



Longevity economy opportunities

Evidence-based options to respond to New Zealand's ageing society

NZIER report to Selwyn Foundation

December 2025

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Key points

Responding to demographic change through a longevity economy lens

New Zealand's population is ageing rapidly. Longevity gains have been significant, with Māori life expectancy improving by over three years since the mid-2000s and non-Māori also living longer. These gains reflect improvements in living standards and healthcare, but they also bring fiscal and social challenges as well as opportunities.

A longevity economy approach reframes ageing not as a cost but as an investment opportunity and imperative. Policies that enable healthy ageing, independence and resilience underpin both wellbeing and fiscal sustainability.

Purpose and scope of this study

Commissioned by the Selwyn Foundation, this report examines the policies and programmes that could or should be implemented to help New Zealand respond effectively to population ageing. Building on earlier work, it focuses on evidence-based, practical solutions that promote independence, reduce system pressures, and support equitable participation in later life.

The report draws from international frameworks – the UN Decade of Healthy Ageing (2021–2030) and the World Economic Forum's (2024) Longevity Economy principles – to develop the evidence base around three key pillars:

- age-friendly homes and communities
- healthy ageing
- financial resilience and employment.

Each pillar represents a set of mutually reinforcing interventions that together create the conditions for longer, healthier, and more productive lives. The three pillars for this report are consistent with those identified in the government's newly released Better Later Life Action Plan (Office for Seniors 2025b).

Key findings

Homes and communities are pivotal to healthy ageing. Evidence shows that home modifications, universal design standards, and innovative approaches to home ownership can extend independent living, reduce health system costs, and support and strengthen community connection. New Zealand's membership in the WHO Global Network for Age-Friendly Cities and Communities is an important foundation, but efforts remain fragmented. Stronger leadership, consistent data collection, and greater inclusion of Māori, Pacific, and migrant communities are needed. Local councils could play a more active role in ensuring homes and communities support health and independence across the life course.

Healthy ageing initiatives that take a preventive approach and focus on keeping older people in their communities, such as social supports, technology-enabled care, adult vaccination, oral health, and falls prevention, have clear evidence of cost-effectiveness. These measures improve the quality of life of older people and relieve pressure on residential care and hospital systems, but New Zealand's adoption of these has been patchy.



Financial resilience and employment provide the supporting conditions for wellbeing in later life. High workforce participation among older New Zealanders has moderated fiscal pressures, but inequities remain stark. Māori, Pacific, women, and disabled people experience lower lifetime earnings, less retirement savings, and reduced ability to work into later life. A sustainable longevity economy requires policies that close these gaps. New Zealand's retirement income system is shifting and will continue to move away from government contributions, but will need to take an increasingly targeted approach to reflect the realities of inequitable ageing. Investments in lifelong learning and in addressing systemic barriers to earning and saving will reduce the burden on taxpayers and support better and more equitable outcomes for future generations of older New Zealanders.

New Zealand's demographic trajectory demands an integrated response

New Zealand already has many of the critical enablers in place. Relatively modest, well-targeted investments have the potential to generate human and fiscal returns. In this report, we highlight the following areas for investment or improvement:

- Increased monitoring and evaluation of age-friendly community initiatives and improved systems to share learnings across communities.
- Resources and support to embed culturally relevant approaches in dementia-friendly communities initiatives.
- Increased development of innovative housing solutions, including shared ownership models to increase the supply of affordable age-friendly housing, home safety assessment and targeted subsidies for higher risk older people to enable them to age in place safely.
- Increased social supports based on a combined professional and volunteer model and including older people in the social support workforce to help community-dwelling older people age in place and avoid loneliness and social isolation.
- Health system initiatives to harness the power of technology to help keep older people at home by remote monitoring of community dwelling older people who are at risk of or have experienced acute health events, increased investment in adult vaccination (shingles, influenza and RSV), a range of hearing, vision and oral health interventions from universal to highly targeted supports, and increased investment in multifactorial falls prevention integrated with home safety assessment and modification.
- Improvements to the retirement income system to address structural barriers across key life stages that disadvantage women, target support to Māori and other disadvantaged New Zealanders who are dependent on government contributions and Superannuation, and increased incentives for private saving.
- Funded support for retraining, re-skilling, up-skilling, and job matching to support New Zealanders working in hazardous, arduous or other work that becomes unsuitable as they age to continue participating in the workforce.

Overall, in reviewing the evidence base, we found that many evidence-based and locally appropriate solutions have already been proposed in New Zealand, but action has been patchy and fragmented. As a small country with primarily centralised services, New Zealand could develop a stronger, more coordinated approach to longevity, but international models also indicate that local governments must play a key role in housing and community initiatives and that the national government should support this.

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1 Background and approach

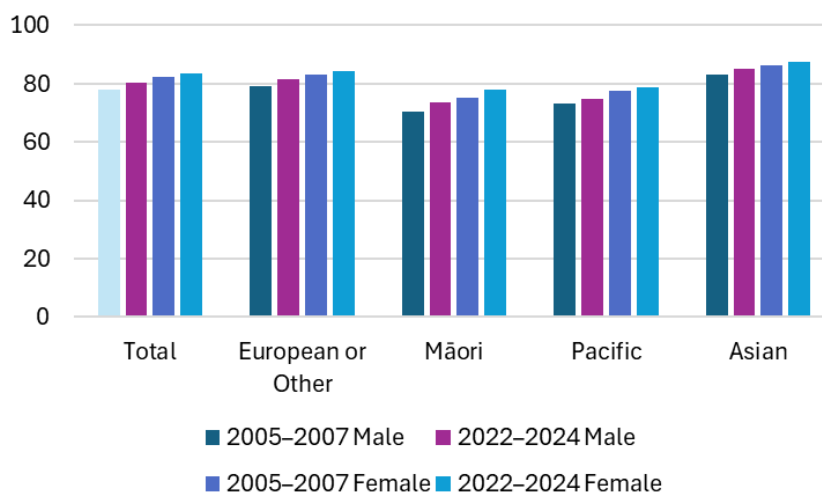
The Selwyn Foundation commissioned NZIER to investigate what policies and programmes could and should be implemented in New Zealand to address the challenges of an ageing population, support healthy longevity and transform New Zealand into a longevity economy.

1.1 Context

New Zealanders are living longer. Gains in life expectancy continue to be made at a significant pace. Encouragingly, the gap between Māori and non-Māori is slowly closing, with the latest data showing Māori gained 3.1 years from 2005–2007 to 2022–2024, while people who identify as European or Other gained only 1.5 years. These gains are the result of improved living standards, enhanced health care and delivery, and reductions in early-life mortality.

