NZIER
NEW ZEALAND INSTITUTE OF ECONOMIC RESEARCH

Longer, better, more sustainable lives

Five priority areas for investment in 2025

NZIER report to Selwyn Foundation

July 2025

About NZIER

New Zealand Institute of Economic Research (NZIER) is an independent, not-for-profit economic consultancy that has been informing and encouraging debate on issues affecting Aotearoa New Zealand, for more than 65 years.

Our core values of independence and promoting better outcomes for all New Zealanders are the driving force behind why we exist and how we work today. Our purpose is to help our clients and members make better business and policy decisions and to provide valuable insights and leadership on important public issues affecting our future.

We are unique in that we reinvest our returns into public good research for the betterment of Aotearoa New Zealand.

Our expert team are based in Auckland and Wellington and operates across all sectors in the New Zealand economy and combine their sector knowledge with the application of robust economic logic, models and data and understanding of the linkages between government and business to help our clients and tackle complex issues.

Authorship

This report was prepared at NZIER by Sarah Hogan and Philippa Miller-Moore.

It was quality approved by Jason Shoebridge.

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Registered office: Level 13, Public Trust Tower, 22–28 Willeston St Wellington
Auckland office: Level 4, 70 Shortland St, Auckland
Postal address: PO Box 3479, Wellington 6140
Tel +64 4 472 1880 | econ@nzier.org.nz | www.nzier.org.nz

"As the demographic transition enters a new stage of a longevity transition, focus needs to extend beyond an ageing society towards a longevity society. An ageing society focuses on changes in the age structure of the population, whereas a longevity society seeks to exploit the advantages of longer lives through changes in how we age. Achieving a longevity society requires substantial changes in the life course and social norms, and involves an epidemiological transition towards a focus on delaying the negative effects of ageing."[1]

[1] Scott 2021.

The longevity economy: Longer, better, more sustainable lives

"A fundamental shift in perspective is required to transform the demographic transition into a driver of strength and economic growth."[2]

Life expectancy gains are a remarkable and ongoing achievement

The life expectancy gains driving long-term population ageing are often seen as a product of the early 20th century, but gains continue to be made at a significant pace: Between 1980 and 2020, 10 years were added to the average New Zealander's life expectancy at birth. It's a remarkable achievement resulting from improved living standards, health care advances, and reductions in early life mortality.

Longer lives present important economic opportunities for New Zealand

As New Zealanders live longer, more are working beyond the traditional retirement age. Labour force participation among 65–69-year-olds rose from 10 percent in 1993 to 49 percent by 2023 – far exceeding the Treasury's 2006 projection of 38 percent. For those aged 70–74, participation grew from 4 to 27 percent, exceeding the projected 19 percent. These shifts have put New Zealand at the top of the OECD for workforce participation of older adults and helped to mitigate the exponential increase in debt that was expected in the absence of offsetting action by government (Stephens 2024).

The ability of people to work beyond age 65 translates into both individual and economic sustainability. For many people, working benefits wellbeing in other ways, including social connection, sense of purpose, and health outcomes.

But there are also challenges for a longevity economy to address

Beneath the positives of longer lives and economic participation lie serious challenges.

Despite high workforce participation, government spending on over-65s still exceeds the tax revenue they generate (Wright and Nguyen 2024). As this group grows, so too will pressure on the tax base and public debt. New Zealand's universal superannuation is now among the most costly in the OECD relative to gross earnings. Since 2006, Treasury has consistently warned that fiscal settings need reform to remain sustainable.

However, reducing support for older people is not the answer. The current imbalance reflects avoidable outcomes and persistent inequities. Longer lifespans have brought not just more healthy years, but also more years in poor health and many older New Zealanders have high support needs, reflecting the cumulative impacts of lifelong disparities in education, health, housing, and social and cultural wellbeing (Wright and Nguyen 2024). Some New Zealanders, especially Māori, also experience age-related health and disability at a much younger age than the age commonly used to define 'older people' (65 years).

This new era requires structural change to social and economic systems

The demographic shift is not temporary. Children born today are expected to live well into their 90s and beyond. An increasing proportion will be Māori, creating an imperative to ensure their full and equal participation in the longevity economy, including their opportunity to reap the rewards of better health and financial resilience.

[2] World Economic Forum 2025

New Zealand must adapt social and economic systems to support longer lives for all New Zealanders.

