 2011, with retail pharmacy margins under pressure, Pharmacybrands pivoted to the primary care sector, acquiring around 20 clinics under ‘The Doctors’ label, growing to 36 clinics by 2014. In 2016, they rebranded to Green Cross Health and listed on the NZX, but almost two

thirds of shares remain concentrated between three key investors, NZ businessmen Andrew Bagnall and Peter Merton, and a Bahamas holding company on behalf of Swiss-based ‘Zuellig Incorporated’.⁸⁶

Growth continued until 2026 when The Doctors reached 65 clinics across the country. From

2020 to 2026, medical services revenue grew by 117%, from \$76.5 million to \$165.8 million (total revenue of \$546 million including the pharmacy network). 2026 was the first year in which profit from Green Cross’ medical services division (\$26 million) surpassed profit from the retail division (\$22.2 million), with margins reaching a record 16% that year.

Figure 8 | Green Cross Health medical services division



In April 2026, Green Cross Health’s GP clinics were being targeted by Adamantem Capital, Australian buyout firm.⁸⁷ Genesis Capital and Tend Health were also competitors in the

running. In June 2026, Tend announced it had entered into a conditional sale and purchase agreement to acquire the medical division for \$270 million, subject to regulatory approval.⁸⁸



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Tend was established in 2020 by entrepreneurs Cecilia and James Robinson as a digital-first health provider that pivoted to a hybrid model that is digitally enabled. They have secured investment from a number iwi investment firms – Ngāi Tahu Holdings is the largest shareholder (24.71%), Ngāti Whātua Ōrākei's Whai Rawa Capital Investments holds 2.43% and Ngāti Maniapoto's Ahuahu Group's has 0.4% – alongside NZ-based private equity fund Pencarrow and insider shareholdings.⁸⁹ In 2025, Tend achieved the significant milestone of becoming its own PHO, allowing the firm to contract directly with Te Whatu Ora HNZ.⁹⁰

Servicing expensive private acquisition debt and delivering returns to shareholders diverts

a share of sector revenue away from frontline health delivery. Through long-standing funding arrangements, the general practice sector has been structured in a way that accommodates these outcomes. Despite consistent and growing public funding, there are limited requirements on providers to disclose the level of public funding received, the profitability of their operations or the numbers or remuneration of their workforce. Increasing corporate ownership and debt leverage within the sector raise questions around whether current accountability settings are sufficient, and whether alternative models of ownership and service delivery could deliver better value from public health expenditure.

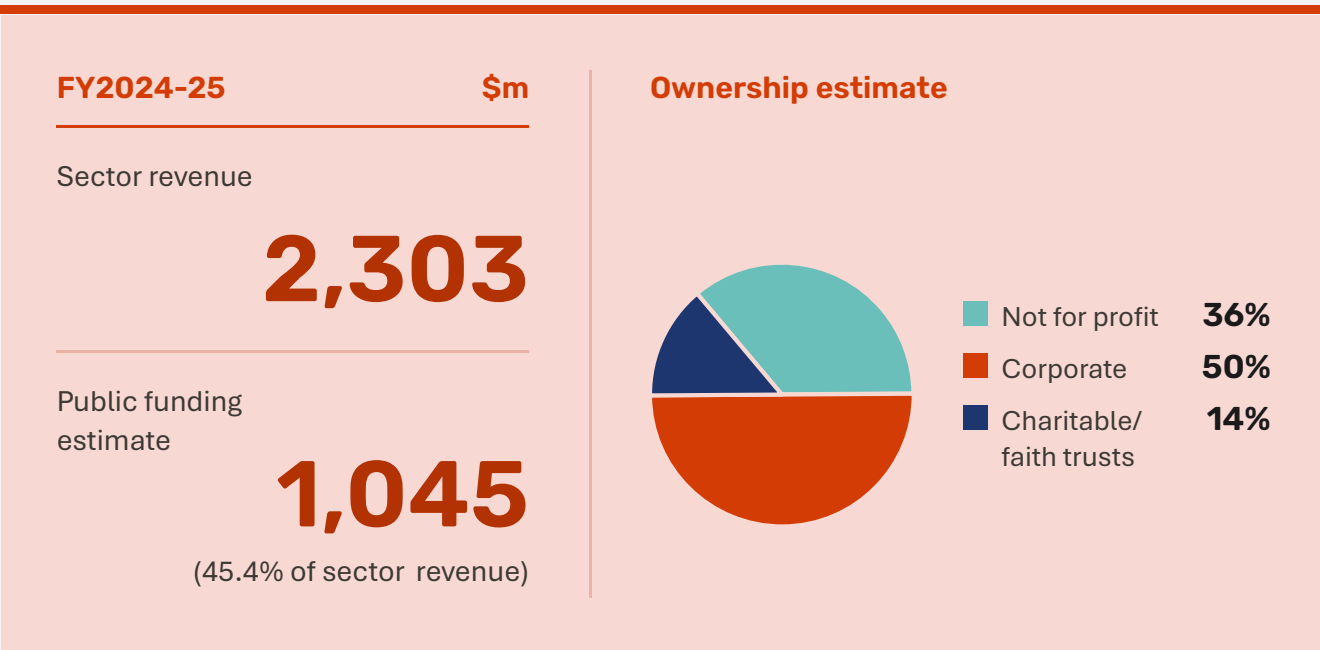
Private hospitals

(including elective surgery and procedural treatment)



HEADLINE FINDINGS

1. Publicly-funded elective surgeries have grown by 93% in four years to more than a billion dollars in 2024/25.
2. Public funding makes up an estimated 45.3% of private hospital revenue, up from 35.1% five years ago.
3. Three entities control 70% of the private hospital market (by bed count).



The country's 86 public hospitals⁹¹ remain the majority provider of surgeries and procedural treatments by volume, but outsourcing to private hospitals has increased in recent years. There are three major players who make up 70% of the private market (by bed count):⁹²

Evolution Healthcare operate 12 facilities primarily in Wellington and Auckland, Southern Cross operate 23 facilities across New Zealand and Allevia/Health Care Holdings operate 8 facilities in the Northern and Te Waipounamou regions.⁹³



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These providers are playing an increasing role in the delivery of publicly funded, publicly planned elective surgical procedures. However, these providers are entering into central planning in the production of treatment services beyond supplementing district demand and capacity constraints. HNZ and private providers are “competing for the same limited workforce,” which means that expansion of private surgical capacity will always be a further drain on public sector capacity and sustainability. HNZ briefings estimate an additional 10-15% of activity in planned care is required to keep up with the estimated growth in patient need and progressively treat more patients who have exceeded the government planned care target of 120 days.⁹⁴

ACC purchases private surgical treatments and procedures from the private sector, motivated in part by the fiscal drivers to reduce compensation liabilities and see claimants return to work as quickly as possible. With more than 90% of ACC-funded surgeries performed in private hospitals,⁹⁵ this publicly underwritten revenue stream enabled private hospital operators to scale up surgical capacity. Widespread cancellations of planned public care during the pandemic created a substantial backlog across the public system, prompting a move towards outsourcing the public elective surgery waitlist. Data from the NZ Private Surgical Hospitals Association data shows just over 230,000 private surgical discharges in 2024/25, roughly two-thirds of all elective surgery performed in New Zealand.⁹⁶