Figure 1 Life expectancy by ethnicity

Years, 2005–2007 and 2022–2024



Source: NZIER, Stats NZ (2025)

Living longer presents important opportunities. If longer lives are also healthy lives, people may continue to work beyond the traditional retirement age, and the data indicate many do: 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 among older adults and have helped mitigate the exponential increase in debt that was expected in the absence of offsetting action by the 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 many New Zealanders are not enjoying these benefits:

- Disadvantaged New Zealanders, including Māori, Pacific and disabled people, have lower employment rates, lower incomes, and therefore lower retirement savings and are less likely to own a home when they retire. The Ministry of Social Development and Office for Seniors draft Long-Term Insights Briefing notes that 25,000 older people (around 3 percent of that population) are in material hardship with a further 30,000 in 'near hardship' (Ministry of Social Development and Office for Seniors 2025).
- The labour market disadvantage for Māori and Pacific New Zealanders is often compounded by the nature of the work they do, which is hazardous or arduous and does not allow them to continue to an older age, even if they wanted to. Working conditions also compound higher rates of long-term conditions, which threaten both economic wellbeing in later life and independence. In 2014, 63 percent of Māori and 74 percent of Pacific people aged 65-plus were classed as disabled, compared with 58 percent of Pākehā and 50 percent of Asian.
- Women continue to experience gender-based disadvantages through gender pay gaps and the effects of parental leave on income and retirement savings. Women make up 53 percent of those aged 65+, 60 percent of those aged 85+, and 65 percent of those aged 90+. Because women live longer, they spend more time supporting themselves in retirement and living alone while doing so (Ministry of Social Development and Office for Seniors 2025).
- People who have experienced life-long disability are at higher risk of poverty and disadvantage later in life (Ministry of Social Development and Office for Seniors 2025).
- The current generation of 'rainbow' older people have often had lifetime experiences of social exclusion, discrimination, victimisation, stigma, and identity concealment which have led to poorer health, social isolation, and lower incomes (Ministry of Social Development and Office for Seniors 2025).
- All New Zealanders who experience major financial setbacks in life, which often result from relationship breakdown, prolonged periods of illness, disability onset, loss of a partner or unexpected unemployment, face a steep recovery that can't be fully overcome when setbacks occur closer to retirement.
- Late in life, many of these disadvantages show up as housing issues (older people in unsuitable and affordable housing, or even homeless), low living standards, and early loss of independence.

Beyond these, there are many systemic barriers to healthy longevity, including ageism.

The Ministry of Social Development and Office for Seniors warn that future hardship for older people is largely dependent on the housing market and how Government responds to increasing costs associated with population ageing (Ministry of Social Development and Office for Seniors 2025).

Addressing later-life challenges is not a simple issue: 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, and yet its relative generosity has largely insulated older New Zealanders from rising inequities in housing, incomes and saving (Ministry of Social Development and Office for Seniors 2025).

Since 2006, Treasury has consistently warned that fiscal settings need reform to remain sustainable.

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 Relevant frameworks

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 (2024)

Both frameworks call for a change in how society responds to ageing to increase older people's independence and reduce their need for costly services.

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.

1.2 Our approach

Most longevity economy solutions have impacts across more than one outcome and can be designed to address more than one issue. To provide a simple yet effective structure, we have translated the two dominant frameworks into three simple intervention areas:

- age-friendly homes and communities
- healthy ageing
- financial resilience and employment.

Our report represents the result of a broad scan of policies and programmes – initiatives implemented in New Zealand and internationally to address the key challenges of ageing populations. We present those that are most supported by evidence of positive impacts and offer high cost-effectiveness or potential for cost savings.

In many cases, New Zealand is already doing the right things, but more is needed, such as national scaling or increased funding, or minor adjustments, which would offer significant improvements. International examples offer insights into how these could be introduced and the likely impacts. In other cases, New Zealand research already offers a substantial and robust evidence base for what is needed, and we prioritise this evidence where relevant.



2 Age-friendly homes and communities

2.1 The concept

Age-friendly homes and communities are foundational to healthy ageing because they enable functional ability (the capability of older people to be and do what they value) across the life course.

Age-friendly homes and communities:

- Support people to age in place, recognising that people's home environment consists of both their home and their local community (World Health Organization 2015).
- Help people maintain their social participation, recognising that:
 - social isolation and loneliness are detrimental to wellbeing and can have significant negative impacts on mental and physical health, with associated high costs
 - older people have much to contribute to their local communities
 - older people may become disconnected from people, places and services as a result of retirement, moving to a new community by choice or necessity, experiencing a major health event or disability, becoming a carer for their partner or spouse, or experiencing the death of a partner, spouse or friends, and forming new connections can be challenging.
- Encourage active lifestyles, including walking, which supports people to remain fit and healthy as they age and helps them recover their fitness and health after an injury or illness.

Practical measures, from barrier-free housing and transport to neighbourhood amenities and social connection, reduce physical and social obstacles, slow the decline in capacity that often comes with age, and help people continue to thrive even as they experience declines in capacity (World Health Organization 2020). In other words, the built and social environment is itself a lever for improved physical and mental health and independence, not just the backdrop against which these occur (World Health Organization 2020; 2023b).

2.2 The rationale

Improvements in homes and communities to support healthy and independent living have the potential not only to improve the wellbeing of all generations but also to reduce downstream costs by better supporting people as they age, reducing the burden on caregivers, and increasing the effectiveness of services. These effects are expected to delay or prevent serious health events and admission to residential care. An added benefit of age-friendly communities is the increased social participation of older people, which can have many important flow-on benefits to the community.

Ageing in place is also consistent with the expressed preference of the overwhelming majority of New Zealanders of all ages (Ministry of Social Development and Office for Seniors 2025). For this reason, homes and communities that support ageing in place are expected to have a significant impact on the wellbeing of all New Zealanders.

Many initiatives are designed to address specific challenges related to:



- disability and activity limitation, which are common within the broader population, but also increase with age due to a variety of factors, including worsening impact of disabilities that people may be born with, disabilities that are acquired by accident or injury, and disability that results from diseases and conditions and their complications affecting people's ability to function well in their own home as well as in the community
- vision and/or hearing loss, which usually occur gradually, and mean people adapt well to a different way of living at home, but lose their confidence outside of their home
- cognitive decline, usually due to dementia, which is a significant and growing concern, with over 8,000 people living with dementia in New Zealand, predicted to rise to 170,000 by 2050 (Alzheimers New Zealand 2021a), with impacts on social connection and safety.

However, age-friendly communities also recognise that social barriers can occur due to environmental factors such as:

- neighbourhoods that people have lived in for long periods of time are changing significantly, potentially with a loss of familiar services or resulting in concerns about safety
- people's social connections being lost due to friends moving away, being admitted to aged care facilities, or dying
- older people needing to move to a new area due to a range of factors and experiencing disconnection from familiar people, places and services
- technological change that alters how people interact with services and can result in reduced service access for digitally excluded communities.