The Decade of Healthy Ageing and the Longevity Economy present a roadmap

Two important and compatible frameworks present a roadmap to solutions: The UN Decade of Healthy Ageing and the Longevity Economy described by the World Economic Forum, shown in Table 1 below.

Table 1 Frameworks for solutions

UN Decade of Healthy Ageing 4 Action Areas	World Economic Forum Longevity Economy 6 Principles
Creating age-friendly environments	Design systems and environments for social connection and purpose
Promoting healthy ageing	Prioritise healthy ageing as foundational for the longevity economy
Fostering a supporting environment	Evolve jobs and lifelong skill-building for a multigenerational workforce Ensure financial resilience across key life events Provide universal access to impartial financial education
Combatting ageism	
	Address longevity inequalities across gender, race and class

Source: United Nations (2020) World Economic Forum (n.d.)

Both frameworks call for change in the way society responds to ageing, to increase the independence of older people and reduce their need for costly services. But they also emphasise that adaptation to longevity requires systemic and institutional change, to ensure an inclusive approach that tackles longevity inequalities, and combating ageism, an insidious barrier that reduces expectations, imposes limiting social norms, and results in lost opportunities for individuals, whānau, communities, and the economy.

Investment in the longevity economy is expected to pay a longevity dividend

Countries that adapt to longevity will gain not just by rebalancing the costs and contributions of ageing populations, but also by attracting skilled migrants and encouraging younger generations to stay and raise families.

The “longevity dividend” refers to the social and economic returns from ensuring more life years are lived in active, productive, and independent ways. These gains include longer working lives (by choice), greater independence in older age, reduced reliance on costly services, and improved wellbeing across the life course. The sooner investments are made, the sooner benefits will be realised.

Change can start now, even with tight fiscal constraints

Reducing the costs of longevity and unlocking its benefits should be an over-arching policy priority. The longer this shift is delayed, the greater the damage to New Zealand’s long-term economic resilience. Current fiscal constraints are, to a large extent, the result of not acting sooner. This is why, despite continuing fiscal concerns, the New Zealand Treasury endorses the need for structural change aligned with longevity economy principles.

In the following pages, we present five priority areas for investment – areas of significant concern but also significant opportunity to set a new course to secure a healthy and sustainable future for all New Zealanders.

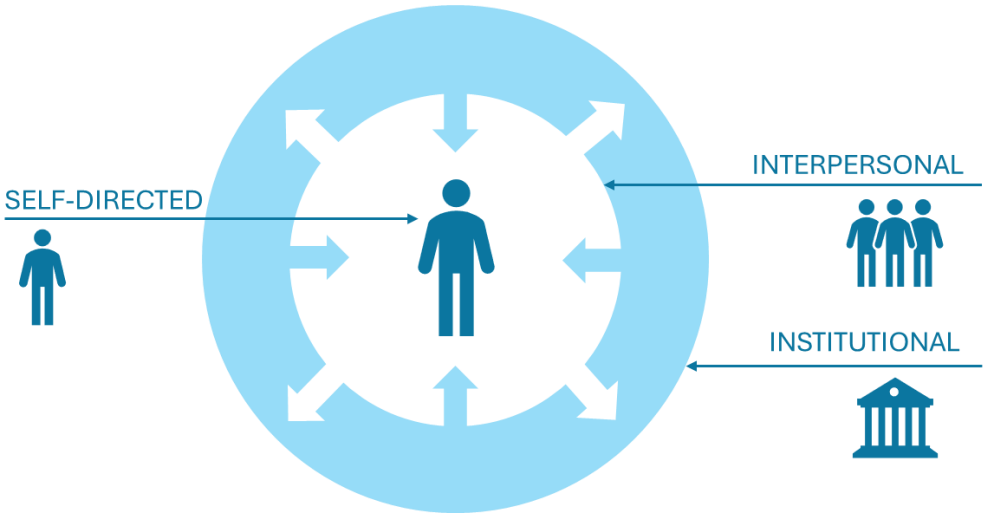
1 A longevity economy requires longevity data and reporting

"We often talk about "over 65" but there is a huge variation in ages that we need to acknowledge. From 65 to 105 we have a 4-decade span of ages, the ages of 65 and 105 are as different for people as 1 and 40…"[3]

Data is critical to good decision-making and understanding the social impact of those decisions. It describes challenges and opportunities, outcomes, and inequities, and is the backbone of evidence-based decision-making.