Figure 9 | Private hospital revenue and estimate public funding

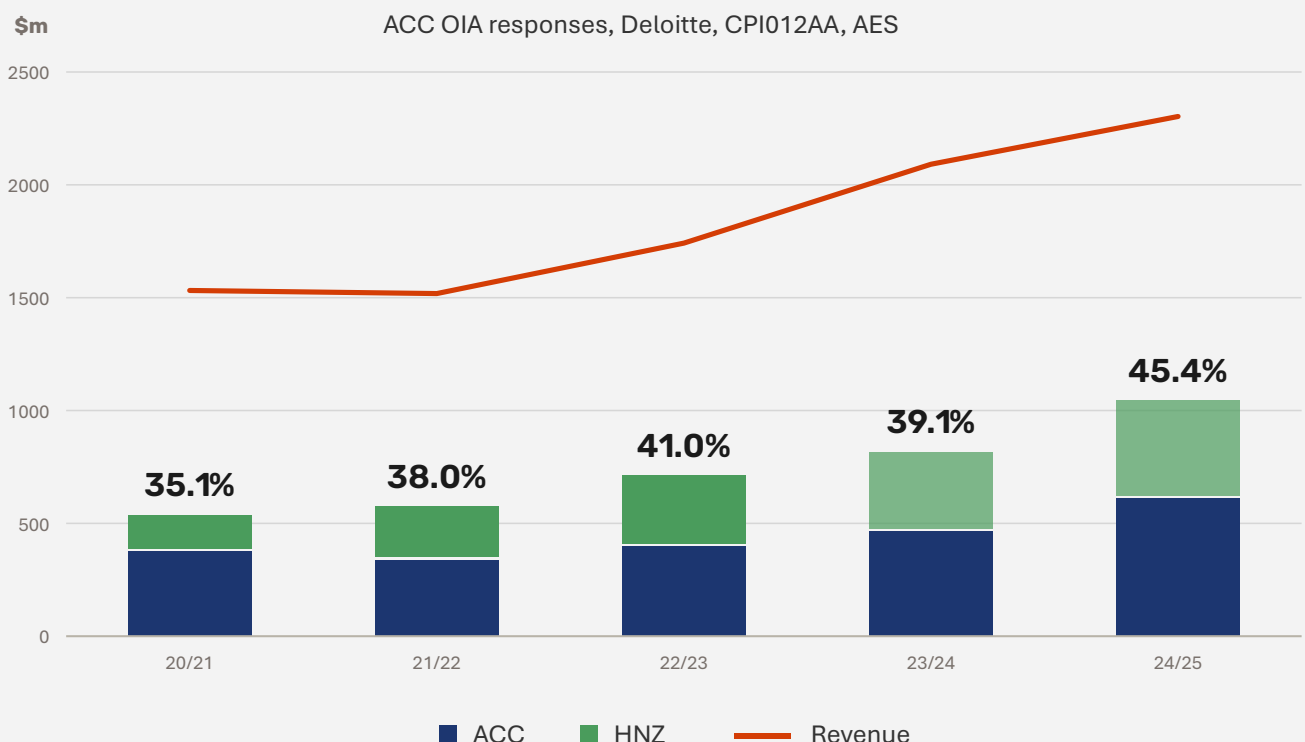


Figure 9 estimates the total of spending on elective surgeries from 2020/21 to 2024/25 from both ACC and HNZ. Across both sources, we estimate that spending on elective surgery outsourcing has increased by 94% over this period, from \$538 million in 2020/21 to \$1,045 million in 2024/25. ACC increased from \$375m to \$609 million over this period, a 65% increase.⁹⁷ **HNZ outsourcing has increased from \$163 million in 2021 to an estimated \$433 million in 2024/25,⁹⁸ which would be a 167% increase over the five-year period.** In August 2026, HNZ noted that its annual outsourced elective surgery budget was \$942 million for 2026/27, which included \$298.4 million in four-year funding,⁹⁹ binding future governments to the outsourcing of elective surgery. Using these figures estimated above, it appears that public funding from HNZ and ACC accounted for 45.4% of hospital sector revenue in 2024/25. Private hospital revenue totalled \$2.3 billion that year, a 57% increase over the previous five years.¹⁰⁰

While HNZ have refused to reveal how much it is paying private hospitals to perform elective surgeries, a HNZ report to the Executive Leadership Team identified outsourcing as the costliest of its options, stating, “[w]here physical capacity is available the lowest cost for additional planned care is through improved productivity of internal provision, the second lowest cost is the marginal

cost of insourcing and then outsourcing.”¹⁰¹ That report then mentions outsourcing has historically “resulted in lost opportunity to manage price, quality and the complexity of the work outsourced.”¹⁰²

SOUTHERN CROSS HEALTHCARE

Southern Cross Healthcare calls itself the largest private hospital provider in New Zealand, with 20 wholly-owned or joint-venture hospitals and surgical centres in 2025, serving 118,000+ patients.¹⁰³ It is owned by a charitable trust rather than private shareholders, and operates alongside the Southern Cross Health Society, the largest health insurer in the country with over 950,000 members (roughly 60% of all privately insured New Zealanders).¹⁰⁴ Southern Cross Healthcare publishes a very limited annual return on the Charities Register, which lists ‘revenue from providing goods and services’ at \$683.9 million in the year to 30 June 2025, with a surplus of \$50.7 million that year.¹⁰⁵ Southern Cross Healthcare appears to have grown substantially in recent years, with revenue up 81% from 2022’s \$377.8 million.¹⁰⁶ They do not provide documentation of public revenue sources, although recent reporting confirms they will receive funding from HNZ to help treat backlogs of orthopaedic patients.¹⁰⁷



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EVOLUTION HEALTHCARE

Evolution is the second largest player in the NZ private hospital market, owning Wellington's Wakefield and Bowen Hospitals, as well as Royston Hospital in Hawke's Bay. It is also a joint venture partner in Tauranga's Grace Hospital,¹⁰⁸ and has investments in other health subsectors, including community rehabilitation, residential disability services and cancer care.¹⁰⁹

In 2014, Evolution (via investment vehicle Connor Healthcare Limited) launched a takeover bid of the NZX-listed Acurity Health Group, which owned the Wakefield, Bowen and Royston hospitals.¹¹⁰ By early 2015, the deal was completed and Acurity was taken private (removed from the sharemarket). In November 2017, they received approval for a substantial real estate deal with the Vital Healthcare Property Trust, in which the Trust acquired the land and buildings at Wakefield, Bowen and Royston Hospitals and committed to \$106.5 million to expand those hospitals,¹¹¹ with the properties then leased back to Acurity. Such transactions, often referred to as 'sale-leasebacks' are a way of generating one-off revenue to an operator which can be used to invest or deliver returns to shareholders. In other jurisdictions like the United States these transactions have typically been used to finance dividends to shareholders while saddling hospitals with long-term lease

liabilities that divert operational funds from direct patient care to real estate investment vehicles.¹¹²