Wiles et al. (2012) explored the meaning of ageing in place for older people in two New Zealand communities. The study found that the majority of elderly people who participated in the study identified "the home" as the primary area of focus, but also highlighted the sense of community as important.

2.3 Age-friendly cities and communities

The Global Network for Age-Friendly Cities and Communities (GNAFCC) was established by the World Health Organization (WHO) in 2010 in response to two intersecting global trends:

- population ageing
- rapid urbanisation.

Its purpose is to support cities and communities worldwide in creating physical and social environments that foster health, participation, and security for older people (WHO 2018). Rather than serving as a certification, the network is a platform for commitment: Local authorities pledge to assess their age-friendliness, engage older residents in decision-making, and share progress and learning with peers (World Health Organization 2018; 2021a).

The mission of the GNAFCC is to stimulate and enable cities and communities to become increasingly age-friendly through inspiration, connection, and technical support. WHO provides evidence-based guidance, case studies, and toolkits to inspire local action; connects cities globally for peer learning; and supports the development of national and



local programmes through mentoring, data collection, and evaluation frameworks (World Health Organization 2018; 2021a). Tools like the Core Indicators for Age-Friendly Cities and mentoring programmes help municipalities measure progress, strengthen leadership, and embed age-friendly design into planning and service systems (World Health Organization 2021a). The WHO identifies that these initiatives align with the UN Decade of Healthy Ageing (2021–2030), which identifies “age-friendly environments” as one of its four action areas (World Health Organization 2020).

Membership in the network is open to any city, community, or local government willing to engage in a structured process of continuous improvement. Members commit to listening to older people’s voices, assessing local strengths and barriers, planning collaboratively across sectors, and monitoring change (World Health Organization 2021a). This approach recognises that becoming age-friendly is a process of ongoing transformation, grounded in local context and participation rather than external accreditation (World Health Organization 2021a).

As of 2024, the network encompassed more than 1,700 cities and communities across 57 countries, collectively representing over 370 million people (World Health Organization 2024). Its growth has been particularly strong in regions such as the Americas and Western Pacific, where regional WHO offices and partners such as the Pan American Health Organization offer training and coordination (Pan American Health Organization 2023).

Through this global collaboration, the GNAFCC operationalises the WHO vision that age-friendly environments are: “Environments that are free from physical and social barriers and are supported by policies, systems, services, and technologies that, (1) promote health and build physical and mental capacity across the life course; and (2) enable people, even when experiencing capacity loss, to continue to do things they value” (World Health Organization 2018). It thus plays a crucial role in translating the Decade of Healthy Ageing’s principles into local action that advances health equity, inclusion, and resilience in ageing societies.

2.4 Age-friendly communities in New Zealand

New Zealand is an affiliate member of the GNAFCC, with membership status managed by the Office for Seniors. The Office for Seniors (Office for Seniors and Boffa Miskell 2021) has identified that urban places in New Zealand often do not enable older people to participate or be included in public life.

The Office for Seniors coordinates the Age Friendly Aotearoa New Zealand Network, a platform linking councils, iwi, and community organisations committed to making their local areas more age-friendly (Office for Seniors 2024).

The Office for Seniors provides practical and policy support for communities seeking GNAFCC membership. It manages information sharing, capacity-building workshops, and access to the Age-friendly Toolkit, which guides councils through WHO’s four-stage process (Office for Seniors 2024). The Office also convenes a national Age Friendly Network, fostering collaboration among the 35 local councils and districts working toward or already recognised as age-friendly (Office for Seniors 2024). This national leadership role strengthens consistency, learning, and international visibility, ensuring that New Zealand’s efforts contribute meaningfully to the UN Decade of Healthy Ageing’s goal of developing age-friendly environments (World Health Organization 2020; 2023a).



Several reports have been published that provide some assessment of New Zealand's progress on age-friendly communities. These are summarised in the table below. Key recommendations include:

- strengthening communication channels among age-friendly initiatives for knowledge sharing and scaling of good practice
- further work to address employment, housing, digital inclusion and elder abuse
- improved monitoring and evaluation with robust and consistent data
- increased attention to equity for Māori and migrant populations.

Table 2 Evidence of New Zealand's progress on age-friendly communities

Report	Achievements/progress reported	Recommendations
Neville, Stephen; Adams, Jeffery; Napier, Sara; Shannon, Kay. 2018. <i>Age-Friendly Community Evaluation: Report prepared for the Office for Seniors, Ministry of Social Development</i> . Auckland: Auckland University of Technology Centre for Active Ageing.	The evaluation of pilot sites in Kāpiti Coast District, New Plymouth, and Hamilton (pilot implementation period November 2017 – May 2018) found that each pilot used different approaches and progressed at different rates. Key success factors included central government/Office for Seniors support, council buy-in, strong community engagement, robust needs assessments, and implementation of age-friendly initiatives. Māori engagement was present but limited; migrant community engagement was minimal.	Recommendations included: developing a toolkit to help other communities become age-friendly; fostering positive working relationships between local councils and communities; providing guidance on engagement with Māori and migrant communities; and undertaking educational and awareness-raising so that local and central government and communities understand what "age-friendly" means.
Office for Seniors. 2024. <i>Creating an Age friendly Aotearoa New Zealand: Annual Update to the World Health Organization Global Network for Age-Friendly Cities and Communities (covering 1 July 2023 – 30 June 2024)</i> .	Achievements include: continued Homeshare pilot, research into mortgage stress and divesting of Council housing, expanded membership of Digital Inclusion Action Group, locally led participation and social inclusion projects set up through the Age friendly grants scheme, increased membership of the Age friendly Network for local councils, validation of the Age friendly Cities and Communities questionnaire for use in New Zealand.	Ongoing actions: Development of Older Workers Employment Toolkit, support for networking and sharing of best practice for Age-Friendly Employers, promotion of age-friendly communities guides and toolkits and membership in the Age-friendly Network, Age-Friendly Fund grants for locally-led age-friendly projects, promotion of the Age Friendly Cities and Communities Questionnaire.
Office for Seniors. 2023. <i>Creating an Age friendly Aotearoa New Zealand: Annual Update to the World Health Organization Global Network for Age-Friendly Cities and Communities (covering 1 July 2022 – 30 June 2023)</i> .	Achievements include building a national network of age-friendly communities (growth of the Age Friendly Network), providing resources (toolkits, guidance), supporting projects via a small grants scheme, funding digital inclusion programmes, senior enterprise pilot, Homeshare pilot, elder abuse prevention grants, and broader policy advocacy.	Ongoing actions: Testing delivery models to support older people aged 50+ to start their own business, research into older Māori and work, progressing the Accessibility for New Zealanders Bill, promoting age friendly communities resources, increasing membership of the Age friendly Network, providing Age friendly Fund grants for locally-led age friendly projects.