But just as data shapes decisions, decisions shape data. The way data is collected, presented and reported shapes knowledge, drives expectations, and reinforces social norms. Racism, sexism and ageism are all present in data and reporting. Ageism in data and reporting is a form of institutional bias, which combines with interpersonal and self-directed bias to deny people their human rights and ability to reach their full potential (World Health Organization 2021).

Figure 1 Forms of ageism



Source: World Health Organization (2021)

Ageism in data and reporting shows up as:

- Age groups being excluded from some surveys or types of reporting, e.g. reporting on the "working age" population (typically defined as 15 to 64 years)
- Age groups being excessively broad, encompassing but obscuring significant variation (e.g. the group aged 65+)
- Vocabulary used in reporting data conveying harmful ideas about older people and ageing
- Imbalance in collecting and reporting data on older people by focusing on negative aspects of ageing (e.g. their service use, their social isolation, etc) and neglecting positive aspects (e.g. their employment, volunteering, and community participation)
- Images, symbols and icons used to refer to older people in reports that portray older people as frail, disabled, or high-cost service users.

[3] Karen Billings-Jensen, Age Concern, quoted in Saville-Smith, Kay, Cram, Fiona, James, Bev and Allanah Robinson (Eds). 2023.

New Zealand has rich data sources, including world-leading data infrastructure, such as Stats NZ's Integrated Data Infrastructure (IDI), and data visualisation tools that make data more accessible to the general public. The usefulness of these tools with respect to older generations is limited because they are often described as a homogenous group of people aged 65 and older. To make matters worse, reporting on the group aged 65 and older often focuses on costs and services used, presenting them as a burden to society, and is not balanced by reporting on participation, contribution, opportunity, and positive trends.

Because of ageism in data and reporting, and the magnification of data ageism in the media, which is rife with its own ageism (Easton 2025) few New Zealanders, including senior public sector decision-makers are likely to have seen the evidence that New Zealanders remaining in the workforce beyond the age of 65 have substantially mitigated the fiscal and economic impacts of our ageing population and that increases in the labour force participation have been far greater than anyone had anticipated (Stephens 2024).

Data and reporting have two key roles to play in a longevity economy:

- Supporting decisions about structural change to social and economic systems by quantifying both the challenges and opportunities presented by longevity
- Dismantling the insidious barrier of ageism that blinds governments, businesses, communities and individuals to the value and potential of older generations and, in so doing, prevents that value and potential from being realised.

If the longevity dividend is to be realised, it is essential that data and reporting reflect:

- More granularity in age groups, as well as gender and ethnicity. The concept of 'seniors' or 'older people' is based on arbitrary age grouping and does not recognise that ageing is continuous, and people experience it differently.
- New groupings relevant to policy decisions, such as homeowners or labour market participants.
- A shift away from constraining language and definitions, such as the 'working age population' to more flexible language like the 'working population' and the use of the 'age dependency ratio"' (the ratio of older people aged > 65 to the number of working-age adults) which implicitly assumes that all older people are dependent, even though many are in paid employment and many more are depended on for informal caring or volunteering.
- More balanced reporting on older people, including their contributions and strengths, not just their needs and challenges.
- Cautious use of artificial intelligence, machine learning, and algorithm-based data processes, which are known to reproduce judgements, prejudices and ideologies shaped by age stereotypes (Rosales and Fernández-Ardèvol 2019) and rely on previously observed patterns to make predictions about the future.

The public sector is not the only source of ageism in data and reporting. For example, research has documented ageism in media coverage of issues affecting older people. However, the public sector can the take the lead with consistency in the use of non-ageist data and definitions and in more balanced data and reporting on older people's experiences.

2 Housing challenges are a major threat to healthy longevity

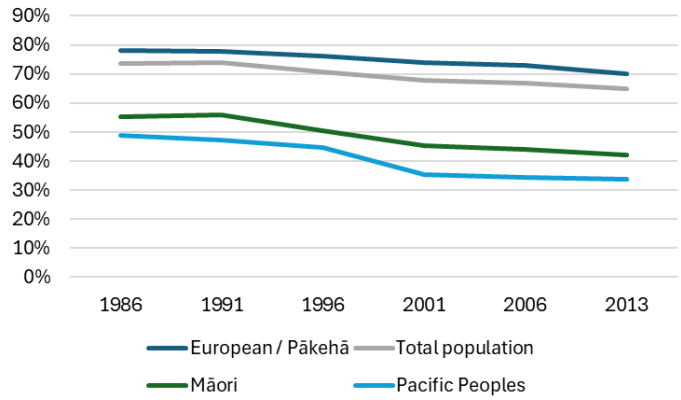
"The 'golden assumption' is that New Zealand retirees will have their financial wellbeing supported via mortgage-free homeownership, with home equity available to support modifications or to provide the agency to select housing appropriate for their needs. However, based on the current trends we are seeing, this will no longer be the case, with accessible and healthy rental housing needed more than ever."[4]