In April 2018, former National Party Health Minister Dr Jonathan Coleman stepped down from politics and assumed the position of Chief Executive Officer at Evolution.¹¹³ In September of that year, Australian private equity fund Pacific Equity Partners acquired a controlling stake in Evolution, in a deal that was rumoured to be worth more than A\$300 million.¹¹⁴ In November 2020, Evolution and JV partner Southern Cross entered into another sale-leaseback deal with Vital Healthcare Property Trust over Grace Hospital in Tauranga.¹¹⁵

In 2022, Evolution was sold to a consortium involving the Queensland government's QIC Group and superannuation fund Australian Retirement Trust, for \$746 million.¹¹⁶ Iwi investment vehicle Te Pūia Tāpapa, which is owned by 28 Iwi and Māori entities, also has a 5% shareholding. The deal was structured through a wholly-owned subsidiary called NZ Healthcare Bidco Limited. Financial statements for its parent company, NZ Healthcare Holdco Limited, half a billion dollars of borrowing¹¹⁷ at the time of the deal, comprising \$355 million in shareholder borrowings and a further \$122.8 million in bank borrowings.¹¹⁸

Interest expenses on those two loans have totalled \$128.5 million over the subsequent three years, helping to ensure that Evolution

Healthcare has never been able to generate taxable income.¹¹⁹ But for these expenses, Evolution would have generated taxable income over the last two years; instead it has generated a loss, which in turn means it is generating income tax credits.¹²⁰ Total interest payments over this period total only \$44.4 million, with most of the interest expense capitalised onto the loans themselves, bringing total borrowings to \$590.3 million in 2025.¹²¹ Interest rates on the bank borrowing have fluctuated between 7.1 and 9.3%, while the shareholder loan appears to carry an interest rate of around 7.8%.¹²² The financial statements do show some ‘specialist contract revenue’ relating to HNZ and ACC contract revenue, but this does not appear to be a complete accounting of the public expenditure. Nonetheless, the extent of public funding, the high interest rates and the growing debt burden raise questions about the long-term sustainability of increasingly leveraged models of healthcare provision to meet public needs.

ALLEVIA (HEALTHCARE HOLDINGS LIMITED)

Healthcare Holdings Limited was formed with the establishment of Ascot private hospital in Remuera (Auckland) in 1998, merging with Mercy hospital in Epsom in 2001 and establishing the MercyAscot surgical network. Nearly half (41.65%) of Healthcare

Holdings’ shares are held by Albert Park Trustee Company,¹²³ an investment vehicle of Warehouse founder Sir Stephen Tindall, who has been a key shareholder in the firm for decades.¹²⁴

In August 2011, Waterman Private Capital acquired a 22% share of Healthcare Holdings Limited, enabling a channel for investment for both the NZ Super Fund¹²⁵ and ACC.¹²⁶ Today Waterman has a total Allevia shareholding of 34.3% through two different limited partnerships.¹²⁷ Until recently Waterman Private Capital was also the sole owner of New Zealand Clinical Research, but on 20 August 2026 announced that it had sold a majority position to leading global private equity investor Advent International.¹²⁸ While the terms of that deal were not publicly available, the company was valued at US\$715 million (NZ\$1.2 billion).¹²⁹ Waterman has also previously held stakes in diagnostic and oncology provider Canopy Healthcare, e-health provider Health Link and life insurance Partners Life.¹³⁰

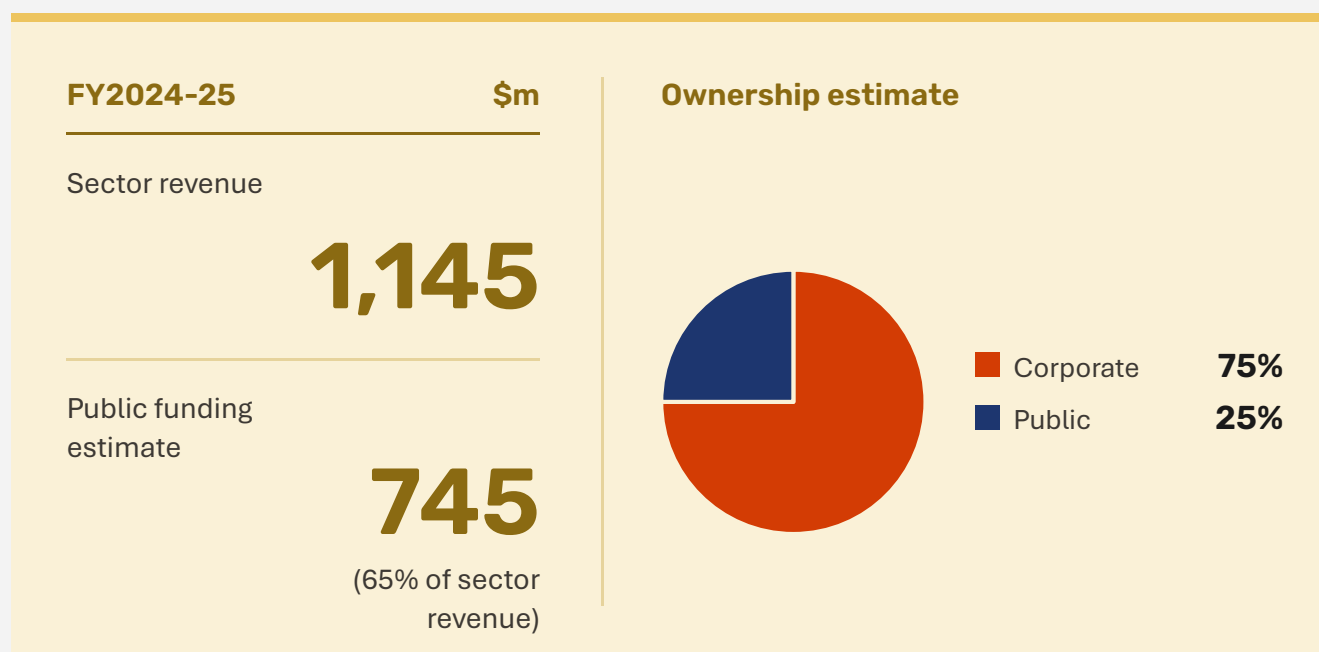
As a primarily NZ-owned private firm, Allevia/ Healthcare Holdings are not required to publish financial statements on the NZ companies register. It is reported to be the largest private healthcare group in the large Auckland market¹³¹ with some 22 operating theatres. In May 2025, it opened the new \$150 million Gilgit Wing at Mercy Hospital¹³² and in August 2025 opened a new Radiation Oncology centre on the North Shore in partnership with Southern Cross Healthcare.

Diagnostic, imaging and radiology services



HEADLINE FINDINGS

1. Public funding accounts for an estimated 65% of sector revenue, with community laboratory almost entirely contracted out.
2. Awanui Labs holds an estimated 75% of the laboratory market and handles 98% of referrals.
3. Debt-funded private equity roll-up RHCNZ delivers more than third of radiology services.