Report	Achievements/progress reported	Recommendations
Office for Seniors. 2022. <i>Creating an Age friendly Aotearoa New Zealand: Annual Update to the World Health Organization Global Network for Age-Friendly Cities and Communities (covering 1 July 2021 – 30 June 2022).</i>	Achievements include launching the “Older Workers’ Employment Action Plan” (OWEAP, April 2022), pilot entrepreneurship support for older workers (50+), digital inclusion and older worker/entrepreneurship pilots, and aligning many central government initiatives with the age-friendly domains (housing, services, participation, accessible environments).	Ongoing actions: Developing a Homeshare pilot, improving understanding of the experiences of older Māori and work, developing and evaluating Senior Entrepreneurship pilots, expanding Digital Skills Training for Seniors, developing an Age friendly Aotearoa New Zealand Research Agenda, improving understanding of the impacts and opportunities of climate change for older people.
Neville, Stephen, Jo Conaglen, and Jeffrey Adams. 2025. <i>Evaluation of the Age friendly Fund</i> . Report prepared for Office for Seniors.	Found that from 2018–2023, the Fund has funded ~65 projects supporting councils or communities to develop age-friendly plans or implement projects; the funded projects largely aligned with intended programme goals; there was national reach; and the overall assessment of the programme was that it had a strong positive impact (rated as “Excellent” in rubric). Challenges included reliance on volunteer contributions, varying infrastructure across communities, and some administrative burdens.	Recommendations included: strengthen communication channels among age-friendly initiatives (improve network connection), improve the newsletter to include project outcomes, revise application guidelines and reporting forms, integrate continuous improvement cycles in grant processes, and provide guidance/support for volunteers (recruitment and retention).
Annear and Hyde. 2025. <i>Taking stock of Age-Friendly Cities in Aotearoa New Zealand: Progress, pitfalls and pathways towards healthy ageing</i> . Australasian Journal on Ageing.	New Zealand cities are facing rapid demographic ageing, with many local councils adopting the age-friendly framework. They document that local communities are using the WHO age-friendly domains (environment, participation, housing, transport, etc.) and embedding age-friendly planning in local policy. They also highlight the shift toward “super-aged communities” needing more innovation in built environment and social systems.	Recommends more evaluation, stronger data monitoring, more attention to equity (Māori, migrant older populations), scaling good practice across councils, and better integration of local evaluation and academic-community partnerships.

Source: As per table

2.5 Dementia-friendly communities

Dementia-friendly communities are a specific type of age-friendly community. They aim to ensure that people affected by dementia (people living with dementia, and carers and supporters) can live well and continue to be active and valued members of their community.

Community-based dementia friendly initiatives have been implemented in many jurisdictions around the world (Buckner et al. 2022), having been extensively promoted by the WHO, which has published a toolkit to support their design and implementation (World Health Organization 2021b).



Dementia-friendly communities (DFCs) are places in which local facilities, services, businesses and public spaces are adapted so that people living with dementia can participate, feel safe, and remain independent for longer.

A key finding is the value estimate provided by the social impact evaluation of the Dementia Orkney initiative, which was estimated to be 5.16 to 1. That is, for every dollar invested, a return of \$5.16 is expected in social value (Thompson-Bradley and Christie 2021).

2.6 Dementia-friendly communities in New Zealand

In New Zealand, Alzheimers New Zealand leads the national Dementia Friendly NZ kaupapa. Its programme includes:

- the Dementia Friendly Recognition Programme, an accreditation framework for organisations and councils
- the Dementia Friends awareness module to mobilise the wider public

(Alzheimers New Zealand 2021a; 2021b; 2025).

The Office for Seniors (Te Tari Kaumātua), as government’s lead on age-friendly policy, supports local work indirectly through the Age Friendly Aotearoa New Zealand programme and its small-grants Age friendly Fund, which resources projects that make services, public spaces and amenities more dementia-inclusive (Office for Seniors 2025a; Neville et al. 2025). Alongside these, sector partners play complementary roles: Dementia New Zealand coordinates regional affiliates delivering community support and education, while the NZ Dementia Foundation curates best-practice resources and convenes sector leadership (Dementia New Zealand 2025a; 2025b).

On the ground, a growing mix of councils, libraries, health and aged-care providers, and community organisations are using Alzheimers New Zealand’s toolkits to shift practice and design. Recent examples include district and city libraries progressing through the Recognition Programme “Working to be Dementia Friendly” and earning formal recognition, illustrating how public institutions adjust staff training, signage, collections and sensory environments to better serve people with dementia (Alzheimers New Zealand 2024a; 2024b; Waimakariri District Council 2025; Westland District Council 2024).

There is emerging evidence of the positive impacts of these initiatives. An independent evaluation of four local Alzheimers organisations found community services (navigation, day programmes, education and carer support) help people live well, improve caregiver outcomes, and identify service gaps to address – pointing to the value of community-based, dementia-capable provision (Alzheimers New Zealand 2020).

At a programme level, the Office for Seniors’ evaluation of the Age friendly Fund concluded the grants had a “strong positive impact” across 65 projects (2018–2023), including several explicitly dementia-friendly services, with benefits such as increased social connection, more accessible public services, and stronger local networks (Neville et al. 2025).

Case material from library implementations highlights practical gains—staff capability, adapted environments and partnerships with police and local Alzheimers groups – that make routine community interactions easier and safer for people with dementia (Alzheimers New Zealand 2024b). These findings align with international evidence that



DFCs can enhance independence and inclusion when sustained through multi-stakeholder effort (Craig et al. 2024).

Funding for dementia-friendly initiatives comes from a mix of public and non-government sources.

- on the public side, the Office for Seniors' Age friendly Fund offers competitive grants of NZ\$5,000–\$15,000 to councils and community organisations for planning and projects that can include dementia-friendly components (Office for Seniors 2025a; Neville et al. 2025)
- Alzheimers and Dementia NZ organisations also receive contracts from Health New Zealand/ Te Whatu Ora alongside philanthropy and donations; sector briefings estimate total funding across 17 organisations at about NZ\$11.8 million annually (circa 2024), roughly 58 percent of which comes via Te Whatu Ora.

Funding levels from these sources have been identified as insufficient to meet demand (Alzheimers New Zealand and Dementia New Zealand 2024).

Alzheimers New Zealand's latest annual report also documents donor-supported initiatives and advocacy for implementing the refreshed Dementia Mate Wareware Action Plan 2026–2031, which sets a five-year roadmap and calls for decisive government investment in community support and dementia-capable systems (Alzheimers New Zealand 2025a; 2025c).