Ensuring older New Zealanders can age in a place they call home, safely, and where possible, independently is a government policy goal (The Office for Seniors 2019) because it is critical to healthy longevity at every age: Housing is fundamental to education, employment, safety, long-term financial security, health, independence, and social connectedness.

Home ownership has been the principal pathway to stable, affordable and healthy housing in later life for New Zealanders. The last century saw rising rates of home ownership, with a peak of 83 percent achieved in 1991 and resulting in older people being highly likely to be mortgage-free owner-occupiers (Pledger et al. 2019). The small proportion of people reaching retirement age and not being home owners was largely served by various public housing (including council housing) systems. However, in recent decades, home ownership has dropped (see Figure 1 below)

Figure 2 Percentage of older people living in an owner-occupied dwelling

1986 to 2013 Censuses, by ethnicity



Source: Stats NZ 2016

Housing and income support policy for older people in New Zealand is predicated on the idea that older New Zealanders typically own their homes – an assumption that is increasingly inappropriate.

As Symes (2022) notes a number of trends indicating new challenges in housing may pose a threat to healthy ageing and the longevity economy, including:

- Longer-term, there appears to be a shift occurring with increasing rates of paying rent rather than owning outright, which is most noticeable in households with a head-of-

[4] Te Ara Ahunga Ora Retirement Commission. 2024.

household in the 45-54 and 55–64 age bands, signalling more people on NZ Superannuation are likely to be in rental housing in the future.

- There also appears to be a shift from owning a mortgage-free home to paying a mortgage for households whose head-of-household is in the 65–74 age band.

Māori experience persistently lower home ownership rates at all ages (Stats NZ 2021). The increasing number of Māori emigrating to Australia for work is also expected to result in an increasing flow of older Māori returning to Aotearoa to retire or spend their final years (Cram and Munro 2020), often facing the need to find suitable rental housing.

The current rental market becoming an increasingly important context for housing for older people presents multiple threats to the longevity economy:

- Renting offers less security of tenure than home ownership or social housing, increasing stress on older people for whom finding suitable housing and re-locating is more difficult and can result in social isolation (James and Saville-Smith 2018).
- Renting puts more financial pressure on older people and increases their need for financial assistance to support them to meet both housing and non-housing costs (Saville-Smith et al. 2022). Senior households paying rent are identified as much more likely to be spending 40 percent or more of their NZ Super income on housing (Symes 2022). With a high proportion of income being spent on housing, many seniors in private rental housing are forced to forego other spending (Te Ara Ahunga Ora Retirement Commission 2024).
- The private rental housing stock is generally in poorer condition than privately owned homes, presenting health risks for older people as demonstrated by health data and New Zealand research: Older renters are twice as likely to suffer from health problems including asthma, anxiety, and depression (Pledger et al. 2019).
- Most houses are not built incorporating principles of universal design (e.g. wider doorways, walk-in showers, etc) resulting in only an estimated two percent of dwellings being accessible (compared with more than 15 percent of occupants needing modifications to live safely in their homes) (United Nations 2021).
- Housing modifications to support older people to remain in their own homes and be independent as functional impairment increases are less easily achieved in private rental accommodation due to high costs to landlords (Saville-Smith and Saville 2012) and low knowledge and use of Government funding for modifications (only 24 percent of landlords are aware of government funding scheme and only 5 percent of modifications have had costs covered by these) (Perceptive 2024).

Unsurprisingly, therefore, research shows that renting can accelerate the ageing process with long-term renters observed to experience faster biological ageing. This is in contrast to other common non-ownership models used by less affluent older people, such as social housing (Clair, Baker, and Kumari 2024).

Previous research has highlighted the urgent need for solutions and has called for research into cost-effective approaches to accessibility across different housing typologies, a better understanding of competing priorities and incentives of different stakeholders, and their impacts on achieving housing accessibility, an improved evidence base on both the demand for and supply of mainstream housing built with accessible design, and improved data and research on housing accessibility related to tenure (James, Saville-Smith and Fraser 2024).