While NZ's public hospitals still provide essential diagnostic capacity, successive governments have relied on contracting, outsourcing and private investment to meet growing demand for community testing and advanced imaging. These newer technologies developed during an era of outsourcing, and little of this specialist capacity has been

developed or retained in the public sector. In recent years, specialist-owned clinics, corporate radiology groups and outsourced community laboratory capacity have been consolidated into dominant consolidated platforms, backed by infrastructure funds, pension funds and private equity-style finance.

AWANUI LABS DOMINATES DIAGNOSTICS

HNZ operates 56% of hospital laboratories directly, but GP-referred testing is almost entirely contracted out to private providers under regional HNZ contracts.¹³³ That market is dominated by one company, Awanui Labs, which alone handles a reported 98% of community referrals and 35% of hospital-referred testing.¹³⁴ Awanui's 75% market share dwarfs its next largest competitors, the East Coast-focused Pathlab (16%) and ASX-listed Sonic Healthcare (9%). And yet, despite Awanui's dominant market position, it remains heavily indebted and seemingly unable to generate taxable profits.

NZ began outsourcing community laboratory testing in the 1990s, with Dunedin-based Southern Community Laboratories leading the acquisition of competitors.¹³⁵ The emerging market attracted Australian corporate healthcare provider Healthscope, who began acquiring pathology providers, forming Labtests in 2006 to tender for the lucrative Auckland DHB contract, before going on to acquire Southern Community Laboratories. In 2015 the pathology business was rebranded as Asia Pacific Healthcare Group (APHG), but when Brookfield acquired Healthscope in 2019 in a \$5.7 billion leveraged buyout, APHG was put up for sale.

The resulting deal in November 2020 was also a leveraged buyout. A consortium involving the NZ Super Fund (48%), the Ontario Teachers' Pension Plan (48%) and Te Pūia Tāpapa iwi investment fund (~4%) in the \$550 million deal.¹³⁶ That deal was a leveraged buyout where the buyers incorporated a firm called NZ Health Investments Limited which took on around \$325 million in debt to finance the acquisition.¹³⁷ Financial statements show that in 2022 the APHG holding company paid out a dividend of \$39.9 million to shareholders and returned \$100.2 million in capital to shareholders, partly funded by a \$37 million increase in borrowing that year.¹³⁸ While this kind of transaction delivers immediate cashflow to investors it further ratchets up indebtedness and with it, interest expenses.

In 2023, APHG was rebranded as Awanui Labs. While still benefiting from largely publicly-funded revenues in excess of \$300 million a year, it has been unable to achieve a taxable income in any year since due to rising finance costs, which surged to more than \$30 million in 2023 and stayed above \$25 million in each subsequent year. Pre-tax losses reached \$21.4 million in 2024.¹³⁹ Elevated interest rates are part of the story here, but their effect is magnified by the decision to deliver \$140.2 million in dividends and returned capital to shareholders in 2022.

In August 2026, it was reported the HNZ was preparing to go to market for a "Radiology Modernisation Programme" valued between



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\$50-\$100 million “to create a single, connected radiology services, replacing fragmented systems in use across the country.”¹⁴⁰ The tender went live on 25 September 2026 and is currently open.

RHCNZ LEADS IMAGING AND RADIOLOGY

In the year to 28 February 2025, HNZ outsourced 169,276 scans at a cost \$100.6 million, in addition to the ~\$40 million in annual contracts for community radiology services funded by HNZ.¹⁴¹ RNZ reports that in 2022/23 ACC spent almost \$130 million on medical imaging scans, up 12% in that year.¹⁴² We estimate that in 2024/25 these combined totals reached around \$290 million, which accounts for around 55% of total delivery. RHCNZ is the largest provider, however it does not explicitly account for the public share of its revenue.

RHCNZ Medical Imaging Group delivers over 35% of the country’s radiology services through the brands Auckland Radiology Group, Bay Radiology and Pacific Radiology Group. At 31 March 2026, RHCNZ operated a network of 66 clinics around the country, with 56.8% of shares in RHCNZ are held by NZ infrastructure investor Infratil.¹⁴³ Infratil also owns a 59.5% interest in QScan, which operates a network of 80 clinics across metropolitan and regional Australia, as well as Anytime Radiology, that provides after-hours services on both sides of the Tasman.¹⁴⁴

Infratil executed a rapid consolidation of key players in the sector in 2021. In April 2021, they had agreed to buy between 50.1% and 60% in Pacific Radiology for \$350 million.¹⁴⁵ In October of that year Infratil and Pacific Radiology announced they had executed a conditional agreement “to partner” with Auckland Radiology Group, with Infratil owning “at least 50.1% of the combined platform.”¹⁴⁶ By December 2021, it had announced it would also “partner with” Bay Radiology, and that “on completion of the acquisition Infratil will own approximately 50.8% of the combined platform.”¹⁴⁷ That stake has now grown to 56%.¹⁴⁸

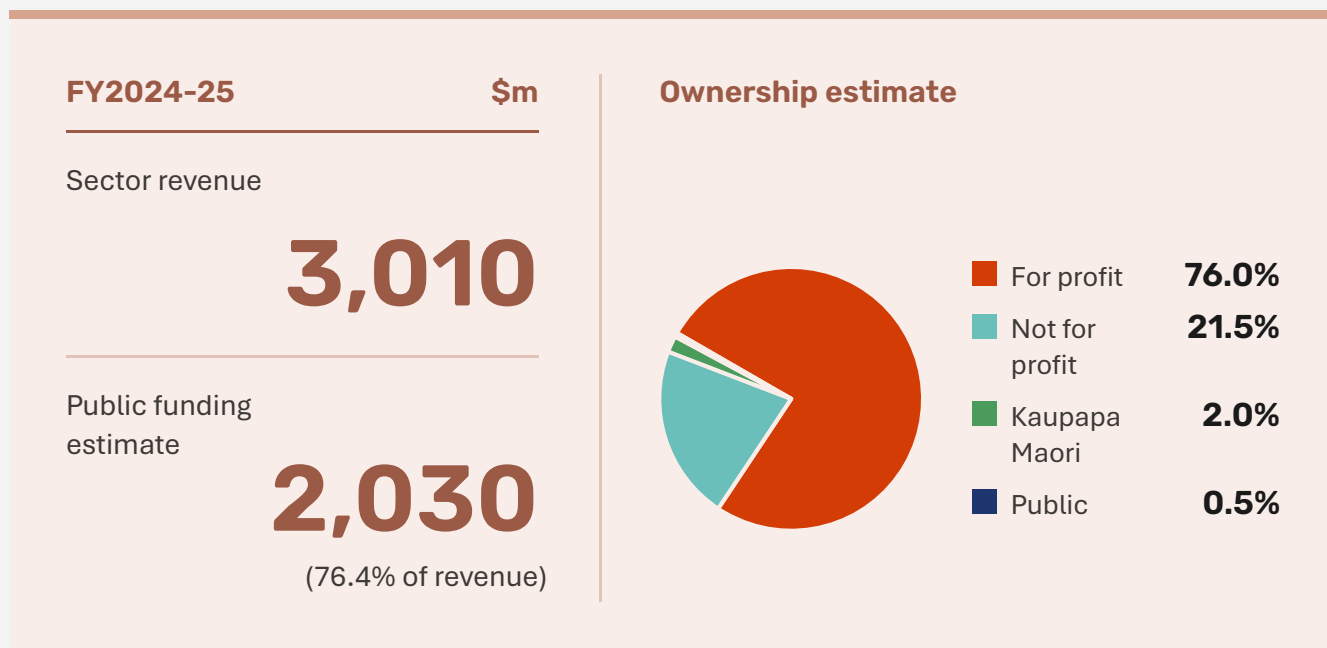
RHCNZ does not publish its own financial statements, but Infratil’s annual reports include some figures on revenue, costs and profitability for the consolidated RHCNZ, covering the four years from 2023 to 2026. Revenue has risen 21% from \$308.6 million to \$373.2 million over the period. Its profitability has declined but remains strong, with pre-tax surplus falling from \$53.7 million in 2023 (a 17.4% margin) to \$42.3 million in 2025 (a 11.4% margin). In 2025, ‘net surplus before taxation’ (a measure of pre-tax profit) jumped to \$68.3 million, an 18.3% margin, despite incurring a net interest expense of \$51.9 million.¹⁴⁹ While some of this is likely misallocated contractor income, this level of profitability seems relatively high, given the predominance of publicly funding work.