There is no single national register of “dementia-friendly communities”. Instead, activity is visible through:

- the number of organisations and councils enrolled or accredited in Alzheimers NZ's Recognition Programme
- Dementia Friends uptake
- age-friendly plans/actions with dementia-specific components.

Public updates on these indicate rising participation, with Recognition Programme enrolments doubling in 2023 and a steady flow of new recognitions in 2024–2025 across multiple districts (Alzheimers New Zealand 2024a; 2024b; Waimakariri District Council 2025). The Age friendly Fund has supported over 65 local projects since 2018, with several tagged to dementia-friendly outcomes, and more are funded annually ().

Given the scale of the challenge, stakeholders emphasise the need to scale evidenced community supports and embed dementia-friendly design across local systems (Alzheimers New Zealand 2025c; 2025d). Several reports have been published which provide some assessment of New Zealand's progress on dementia-friendly communities. These are summarised in the table below. Key recommendations include:

- more culturally relevant services
- greater reach into rural and isolated communities
- better connection/integration with health services
- stronger communication across initiatives to improve information sharing and scale successful initiatives
- increased public awareness and organisational uptake.



Table 3 Evidence of New Zealand's progress on dementia-friendly communities

Report / Evaluation	Achievements/progress reported	Recommendations
Alzheimers New Zealand (2020). <i>Evaluation of Services for People Living with Dementia Provided by Four Local Alzheimers Organisations</i> . Wellington: Alzheimers New Zealand.	Community services from local Alzheimers organisations (navigation, day programmes, carer education/support) were found to meet needs, help people live well with dementia, and benefit carers; gaps included limited resourcing and variable reach, especially for Māori, migrants, rural/isolated areas.	Increase and stabilise funding; strengthen culturally relevant services (especially for Māori); improve reach to rural/isolated communities; improve information flows to other health providers.
Neville et al. (2025). <i>Evaluation of the Age friendly Fund</i> . Report prepared for Office for Seniors	The Age friendly Fund (NZ\$5,000–\$15,000 grants) supported ~65 projects 2018–23, with strong positive impact overall; several projects explicitly advanced dementia-friendly practice (e.g., making public services and spaces more inclusive).	Strengthen communications and sharing of outcomes across initiatives; refine application/reporting guidance; embed continuous improvement in grant processes; support volunteer recruitment/retention.
Alzheimers New Zealand. 2024. "Strides Made in Dementia Friendly Recognition Programme."	Reported momentum in the Dementia Friendly Recognition Programme (DFRP), including councils maintaining or extending "Working to be Dementia Friendly" status (e.g., Marlborough) and broader uptake across public institutions.	Sustain and scale organisational participation; continue staff training and environmental adaptations as part of maintaining/renewing recognition cycles.
Alzheimers New Zealand. 2025. "Dementia Friendly Recognition Programme."	National accreditation/ recognition framework in place for organisations and councils; provides structured pathway (assessment, action, recognition) to make environments, services and workplaces dementia friendly.	Use the DFRP to plan, train staff, adapt environments and review progress regularly; pair with public awareness via <i>Dementia Friends</i> to build community capability.
Waimakariri District Council. 2025. "Waimakariri Libraries Become Even More Dementia Friendly."	Waimakariri Libraries formally recognised as "Working To Be Dementia Friendly"; practical measures include staff capability building and adapted collections/spaces, with continuing improvements signalled.	Keep progressing through the DFRP pathway and embed dementia-friendly practice.
Westland District Council. 2024. "Library a Dementia-Friendly Space."	Westland District Library joined the DFRP; Alzheimers NZ publicly endorsed the milestone, highlighting a model for other public services to follow.	Encourage wider organisational uptake across council and community services; continue staff training and environmental changes consistent with DFRP standards.

Source: As per table

Given the findings of reviews of New Zealand's approach, improving cultural relevance in dementia-friendly communities would be best aligned with the principles of the UN Decade



of Healthy Ageing and the World Economic Forum's longevity economy. This would be best done by engaging with Iwi and Pacific communities, as well as Asian and other migrant communities, at both a governance level and in service design and delivery.

2.7 UK approach and examples of culturally inclusive practice in dementia-friendly communities

The UK Prime Minister's challenge to establish "dementia-friendly communities" (DFCs) saw more than 82 places commit to becoming dementia-friendly in early 2015. The Prime Minister's Challenge in 2015 pledged that by 2020, over half of England's population would be living in a DFC. As of July 2020, there are approximately 350 DFCs in England, according to the Alzheimer's Society Dementia Friends website.

The DEMCOM study (Goodman et al. 2019) was funded by the Department of Health and Social Care to carry out a national evaluation of DFCs. The study ran from January 2017 to July 2019. It evaluated how DFCs support people living with dementia and their carers, the approaches that have worked best, and how to keep DFCs going. DEMCOM used a mix of research methods, including: a scoping review, data on how many people have dementia in the population, linking this geographically with DFC activities, a survey and detailed case studies of DFCs.

People living with and affected by dementia were involved throughout all phases of the study.

The study makes a number of recommendations around embedding cultural relevance:

- Communities need to adapt their DFC approach to the local demographic context (including ethnic diversity, migrant communities, and different languages).
- Communities should use local co-design with people living with dementia (and their families/carers) from diverse ethnic backgrounds, ensure volunteer and staff training is culturally competent, and adapt materials in multiple languages.
- Working with diverse cultural communities on dementia initiatives requires an understanding of how cultural beliefs about dementia may differ, with stigma or different understandings, which means awareness and engagement approaches must be tailored.
- Local demographic data should be used to guide plans.
- Some DFCs that were more successful engaged with faith groups and ethnic community centres, used multilingual resources or volunteers from minority communities, and leveraged existing social networks and cultural organisations to tailor outreach, indicating that communities should build stronger partner networks within specific cultural communities.
- Anchor institutions (statutory bodies, local councils, voluntary groups) that understand local cultural diversity should help to adapt local materials and resources.
- Monitoring and evaluation data should be segmented by ethnicity or demographic groups so that DFCs can assess if they are reaching all sub-populations.

Specific UK examples of good practice have emerged, including London's Connecting Communities initiative, a dementia-friendly community outreach programme run by Alzheimer's Society, which embeds cultural and linguistic tailoring across eight diverse



boroughs. An independent evaluation found the project delivered over 540 awareness sessions reaching over 8,300 people from diverse ethnic communities; created multilingual resources (e.g. “What is dementia?” in 12 languages); and reported measurable shifts in engagement, with a third of participating dementia services seeing increased uptake by minority ethnic groups. A key to the success of this initiative was the recruitment of volunteers from within target communities, co-design, sustained partnerships with faith and cultural organisations, and translated, culturally relevant, locally tailored materials (Greater London Authority 2022).