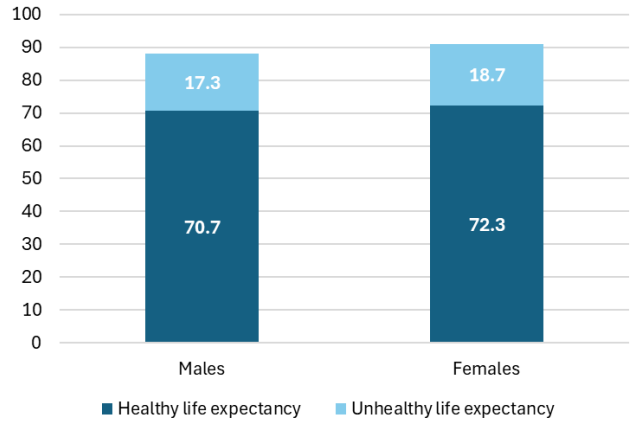
3 New Zealanders must plan for longevity, not just retirement

"An aged person is no longer seen as a quitter but rather as one empowered to direct their own trajectory of potentially healthy longevity."[5] *"A key component of a longevity society is a focus on how we age and not just on supporting those who are old."* (Scott 2021)

Ageing is malleable and reflects the "lifespan accumulation of experiences" (Morganti 2024) just as financial wellbeing in later life reflects the accumulation of wealth across the lifespan. Achieving lives that are not only longer, but better and more sustainable requires planning for more than just retirement. The need to extend the 'healthspan' to keep pace with the lifespan[6] means New Zealanders need to become adept at long-term planning, supported by information and resources that allow them to understand what actions they can take at each life stage to protect themselves from poor late life outcomes.

Figure 3 Lifespan versus healthspan in 2025

Breakdown of total life expectancy into expected healthy and unhealthy years



Source: NZIER, Stats NZ (life expectancy data) and World Health Organization (healthy life expectancy data)

Currently societal systems are not designed to help individuals navigate a life that could span nine or ten decades or more. Fragmented supports, short-term policy thinking, and reactive health and social care services leave individuals vulnerable to poor outcomes in older age.

Financial planning, which depends on financial literacy (the knowledge, skills, attitudes, and behaviours needed to make informed financial decisions), to support greater financial resilience and wellbeing across the life course and especially in later life, is a critical component of longevity planning. Alongside financial access and consumer protection, this is recognised by the OECD as critical to economic security (OECD, n.d.) and by the Reserve Bank as key to a sound financial system (Widdowson and Hailwood 2007).

But in 2022, only 44 percent of New Zealanders considered themselves financially literate, down from 50 percent in 2020 (Financial Services Council NZ 2022). The Retirement

[5] Morganti, Francesca. 2024

[6] Babies born in the 2020s are expected to live to around 88 years (for males) and 91 years (for females) (Stats NZ) but healthy life expectancy in 2025 is considerably less: 70.7 years for males and 72.3 years for females (World Health Organization).

Commission estimates that half of the population is not planning for their financial future (Te Ara Ahunga Ora Retirement Commission 2024).

Many people experience reduced income due to poor health and disability, yet one in six report they do not actively manage their health (Ministry of Health 2024a). For New Zealanders aged 50 to 69 years, preventable and manageable conditions – low back pain, ischemic heart disease, type 2 diabetes and lung cancer rank in the top causes of health loss (Ministry of Health 2024b). The impacts on employment and income have been well-documented (see for example Harcombe et al. 2009 and Dixon 2015).

The Stanford Center on Longevity (2017) identified that:

- Healthy longevity is more realistic for people who adopt healthy behaviours, are socially engaged, and can build financial security throughout their lives.
- Many people aren't taking the necessary actions they need to take today.
- Many of the actions needed to achieve healthy longevity are not costly.
- Best results require information and knowledge, but also motivation and inspiration.

But health and financial wellbeing also interact with other domains across the life course in complex ways. For this reason, the Stanford Center on Longevity identified essential planning strands – domains for longevity planning to focus on (see Table 2 below).