Aged residential care



HEADLINE FINDINGS

1. Public funding accounts for an estimated 76% of aged residential care revenue, yet almost all facilities are privately owned.
2. The Big Six alone received \$627.3 million HNZ funding in the latest year for which data is available.
3. Two of the Big Six providers have been ‘taken private’ by offshore private investors.



Aged residential care (ARC) beds are contracted and price-regulated by HNZ, but almost all facilities are privately-owned and operated. There are currently around 690

aged residential care facilities in New Zealand providing around 43,300 beds.¹⁵⁰ The market has been dominated by the “Big Six” – Ryman Healthcare, Summerset, Metlifecare, Bupa,



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Oceania Healthcare and Arvida Group – who in 2024 owned 47% of retirement villages and 63% of village units nationally.¹⁵¹ Ryman, Summerset and Oceania are all dual-listed on the NZX and ASX, Metlifecare and Arvida are private equity-owned, and Bupa is owned by a private multinational healthcare group with no shareholders. In October 2026 following the completion of this analysis, Heritage Lifecare acquired NZ Aged Care Services, becoming the second-largest provider of aged care services and the largest provider of high acuity beds in New Zealand.¹⁵² Heritage Lifecare is owned by the Australian private equity firm Adamantem Capital.

All of these firms operate on a ‘continuum of care’ model, meaning they combine both retirement villages and aged residential care facilities.¹⁵³ The recent Ministerial Advisory Group Report on aged care noted “‘standard’ residential care beds (for which providers do not charge additional ‘premiums’ or fees) are funded **below the cost of provision**”.¹⁵⁴ It is likely that the retirement village side of businesses in the sector has helped to sustain returns across the groups, but declining house prices over the last half a decade have slowed the move to a village for many would-be residents, and with it the development pipeline. Large providers are now increasingly focused on converting standard ARC beds into ‘care suites’, which are often sold through Occupational Rights Agreements (ORA), where

residents are required to pay an upfront sum and on leaving receive the resale proceeds minus the fees. Alongside this, there has been a shift for providers to shift towards offering premium rooms, where they can charge unregulated premium fees for larger rooms and extra amenities, such as a private bathroom as a way to to capture private revenue on top of public funding.

Despite being delivered by private providers, public funding underpins the sector. A 2024 review of aged residential care funding put the HNZ contribution at \$1,352 million, “with residents paying \$1,010 million because of means testing (including superannuation deductions).”¹⁵⁵ That report also noted a further \$732 million in public spending for in-home care in 2022/23. In 2024/25, “the government spent \$2.5 billion in aged care across in-home and residential care, and New Zealanders contributed about \$1.26 billion to the cost of care.”¹⁵⁶ Assuming in-home care has since grown to around \$750-800 million, we can infer that HNZ funding for aged residential care has reached \$1.7-1.75 billion in 2024/25. Subsidised residents also surrender most of their superannuation payments to the provider, which likely accounts for around half of the \$1.26 billion paid in resident fees in 2024/25. Estimating superannuation deductions at \$600 million brings total public funding to around \$2.3 billion out of total sector revenue of just over \$3 billion.

In line with the trend seen across the wider health system, the ageing population is expected to continue to put severe pressure on the aged residential care system, with the number of beds required to meet demand projected to almost double over the next two decades. The Ministerial Advisory Group recommended a “price uplift” for residential care, beginning with an increase in subsidies of 7.1% in 2027/28 and that in 2028/29 new residential care rooms should enjoy a 13.8% above inflation price uplift “to ensure the construction of new residential care capacity at scale is commercially investable”.¹⁵⁷

The following table presents the latest available data on care beds and HNZ funding for the Big Six. Five of the Big Six, with Bupa as the exception, provide regular reporting of the number of care beds in their annual reports, although it is not clear that the numbers are presented consistently between operators. Those same five companies also regularly report their annual funding from HNZ. The combined HNZ aged residential care funding for Ryman, Oceania, Arvida, Summerset and Metlifecare for the latest available year totalled \$465.1 million. Adding the latest available Bupa ARC figure brings the total to \$627.3 million.

Provider	Ownership	Latest year	Aged care beds/suites	HNZ funding
Ryman Healthcare	NZX/ASX listed	Year to 31 March 2026	3927 aged care beds ¹⁵⁸	\$182.2 million ¹⁵⁹
Bupa	Non-profit parent	Year to 30 June 2024 for HNZ funding, 31 Dec 2024 for aged care beds	3150 care beds ¹⁶⁰	\$162.2 million ¹⁶¹
Oceania Healthcare	NZX/ASX listed	Year to 31 March 2026	2013 care beds/suites ¹⁶²	\$98.9 million ¹⁶³
Arvida Group	Private equity (Stonepeak)	Year to 31 March 2026	1688 care beds ¹⁶⁴	\$78.4 million ¹⁶⁵
Summerset Group	NZX/ASX listed	Year to 31 December 2025	1475 care units ¹⁶⁶	\$60.7 million ¹⁶⁷
Metlifecare	Private equity (EQT)	Year to 30 June 2026	1199 care suites and beds ¹⁶⁸	\$44.9 million ¹⁶⁹

These figures do not include the superannuation deduction component of funding for the aged residential care sector, which could bring the total public contribution for these six companies up close to around \$750 million.



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LISTED PROVIDERS: RYMAN, OCEANIA AND SUMMERSET

Three major aged care providers – Ryman, Oceania and Summerset – remain dual-listed on the NZX and ASX. With a diverse mix of investors including Australasian superannuation funds, Australian institutional capital and retail kiwi investors, these three firms are all encountering the same macro trends of high debt servicing costs, a sluggish domestic housing market and chronic underfunding.