Several reports have been published that demonstrate how culturally inclusive practice has been embedded in UK dementia-friendly communities, such as London’s Connecting Communities initiative. These are summarised in the table below.

Table 4 Evidence from UK dementia-friendly communities

Report/Evaluation	Initiative locations	Achievements/progress reported	Recommendations
Dean, Janet; Kay Silversides; Janet Crampton; and Julie Wrigley. 2015. Evaluation of the Bradford Dementia Friendly Communities Programme. Bradford City & District, UK: Joseph Rowntree Foundation.	Bradford Metropolitan District, West Yorkshire, England (multi-ethnic, multi-faith communities).	DFC work was tailored to Bradford’s diversity; outreach with faith/community organisations and involvement of people with dementia and carers from minority groups helped shape a “Dementia Friendly Bradford.”	Use local demographic/cultural data from the outset; co-design with minority ethnic communities; partner with faith/community groups; provide linguistically/culturally adapted materials; share the model with other diverse places.
Association for Dementia Studies, University of Worcester. 2015. Connecting Communities Project External Evaluation: Final Report. London, UK: Alzheimer’s Society/partners.	Eight London boroughs with high ethnic/linguistic diversity (e.g., Brent, Ealing, Hackney, Haringey, Harrow, Lambeth, Lewisham, Tower Hamlets).	Delivered 540+ awareness sessions reaching 8,300+ people from BAME communities; built partnerships with faith/cultural orgs; produced multilingual materials—leading to increased engagement from target groups.	Sustain volunteer networks drawn from target communities; maintain translation/local tailoring; embed DFC awareness in borough strategies; resource co-design with cultural groups for legacy beyond short-term projects.
Thompson-Bradley, O, and J Christie. 2021. Evaluating the Impact of Life Changes Trust-Funded Dementia Friendly Communities in Scotland: Social Return on Investment Studies. Report. The Dementia Centre, HammondCare.	Orkney Islands, Scotland (island communities; strong place-based culture).	Independent SROI estimated £5.14 social value per £1 invested; community-anchored DFC actions (awareness, inclusion, local partnerships) reduced isolation and improved participation—showing benefits from culturally grounded, place-based design.	Embed DFCs in local governance/partnerships; use assets-based, culturally rooted approaches; maintain stable funding to protect value created; continue measuring outcomes meaningful to local culture and geography.
Dean, Janet; Kay Silversides; Janet Crampton; and Julie Wrigley. 2015b. Evaluation of the York Dementia Friendly Communities	City of York, England (heritage city; distinct local identity; “Four Cornerstones” model emergent	Programme embedded local identity and participation (people with dementia shaping priorities), integrating DFC actions into city	Build DFCs around local culture/identity; integrate across city systems; use ongoing co-production with people with dementia and



Report/Evaluation	Initiative locations	Achievements/progress reported	Recommendations
Programme. York, UK: Joseph Rowntree Foundation.	from earlier JRF work).	institutions—an example of culturally/locally grounded DFC practice (place-culture rather than ethnic culture).	carers to sustain relevance and impact.

Source: As per table

2.8 Age-friendly housing

Housing itself is the foundation of age-friendly communities, yet 14 percent of older people experience housing vulnerability, including poor housing quality and/or over-crowding, with Pacific and Māori older people experiencing much higher rates (39 percent and 27 percent, respectively) (Ministry of Social Development and Office for Seniors 2025).

While the government should ensure all home builders and developers adopt universal design principles to futureproof the housing stock, which would ultimately mean there will be less need to provide housing designed exclusively for older people, that ideal is likely two to three generations away from being the default for New Zealand housing.

This means some specialised accommodation will be needed over the next 30 years, and a key feature identified across multiple sources is that these should include some communal space to meet the social needs of older people within close proximity to their own home (Housing LIN 2023). Alongside these, existing homes will need to better support ageing in place and healthy ageing.

2.9 Shared home ownership for affordable age-friendly housing

Recognition of an increasing and significant need for affordable rental housing for older people over the next 30 years motivated a call for a UK national strategy on this issue (Best and Martin 2019). Some of the solutions being proposed in the UK context may be directly relevant to tackling this issue in New Zealand.

Shared ownership was proposed as a potential solution for some less affluent older people who may wish to become homeowners. This concept represents a stepped approach to social housing in which the state co-owns property with the person who can afford to purchase only part of it. Arrangements for rent payment on the state-owned share can be a function of both the share of state ownership in the property and a means-tested level. Shared ownership for older people is described as a different proposition from traditional shared ownership products. While still based on a part-own, part-rent model, it is designed primarily to provide homes for those with existing housing equity (unlike for first time buyers) but who cannot afford to move to a suitable home that meets their particular needs and the shared ownership package for older people often also includes access to extra care and support if required (All-Party Parliamentary Group on Housing and Care for Older People 2023).

This solution can help many older people manage the process of downsizing to release equity while also securing a more fit-for-purpose, age-friendly and low-maintenance property in a location that provides good access to transport and services. In reality, many older people who downsize to a property with all these characteristics find that it does not



allow sufficient release of equity, as such properties can be high-cost despite being smaller than the home they may currently live in (Saville-Smith 2017).

Another advantage of the arrangement is that the state can also allow continued stepping down of home ownership, enabling people to gradually release more equity as they age.

One example of this approach is the Swallowtail Place development in Norfolk, UK (Maraj 2023). Swallowtail Place is a 58-apartment, mixed-tenure Independent Community Living Plus scheme. The development includes a GP clinic, library, shops and good access to rail and bus links. The design is closely aligned to the “Housing our Ageing Population Panel for Innovation” (HAPPI) principles, which help to make older people’s housing an appealing alternative to a traditional home. Swallowtail Place also allows pets, which is a significant concern for many older people who remain in unsuitable housing out of fear that they cannot keep a beloved pet otherwise.

The UK government has established the Older People’s Shared Ownership (OPSO) scheme to support shared ownership arrangements. Under the OPSO scheme, shared owners who buy a 75 percent stake in their home do not have to pay rent on the remaining share. This makes the product affordable to more homeowners who wish to downsize and retain enough income to pay the ongoing service charges and any care costs if applicable. However, the unfairness of requiring 30 percent rent for those who can only afford a 70 percent share has been noted. This could be addressed by removing the 75 percent threshold and introducing means-tested rent.

2.10 Home modifications

Home modifications are often needed to make homes suitable for allowing disabled people to live as independently as possible.

Home modifications are a common way of achieving age-friendly housing and will need to be part of a short to medium-term strategy of making the housing stock more age-friendly, as initiatives focused on new builds can only have a significant impact in specific areas where major developments take place in the short to medium term.