Table 2 Stanford Center on Longevity essential planning strands

Strand	Description
Financial Planning	Includes superannuation, savings, pensions, insurance, and investment strategies that adapt to longer life expectancies. It also involves planning for different income streams and cost-of-living needs, including aged care and health costs.
Health and Wellbeing Planning	Encompasses regular screenings, preventative care, mental health, chronic disease management, and fitness. It includes advance care directives and understanding aged care services.
Housing and Living Arrangements	Focuses on ageing in place, downsizing, home modification, co-housing models, and accessing supported living. Good housing planning is linked to health, social connection, and financial security.
Education and Lifelong Learning	Encourages continued learning to support brain health, personal development, or career pivots. Digital literacy is also critical for accessing services and staying connected.
Employment and Transitions	Covers career continuity, flexible work options, retraining, phased retirement, and age-inclusive workplaces. It also includes planning for unpaid roles like volunteering and caregiving.
Social Connection and Purpose	Building and maintaining social networks, community involvement, and purposeful engagement—key protective factors against isolation, depression, and cognitive decline.
Legal and End-of-Life Planning	Includes wills, enduring powers of attorney, guardianship, care planning and end-of-life preferences. These are essential for protecting personal wishes and reducing family stress.
Mobility and Transport Planning	Ensures access to safe, affordable, and age-friendly transport to maintain independence, especially when driving is no longer an option.
Digital and Technological Readiness	Encourages use of assistive technologies, smart home devices, health trackers, and digital services that can support autonomy and safety in later life.

Source: Stanford Center on Longevity

Longevity planning needs to be not just holistic, but flexible and dynamic. People's lives are not linear and unexpected events and opportunities, or changes in needs and preferences can necessitate a change or re-setting of plans.

4 Integrated care is needed to increase late life independence

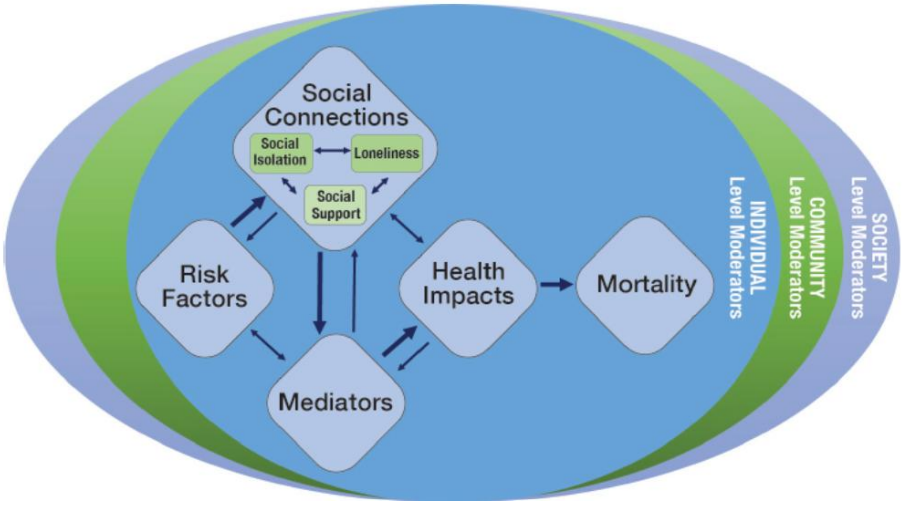
"…the health care system alone cannot solve all of the challenges of social isolation and loneliness; rather, the health care system needs to connect with the broader public health and social care communities."[7]

A longevity economy recognises that 'healthspan', not lifespan, is the key to a longevity dividend. When the years lived in good health don't grow at the same rate as life expectancy, the costs of longevity grow relative to the benefits.

Healthy ageing, as defined by the World Health Organization, is the process of developing and maintaining the functional ability that enables wellbeing in older age (World Health Organization 2015). Healthy ageing and the longevity dividend require a fundamental shift in the relationship between ageing and health, responding to increased risk across the life course and altering those risks throughout life to reduce later loss of independence.

Healthy ageing depends on preventive healthcare, good nutrition, and regular physical activity to delay the onset of chronic conditions and maintain functional independence (Gianfredi et al. 2025). But the World Health Organization warns that "more of the same will not be enough" (World Health Organization 2015). Increasingly, social connections are being recognised as critical to healthy ageing.

Figure 4 Conceptual framework of social connection and health



Source: National Academies of Sciences, Engineering and Medicine 2020

New Zealand research shows high levels of social isolation, loneliness and related social vulnerability (older people living alone and not being involved in volunteering or helping whanau):

- Approximately 10 percent of people over the age of 65 are lonely all or most of the time (Gott 2022)
- 50 percent of people aged 80 or older are lonely all or most of the time (Gott 2022)

[7] National Academies of Sciences, Engineering and Medicine 2020

- One in five frail adults is considered ‘chronically lonely’ (Gott 2022)
- 17 percent of people aged 65+ in New Zealand are socially vulnerable (Social Investment Agency 2023)
- Over 23 percent of the most socioeconomically deprived older people experience social vulnerability (Social Investment Agency 2023).