For decades Ryman Healthcare has been the market leader with a substantial capital-intensive growth, relying on corporate debt. Twin billion dollar equity raises in 2023 and 2025 signalled a new direction that aimed to reduce debt and lower its leverage.¹⁷⁰ Ryman remains the largest recipient of HNZ funding, with its 2026 total of \$182.1 million (a record amongst operators), up \$67.1 million since 2020. Summerset's ARC funding from HNZ is also rising, hitting \$60.7 million in 2025, up 75% since 2020.

Oceania, on the other hand, has reduced its exposure to public funding in the last couple of years, reducing Health NZ funding from \$113.9 million in 2024 to \$98.9 million.

PRIVATE EQUITY: METLIFECARE AND ARVIDA

Since the pandemic, both Metlifecare and Arvida Group have been delisted and taken private by offshore private equity funds. In both instances the firms still publish financial statements, which may indicate these are 'turnaround' investments, with the funds restructuring the businesses before a possible relisting.

In November 2020, Metlifecare was delisted after a tumultuous takeover bid in which Swedish private equity powerhouse EQT invoked the pandemic to squeeze down their takeover offer, with anchor shareholders the NZ Super Fund and Infratil accepting a revised price of \$1.28 billion.¹⁷¹ Metlifecare's heavy emphasis on villages rather than higher-margin acute care beds meant its shares had underperformed compared to the other big players.

Metlifecare was acquired by the €9 billion EQT Infrastructure IV fund,¹⁷² using a firm called Asia Pacific Village Group Limited whose ownership records on the Companies Register trace to Singapore.¹⁷³ The fund is managed from Luxembourg and is heavily invested in digital infrastructure and renewable energy.¹⁷⁴

However, other EQT investments in aged care around the same period include the acquisition of Colisee in 2020 (with 270 nursing homes across France, Belgium, Spain and Italy) and Levande's 58 Australian assisted living homes in 2022.

In December 2021, Metlifecare completed NZ's largest ever sustainable re-financing worth \$1.25 billion, comprising \$600 million in existing debt and \$650 million in new debt, linked to sustainability performance targets, including building six new facilities with a green star rating within five years and increasing their dementia care beds six-fold in five years.¹⁷⁵ Debt servicing costs are now five times their previous level, but instead of being paid, this is being capitalised into additional debt as the firm pursues a rapid buy-and-build strategy. In February 2026 Australian and New Zealand media reported that Metlifecare had tapped a number of banks and was considering a dual listing on both share markets.¹⁷⁶

Metlifecare's latest annual report shows the changing nature of aged residential care. In 2022, the company's care portfolio consisted of around 800 care beds. By 2026 the total care portfolio had increased by roughly half to around 1,200 care beds and suites, but roughly

half of its 2022 care beds had been converted to care suites, while an additional 400 new care suites were added through new village developments and acquisitions.¹⁷⁷ Within just four years, it appears that Metlifecare's care portfolio has shifted from 100% care beds to just 33% care beds.

In July 2024, it was announced that the US private equity firm Stonepeak would acquire Arvida Group, in a deal which valued Arvida's equity at \$1.25 billion.¹⁷⁸ In September 2024 Arvida was taken private, delisting from the NZX. Stonepeak describes itself as a "leading alternative investment firm" with US \$93 billion in assets under management.¹⁷⁹ The acquisition was undertaken by Stonepeak's first Asia Infrastructure Fund, with an ultimate holding company registered in the Cayman Islands.¹⁸⁰

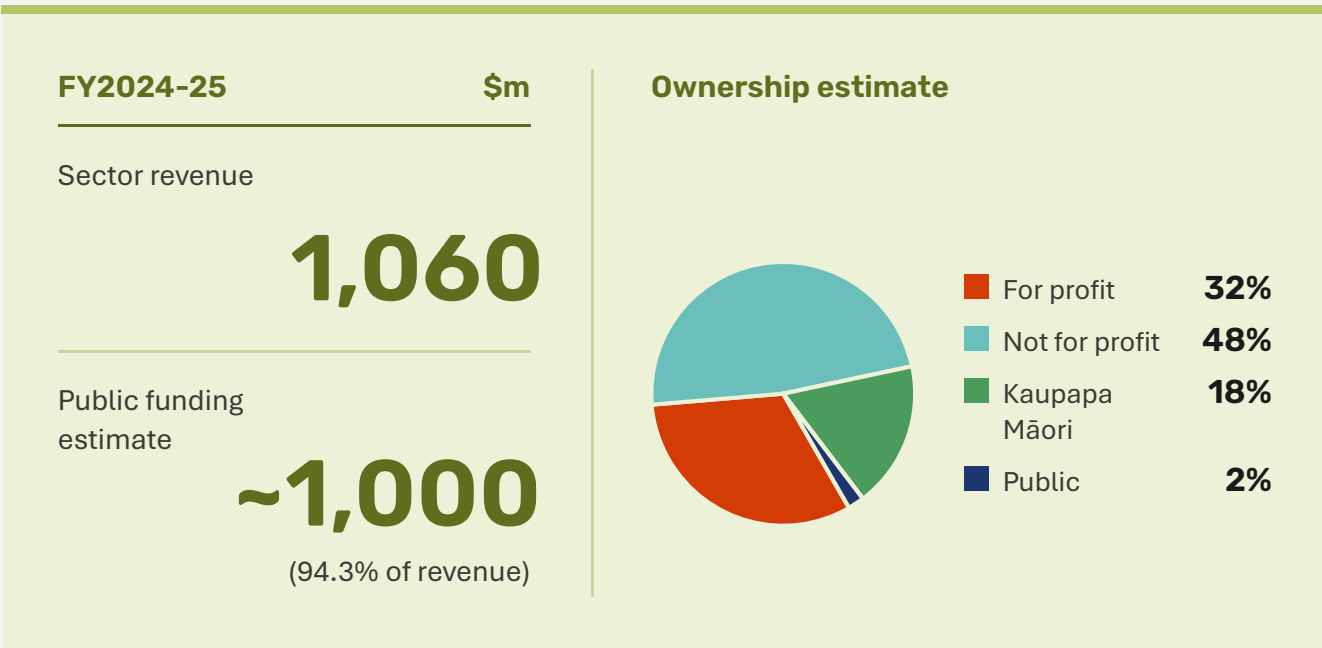
From its 2014 founding to its buyout, Arvida Group had executed a 'roll-up' strategy that saw the company borrow to acquire new facilities, such as the 2021 acquisition of Arena Living six villages.¹⁸¹ Bank loans have increased from \$657.4 million to in 2024 to \$983.1 million in 2026,¹⁸² pushing up interest expenses from \$24.8 million \$39.8 million.¹⁸³

Home and Community Support Services (HCSS)



HEADLINE FINDINGS

1. An estimated 94% of HCSS revenue comes from public sources.
2. The largest provider in the sector – NZ Health Group – paid a \$32.6 million dividend in 2025 and has just been acquired by Fisher Funds and Direct Capital..
3. In 2023, Access Community Health was sold to Australian private equity fund Anchorage Capital Partners.