In New Zealand, home modifications can be funded if the person and their home meet certain criteria. Modifications exceeding \$8,076 (incl. GST) (or \$15,334 if the modification applies to access between levels) require an income and cash asset test to determine what level of funding the person is eligible for. A key constraint that is likely to be inequitable in New Zealand’s approach is that the \$8,076 funding cap applies to all modifications from age 16 onwards. In other words, it is a lifetime cap.

The capped contribution to home modifications means those who need more extensive home modifications are disadvantaged. With people living longer lives and potentially experiencing more than one type of disability, this cap is especially restrictive. Those most impacted will be people who experience a disability early in life, as this does not provide any protection against new acquired disability later in life.

While many older people may be able to pay for home modifications, the value these can provide in terms of reduced need for support services and reduced health service costs resulting from falls in the home may justify increased funding to incentivise more older adults to undertake all the necessary home modifications to support independent living. For example,



- Hwang et al. (2011) found a robust positive relationship between home modifications and ageing in place.
- Chase et al. (2012) found that home modifications are a core component of effective multifactorial fall prevention programmes for community-dwelling older adults.
- A New Zealand randomised controlled trial in the Taranaki region (Keall et al. 2015) found that injuries specific to the home-modification intervention and requiring medical treatment were cut by 39 percent per year exposed.
- A New Zealand modelling study (Wilson et al. 2017) found that home safety assessment and modification (HSAM) is effective in reducing falls in older adults and that in the Counties Manukau region alone, an HSAM programme:
 - could achieve health gains of 2,800 quality-adjusted life years
 - could offer health system cost savings of \$8.44 million, in Counties Manukau alone, based on its 2011 population
 - was cost-effective with an incremental cost-effectiveness ratio (ICER) of \$5,480 when universally offered
 - was cost-effective with an ICER of \$700 to \$832 if targeted to at risk people aged 65+ or 75+, respectively
 - was cost-saving if targeted to people aged 65+ or 75+ with previous injurious falls.

Wilson et al. (2017) note that the results of the study are likely to be generalisable but that health gains would likely be greater in regions with higher life expectancy due to people receiving more years of benefit from the intervention.

Given the likelihood of cost savings in people aged 65+ with previous injurious falls, universal funding of necessary home modifications is likely to be justified. These findings also suggest there could be a robust argument for increasing the cap on non-means-tested home modifications for at-risk older people.

A high-level assessment of the level of funding available in different jurisdictions indicates that some other jurisdictions fund home modifications more generously or on a more equitable basis, including:

- Scotland. Scotland's mandatory grants fund home modifications on a percentage of cost basis (80 percent of essential adaptations without means-testing, with means-tested top-ups to 100 percent of the cost). Funding on a percentage basis means those with more significant disability receive proportionate support and reduces the incentive to minimise expenditure on what may ultimately return health and disability system savings as well as improved wellbeing.
- Wales has required local councils to cease means testing for small and medium cost home modifications as a condition to receive national government funding under the Enable grant scheme, resulting in a non-means-tested cap of £10,000 (equivalent to over NZ\$23,000).



Table 5 Home modifications schemes: Evidence reviewed

Initiative	Location	Description	Source
Disabled Facilities Grant (DFG)	England & Wales, UK	Statutory grant for major home adaptations (bathrooms, ramps), available to owners and tenants.	Department for Levelling Up, Housing and Communities (2023)
MaPrimeAdapt'	France	National one-stop adaptation grant (2024–) consolidating subsidies for home modifications to prevent loss of autonomy.	Ministère de la Transition Écologique et de la Cohésion des Territoires (2024)
ENABLE and the Disabled Facilities Grants scheme	Wales	Local authorities receive ENABLE funding to provide grants for home modifications under the Disabled Facilities Grants scheme.	Government of Wales (2021)
Barrier-Reduction Grant (KfW 455-B)	Germany	Federal cash grant/loan scheme for barrier-free retrofits in owned or rented dwellings.	KfW Development Bank (2023)
Residential Adaptation Assistance Program (RAAP)	Québec, Canada	Provincial funding for accessibility adaptations (ramps, bathrooms, lifts) for people with disabilities and older renters.	Société d'habitation du Québec (2023)
Long-Term Care Insurance (Pflegeversicherung)	Germany	National LTC insurance allowing cash benefits for home care and modifications enabling ageing in place.	Rothgang (2022)
Scheme of Assistance / Mandatory Grant for disabled adaptations	Scotland	Mandatory grants for structural or permanent home adaptations that are essential for disabled people, whether homeowners or private tenants.	Scottish Government (2011)

Source: As per table

2.11 Homesharing

Homesharing is an arrangement that allows two unrelated persons to share their lives and living situation for their mutual benefit.

Homesharing is one option for supporting older people who own a home with a spare room and are willing to make it available to another older person who needs a home and agrees to provide suitable companionship and/or home help in exchange for reduced-cost accommodation. Often, the 'homesharer' (the person who rents a room and offers help and/or companionship) is younger than the homeowner, bringing the added benefit of inter-generational connection. Each homesharing arrangement is uniquely designed to meet the needs of the homeowner and homesharer.

Homesharing programmes have been run internationally for many years, with reported benefits including:

- Reduced dependence on aged care (including reduced admission to aged residential care) and disability services
- Reduced loneliness for older people
- Increased social connection for older people with their local community



- More positive attitudes to ageing.

This concept already exists in New Zealand, although it is only available in specific areas. Until 2022, there were few examples (Office for Seniors 2022), and these were very small-scale, such as:

- Let's Share (Hawke's Bay). In 2020, Hastings District Council funded Age Concern Hastings to administer the Let's Share programme. As of 2024, it had three active home share arrangements, which were reportedly working well. Organisers reported difficulty finding potential homeowners and homesharers in a rural area due to low population density.
- Eastern Bay Villages (Eastern Bay of Plenty). This initiative helped organise two long-term home share arrangements. The Eastern Bay Villages home share programme has relied on lottery grants funding and charges a one-off payment of \$500 from homeowners, and a weekly payment of \$10 from homesharers to cover ongoing costs of monitoring and problem solving. Organisers report the programme suffers from a lack of interest from Māori homeowners and potential homesharers.

Recognition of the potential value of these programmes and also of the need for administrative support, Budget 2022 allocated \$390,000 over three years for the Office for Seniors to pilot a homeshare programme under the name Homeshare. Homeshare is managed by Age Concern Auckland in partnership with Homeshare Australia and the Homeshare Australia & New Zealand Alliance Inc. (HANZA) and is funded by the Office for Seniors. It is currently running as a pilot in the Auckland region with a goal of establishing 40 to 50 homeshares over 18 months.