New Zealand research has shown that almost 25 percent of people who are lonely may be at risk of premature death and that the reduction in lifespan resulting from severe loneliness is equivalent to smoking 15 cigarettes a day (Gott 2022). Overseas research has shown that social isolation is been associated with an approximately 57 percent increased risk of ED visits and a 68 percent increased risk of hospitalisation (National Academies of Sciences, Engineering and Medicine 2020).

Studies show that higher levels of loneliness predict increased frailty over time (Jarach et al. 2021 and Gale, Westbury, and Cooper 2018). Conversely, frailty can exacerbate loneliness by limiting older adults’ participation in social activities and their ability to maintain social connections (Ayeni, Sharples, and Hewson 2022).

Interventions to address social isolation and loneliness should, therefore, be integrated with health services due to the interactions between risk factors, social connections, and health impacts.

Internationally, there has been a growing focus on loneliness as a serious health issue. In 2016, the UK created the world’s first Minister for Loneliness. The Scottish and Welsh governments have implemented approaches to tackling loneliness that focus on connections and communities. The UK government’s loneliness strategy (Department for Culture, Media & Sport 2023) focusses on advancing three areas:

- reducing the stigma surrounding loneliness so that people feel able to talk about loneliness and reach out for help
- creating lasting change in the understanding of loneliness and its inclusion in policymaking and service delivery
- identifying what interventions work to reduce loneliness and ensuring people can access information to support decisions through challenging situations.

Other jurisdictions have also implemented significant programmes to address loneliness, including Canada, where one programme (McMaster University’s Health Tapestry programme) involving community volunteers in conducting health and wellness assessments in clients’ homes to establish unmet needs and link them to interprofessional primary care teams and community resources has been shown to be cost-effective and a preferred strategy compared with usual care (Tarride et al. 2024).

But in New Zealand, the matter has been relatively overlooked, particularly regarding Māori and minority groups (Gott 2022).

5 Healthy ageing sometimes requires specialist support

"Acute illness and hospitalization are important events in the trajectory leading to disability in elderly people"[8]

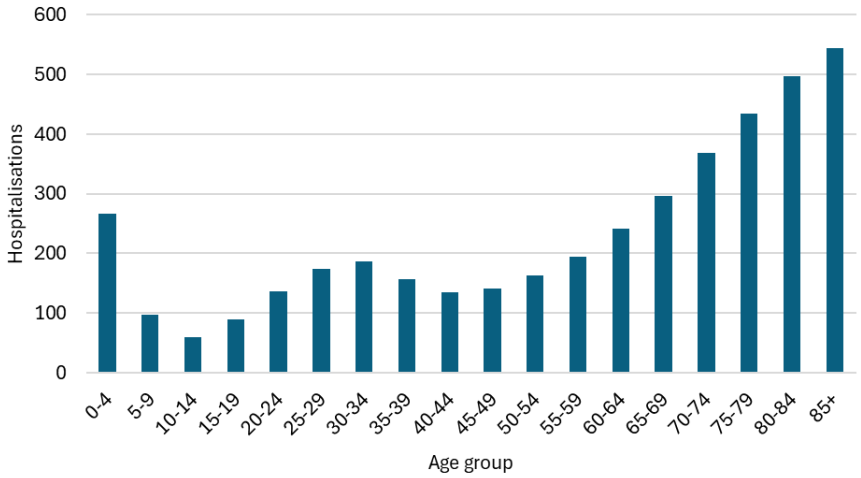
While New Zealanders can age well and remain healthy and strong until an advanced age, most experience significant loss of health and increased disability. As people age, health care needs change and become more complex. Inevitably, all people will experience episodes of acute illness, but when this occurs in older people the risks are greater because they can deteriorate faster and experience more complications, their diagnosis and treatment is more challenging due to the presence of more pre-existing conditions, and their full recovery and rehabilitation is less certain. One in four people aged 65 or older have 2 or more physical and/or mental health conditions (Social Investment Agency 2023).