The Home and Community Support Services (HCSS) sector is composed of in-home personal care, domestic assistance and injury recovery support. We estimate that HCSS is 95% funded through public spending, including

HNZ,¹⁸⁴ ACC¹⁸⁵ and Whaikaha¹⁸⁶ disability contracts, with a small component of private fee-for-service top-ups for clients purchasing additional hours of care and support.

Service delivery is almost entirely outsourced to third-party providers rather than delivered directly by the Crown. Historically, home care was delivered by non-profit entities, but as funding has grown and evolved into a competitive tendering environment, so too has consolidation. Emerging corporates like the New Zealand Health Group and Access have targeted urban centres and relatively higher margin revenue, using vertical integration to reduce costs. Today the sector is a mixed market of a few large corporate groups alongside a much larger group of charitable trusts not-for profits, and iwi providers, both large and small.

NEW ZEALAND HEALTH GROUP

The largest provider in the sector is the New Zealand Health Group (NZHG), which operates subsidiary brands HealthCare NZ, Geneva Healthcare, Solora, NZ Care and Explore. NZHG employs around 10,000 staff that together serve more than 30,000 people.¹⁸⁷ NZHG earned \$727.6m in revenue in 2025 (down from \$833.8m in FY2024), however not all of this is from the HCSS sector.¹⁸⁸

In 1988, businessman Doug Catley formed Healthcare NZ, which grew through the 1990s and 2000s by acquiring small home care providers to build a nationwide footprint of Ministry of Health contracts. Healthcare NZ fought for market share alongside Geneva Healthcare, which was founded in 1996

and pursued home care and ACC injury rehabilitation contracts through the 2010s.¹⁸⁹ In December 2016, Australia-based Quadrant Private Equity (QPE) acquired a 40% stake in Healthcare NZ's holding company, Healthcare of New Zealand Holdings Limited.¹⁹⁰ The QPE deal was structured through a broader Australian consolidation platform alongside other investors called MyHomeCare.¹⁹¹ By September 2017, Healthcare NZ had acquired rival Geneva Healthcare and its subsidiaries for \$51.9 million, funding the acquisition through a \$40 million bank loan.¹⁹² Geneva founder Josephine Gagan became a Director of the merged entity, which was renamed the NZ Health Group.

Catley passed in November 2024. At the time of writing his widow Penelope Catley and Donna Cooper were the largest shareholders (58.2%), alongside MyhomecareNZHG Holdco Limited (38.8%) and the Gagan Family Trust (3%).¹⁹³ However, in September 2026 it was reported that private equity firm Direct Capital and Kiwisaver provider Fisher Funds had agreed to acquire NZHG from the Catley family and QPE for an undisclosed sum, with Fisher Funds and Direct Capital each holding around 45% and Director Gagan a 10% share.¹⁹⁴ In March 2025, the NZ Super Fund announced it had committed to invest \$50 million in the fund concerned (Direct Capital VII LP), taking their total exposure to Direct Capital to \$330 million.¹⁹⁵

While the HCSS industry tends to operate on relatively low margins, NZHG's scale means



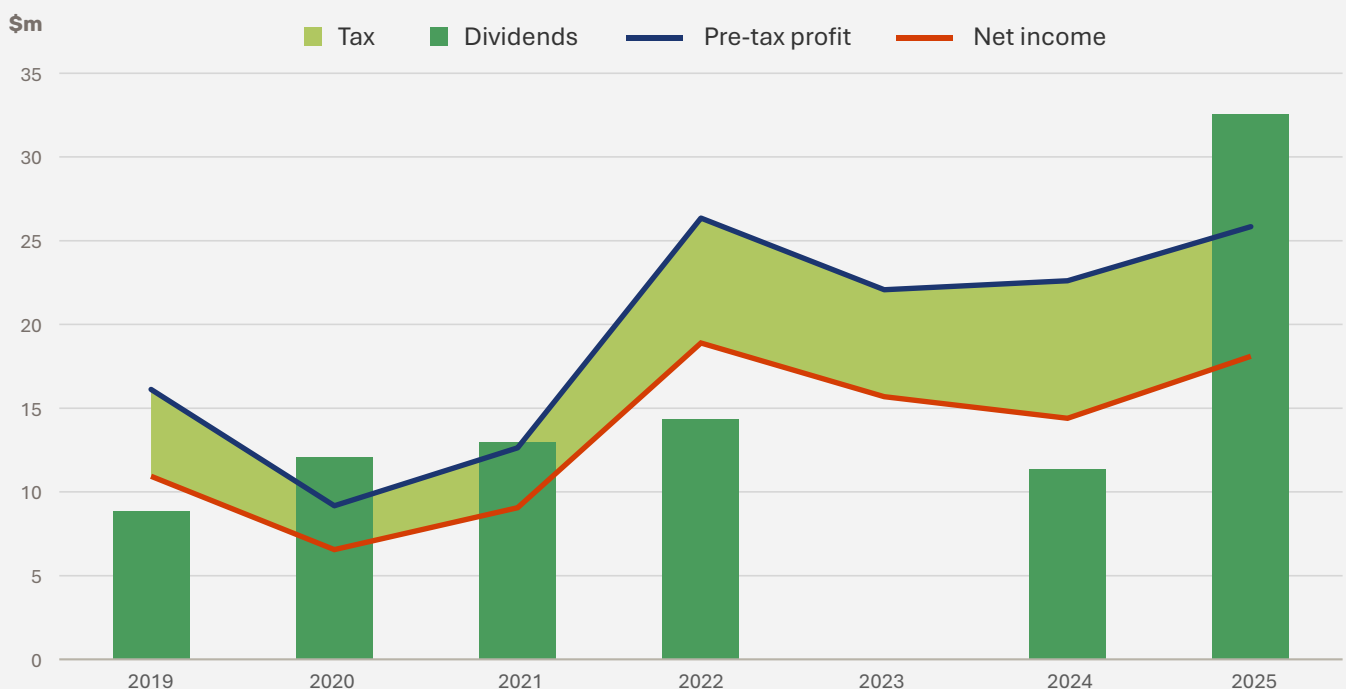
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they have continued to generate strong earnings, delivering dividends to shareholders. Since 2022 the company has achieved relatively higher margins, with pre-tax profits have consistently topped \$20 million a year.

These profits tend to get largely paid out in dividends, with more than \$10 million paid

in 2020, 2021, 2022 and 2024. In 2025 the company paid a windfall dividend of \$32.56 million to shareholders, well in excess of the \$18.1m in net profit earned by the company that year.¹⁹⁶ In FY 2025 key management personnel and directors were paid \$3.5 million in remuneration.¹⁹⁷

Figure 10 | NZ Health Group



ACCESS COMMUNITY HEALTH

Tracing its roots back to the Women's Division of the New Zealand Farmers Union in the 1920s, Access Homehealth emerged during the health restructuring of the 1990s as the community care sector was formalised. It grew to become one of the largest non-profit home care providers with major DHB and

ACC contracts, and in 2014 was acquired by the NZX-listed Pharmacybrands, which rebranded to [Green Cross Health](#) the same year, with Access rebranding to Access Community Health.