Acute illness and hospitalisation in older people are recognised as pivotal events in the trajectory leading to loss of independence (Palleschi, Galdi, and Pedone 2018)

The demographic shift we are experiencing in a context that has not systematically supported healthy ageing has brought with it increasing numbers of older people presenting to emergency departments (EDs) with acute illness. In the ED, their experience of care is poor, with longer waits in a stressful, chaotic environment with little support. Health data shows that older people presenting to the ED are more likely to be admitted to hospital. There is a steep gradient in the rate of hospitalisations by age (see Figure 5 below), resulting in higher costs of hospitalisations for older age groups.

Figure 5 Hospitalisations by age group

Rate per 1,000 population, 2021/22



Source: NZIER based on Health NZ data (NMDS)

Published research shows that up to half of older adults will experience new functional impairments related to daily living after discharge from hospital, increasing their need for support services and their risk of admission to aged residential care. This outcome is so

[8] Palleschi, Galdi, and Pedone 2018

common and well-recognised that it has been coined “hospital-associated disability” (Martinez, Falvey, and Cifu 2022). The model of care needs an urgent overhaul.

A longevity economy recognises that an episode of acute illness presents an opportunity to investigate causes, identify other issues, support effective recovery, adjust where needed, and reset the course to ensure the best outcomes are achieved. It also requires optimal use of public resources.

A key population amongst older adults is those who are frail. Frailty is an age-related, progressive geriatric syndrome with physical, cognitive and social dimensions and causes. Frailty is characterised by reduced strength, endurance and physiological and psycho-social function and it increases a person’s vulnerability to poor health outcomes. It is most common in people aged 85 years and older (Health Quality & Safety Commission 2023). The progression of frailty can be dramatically slowed by effective interventions.

Twenty percent of New Zealanders who live in retirement villages have been identified as moderate-to-severely frail and have high rates of acute hospitalisations (Bloomfield et al. 2022).

Frail older people and older people at risk of frailty benefit from geriatric specialist input. Geriatric medicine has a crucial role in promoting health and managing complex combinations of medical, cognitive, social, and psychological issues in older people (Kotsani et al. 2021). Geriatric medicine typically involves a multidisciplinary approach to caring for older adults, with geriatricians working collaboratively with nurses, therapists, pharmacists, social workers, nutritionists and other health professionals to provide comprehensive and coordinated care (Geo 2023).

Interventions that keep people out of the hospital can offer significant cost savings as well as supporting people to remain at home and maintain functional independence. Geriatric assessment is an effective intervention that can support this. A geriatric assessment is a multidimensional, multidisciplinary assessment designed to evaluate an older person’s functional ability, physical health, cognition, mental health, and socioenvironmental circumstances. The assessment not only improves the patient’s diagnosis of medical conditions but also supports the identification of effective treatment, follow-up, coordination of care, and evaluation of long-term needs (Elsawy and Higgins 2011).

Many examples of targeted geriatric assessments overseas show that these interventions can:

- help more people recover at home, avoiding inpatient hospitalisation
- support better health outcomes, through the initiation of short-term or long-term treatment or community supports that reduce the risk of further acute illness
- reduce admission to aged residential care
- strengthen people’s longer-term health resilience, allowing them to continue participating socially and economically, and reducing the risk of admission to aged residential care.

Planned comprehensive geriatric assessment in the community (Garrard et al. 2020; Leahy et al. 2024) targeted geriatric assessment in the ED (such as the model adopted by Melbourne’s St Vincent’s Hospital), and older people’s assessment units (e.g. “Hot Clinics” at King’s College and Guy’s Hospitals) have been shown to improve functional independence for older people and reduce hospital admissions, freeing up beds for people of all ages (Carbonell and Branley 2025 and Waitemata District Health Board and the National Institute for Health Innovation n.d.).

6 Conclusion and recommendations

While the life expectancy gains seen over the past two generations have been a remarkable achievement, too little attention has been paid to how New Zealanders age and how they live in the later stages of life.

The UN Decade of Healthy Ageing and the World Economic Forum's Longevity Economy present an alternative way of thinking about ageing – one in which investments in healthy ageing and age-friendly systems and communities pay a dividend in individual quality of life and fiscal sustainability.

In this report, we have presented five areas for investment including broad, universal and low-cost investment as well as targeted investment for those most in need of direct intervention. The priority areas represent the most significant challenges of New Zealand's current approach to longevity: Ageism, unsuitable and unaffordable housing, a lack of long-term planning, loneliness and social isolation, and poor health outcomes.

We recommend that government agencies and non-government organisations work together to design and implement interventions to begin addressing these challenges.

7 References

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