Green Cross Health's financial statements show the scale of the business. By 2017 Green Cross' community health division generated \$115.7 million in revenue, 24%

of total revenue.¹⁹⁸ By 2022, it had reached \$192.2 million, some 40% of total revenue. That year profit for the community health sector hit \$5.6 million, a margin of 2.9%, well below the pharmacy division (9.8%) and the medical division (14.4%).¹⁹⁹

In February 2023, Green Cross announced it was selling Access Community Health to Australian private equity firm Anchorage Capital Partners for an enterprise value of \$50 million.²⁰⁰ It appeared that much of this purchase price was paid out as dividend to Green Cross' shareholders, with dividends jumping from \$10.1 million in 2023 to \$48.9 million in 2024.²⁰¹ Anchorage Capital Partners' portfolio also owns Evolve Education Group, the second-largest provider of early childhood education in New Zealand.²⁰² Access Community Health employs a current workforce of over 3,200 providing services to over 33,000 clients.²⁰³ Financial statements for holding company Access Hauora Limited showed revenue has reached \$272.3 million while pre-tax profit was \$10.7 million for the year to 31 March 2026,²⁰⁴ a 3.9% margin. The scale of public funding is not disclosed.

CHARITABLE PROVIDERS: NURSE MAUDE AND VISIONWEST

Nurse Maude is a large charitable HCSS provider, whose operations are concentrated

around the Lower North and South Islands, drawing its roots from the Nurse Maude District Nursing Association, founded in 1901.²⁰⁵ It holds the primary regional contract to deliver district nursing services in the Canterbury region, as well as operating hospital and rest home level care at the Nurse Maude Hospital.²⁰⁶ In 2024/25, it claimed "1,251 staff caring for people every day of the year", who together racked up nearly a million home care visits.²⁰⁷

Nurse Maude's total revenue reached \$108 million in 2025, up 53% since 2019 (\$65.9 million). Employee remuneration – by far the largest cost in the sector – increased only 38% over the same period, from \$54.5 million to \$75.4 million.²⁰⁸ This squeezed down the labour share of income from 82% in 2019 to 70% in 2025. The reduction in the labour share resulted in an improvement in Nurse Maude's financial position, from a \$8 million deficit in 2019 to a \$6.1 million surplus in 2025.²⁰⁹

Visionwest Community Trust is a faith-based charitable provider headquartered in West Auckland but with operations across the North Island and Canterbury regions.²¹⁰ It is a wraparound social services provider, but its largest source of revenue is from "Home Healthcare", which in 2025 accounted for \$83.5 million of its \$129.3 million in revenue.²¹¹ In August 2026, HNZ announced it would not be renewing contracts held by Visionwest in Auckland, alongside other not-for-profit providers Lifewise and Presbyterian Support Northern.



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- 18** Explaining Policy Choices: The Case of Health Restructuring, p.116-7.
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- 59** Nāti Growth (2026) [Nāti Growth invests in Tend Health to support acquisition of The Doctors](#).
- 60** Corporate ownership figure from NZ Doctor (2026) “[Need for union protection grows with corporate ownership says senior doctors’ leader](#)” (7 May). Other figures from [RNZGP 2022 Workforce Survey](#), p.49, it has been assumed that the increase in the corporate share has resulted in a commensurate reduction in the share of GP-owned practices.
- 61** Data extracted from Stats NZ (2025) “[Business performance benchmarker](#).”
- 62** For ACC component see Note 58. For capitation funding see NZ Doctor “[Primary care/capitation funding from 2013/14 - 2023/24](#).”
- 63** The first Labour government’s original plan was for the general practice sector to be free by paying doctors a fixed public rate. Doctors opposed this and instead were able to secure a fee-for-service arrangement that allowed them to receive government payments while still charging patients fees on top of their public funding. Michael Belgrave “[Improving access to health care, 1900s-1970s](#)” (21 April 2011) Te Ara – The Encyclopedia of New Zealand.
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68 MBIE (2024) [Accident Compensation Cost of Treatment Amendment Regulations 2024](#). This estimate is derived by applying ACC's regulated consultation and procedure rates to GP claim volumes, based on the 34.9% of ACC's 2.04 million claims lodged in general practice. 2025 and 2023 data calculated as proportionate based on capitation funding.

69 Rashbrooke had inflation adjusted an existing calculation using 1998-99 data. Rashbrooke, M. (2022) ["Lightening the Load"](#), p.16.

70 Ian Powell ["GPs close to death by a thousand cuts"](#) (12 June 2023).

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74 <https://www.lin.govt.nz/our-work/overseas-investment-regulation/decisions/2022-03/202100807>

75 There are five additional holding companies before reaching ["Lorien NZ Holdco Private Limited"](#)

76 TPG Inc [Annual Report on Form 10K](#), United States Securities and Exchange Commission.

77 LINZ (2026) ["Overseas investment decision for case 202500793 - TECA Lorien NZ BidCo Private Limited."](#) Vendor Tamaki Health Group Limited is described as 72% New Zealand, 20% North America, 7% Australia and 1% other, while ownership of the acquiring TECA Lorien NZ Bidco Private Limited is described as 47% Asia, 43% North America 43% United Kingdom 5% and New Zealand 5%.

78 LINZ (2026) ["Overseas investment decision for case 202600530 - PEF Pass AI, C.V."](#)

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80 ["Kirkland Advises TPG on Debt Financing for its Acquisition of Tāmaki Health Group"](#) (30 April 2026) Kirkland & Ellis.

81 ["Portfolio"](#) (30 June 2026) HPS Corporate Lending Fund.

82 Author's calculation.

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84 NZ Herald "Tend Health to buy The Doctors GP network for \$270m in iwi-backed deal" (2 Jun 2026). Iwi/NZ investors (Ngāi Tahu Holdings, Ngāti Whātua Ōrākei, Ahuahu Group, Nāti Growth) hold a substantial minority-to-large shareholding.

85 Life Pharmacy was then majority controlled by businessman Andrew Bagnall, while Unichem was owned by Cape Healthcare. 49% of Cape shared are owned by New Zealander Peter Merton, but a 51% majority stake is owned by 'The Zuellig Group Incorporated', incorporated in tax haven the Bahamas. Nick Stride ["Bagnall in control of Life Pharmacy"](#) (24 June 2009) Stuff.co.nz. ["Cape Healthcare"](#) New Zealand Companies Office.

86 ["Green Cross Health Care Limited. Shareholdings"](#) New Zealand Companies Register.

87 Sarah Thompson, Kanika Sood and Emma Rapaport ["Sydney buyout firms in talks to buy GP clinics from Green Cross Health"](#) (13 April 2026) Financial Review.

88 Tom Raynel ["Tend Health to buy The Doctors clinics from Green Cross Health for \\$270m"](#) (2 June 2026) NZ Herald.

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