Age Concern Auckland (Age Concern) managed the Homeshare pilot programme, supported by the Office for Seniors, which ran from late 2022 to mid-2024. The programme was developed by Age Concern Auckland, with initial support from the Homeshare Australia & New Zealand Alliance (HANZA), ensuring that insights from established Australian programmes were incorporated but that the programme reflected Auckland (and New Zealand's) unique differences. The pilot project ended in 2024 and Age Concern Auckland has now embedded Homeshare as an integral part of its Social Connections programme. The Homeshare element of this programme is not funded by government.

In practical terms, Age Concern Auckland recruited the homeowners and homesharers, assessed applicants for suitability (including interviews, police checks, and reference checks) and facilitated matches. Age Concern also facilitated with the development of a written agreement clarifying the basis and terms of the sharing arrangements (spaces to be shared and the assistance the homesharer will provide) and any agreed contribution to be paid by the homesharer. It should be noted that the programme was not based on a primarily financial model, and although reasonable contributions towards additional financial costs are normally agreed, the primary focus is on general in-home support and companionship. If arrangements come to a natural end (normally as a change of circumstance of the homesharer), Age Concern also facilitated renewals or the establishment of new matches. (Age Concern Auckland 2023)

The potential benefits of homesharing are substantial if the homesharing programme can meet the needs of older people and younger people alike: The Ministry of Social Development notes that as of 2024, mortgage holders aged 65 and over held an average mortgage debt of \$185,294, and the age group as a whole held a total of \$25.2 billion in



mortgage debt. Both the number of older people paying a mortgage and the size of outstanding mortgages are increasing (Ministry of Social Development 2024). With homesharers paying a small amount of rent, homesharing can be an important option for older people who are still paying a mortgage to more easily afford their payments.

Experience indicates Homeshare can only be a small part of housing solutions

Experience of Homeshare in the UK and in New Zealand has shown there are also significant challenges that are likely to mean this can only ever be a small part of the housing solution for older people.

The most comprehensive evaluation has been in the UK context. The Homeshare UK Pilot Programme (HSP) (England and Scotland) was established by Lloyds Bank Foundation for England and Wales (LBF) and the Big Lottery Fund (BLF), which jointly invested £2m in the HSP to support eight HSP sites in England and Scotland between June 2015 and December 2017. HSP sites were awarded grants of a value between £111,400 and £267,091 from funders, which some HSP sites supplemented with funds from their own organisations to develop and deliver Homeshare. The eight selected HSP sites were provided with contracts and were monitored by the funding organisations (Traverse 2018).

The Traverse evaluation identified that:

- the average age of all homesharers was 34.1 years
- the average age of householders was 78.5
- the majority of both householders (75 percent) and homesharers (74 percent) were female
- the majority of householders and homesharers were single (76 percent and 86 percent, respectively), including 35 percent of householders who were widowed
- the majority of householders were retired (89 percent), and the majority of homesharers were in employment (74 percent).

Interviews for the Traverse evaluation and a rapid evidence review by Age UK for the Social Care Institute for Excellence (Age UK n.d.) identified the following key benefits:

- improved wellbeing for the homeowner (improved mood, reduced anxiety, confidence in mobility, improved sleep, increased activity)
- reduced loneliness as measured by the UCLA loneliness scale and greater connection to the community
- reduced dependency on other formal or informal supports for home help
- increased communication with formal and informal carers
- reduced living costs for the homesharer
- intergenerational learning
- reduced burglaries.

However, the programme only ever succeeded in establishing around 500 homesharing arrangements, due to a range of concerns including concerns about safety, concerns about privacy and boundaries, and challenges in finding suitable matches.



The key role of agency facilitation in the success of these programmes by supporting positive experiences for all participants has been highlighted in published research which also notes that evidence from international models may not be relevant as the level of support and oversight can vary considerably (Martinez et al. 2020).

The New Zealand Homeshare pilot project also demonstrated that there can be significant challenges. The key finding from the pilot project was that the length of time to develop the programme to its fullest extent far exceeded the limited time-period allocated for the pilot. In a large, multi-centred metro area such as Auckland, it takes significant time to develop a sizeable cohort of homeowners and homesharers at a scale where matches can be facilitated. This is because of the need for homesharers and homeowners to overlap in terms of geographical location (of the homeowner) and desired location (of the homesharer).

It may prove easier and quicker to establish Homeshare programmes in smaller communities where there is a more defined, single area as opposed to a multi-centred metro area. Where successful matches have been made, the results have been very encouraging, with a significant benefit being realised by the homeowner (Age Concern Auckland 2025).

Evidence from Ireland's THE HomeShare programme shows that context and programme maturity may be key to the success of these programmes. Ireland's THE HomeShare programme has achieved a similar scale to the UK programme, despite a significantly smaller population. Factors that may have contributed to Ireland's relative success with THE HomeShare include:

- a longer standing homeshare model for disabled people (established in 2003)
- a more significant housing crisis than the UK's
- availability in smaller communities
- complementary policies such as the Rent a Room policy that allows home owners to earn up to €14,000 per year tax-free by renting out a room (or rooms) in their home to private tenants (Homeshare International n.d.), the result of lobbying by the National Home Sharing Network (NHSN) in 2020 (National Home Share Network Ireland 2023)
- cultural factors may also have contributed to its relative success.

Whatever the reasons for Ireland's relative success with homesharing, it has become the first country in the world to embed homesharing into national policy allowing for increased funding, streamlined access to participants, and integration with health and social services (THE HomeShare 2024).

Funding for New Zealand's Homeshare ended in 2024 but it continues as part of Age Concern's ongoing social connection work.

Table 6 Homesharing: Evidence reviewed

Initiative	Location	Description	Source
Homeshare Pilot (Age Concern Auckland)	Auckland, New Zealand	Agency-facilitated matches between older homeowners and adult homesharers who provide agreed help in exchange for low-cost lodging; government-supported pilot.	Age Concern Auckland (2021); Office for Seniors 2025c).



Initiative	Location	Description	Source
Homeshare UK (Shared Lives Plus network)	United Kingdom (national network)	National support network for local programmes that match “householders” with “homesharers,” with ongoing oversight by member organisations.	Shared Lives Plus (n.d.)
THE HomeShare Ireland	Ireland	Established in 2017 and run by a group of non-profit organisations often in collaboration with local governments and the Health Service Executive (HSE). Now endorsed by the national government and embedded in national policy. Complemented by a tax-free rent policy implemented in 2020.	Homeshare International (n.d.) THE HomeShare 2024 National Home Share Network Ireland 2023
Canada HomeShare (NICE)	Canada (national)	National not-for-profit programme pairing over-housed older adults with students for affordable housing and support to age in place.	Canada HomeShare, (n.d.)
NYFSC Home Sharing Program	New York City, USA	Free matching service (since 1981) linking adult “hosts” (one aged 60+) with “guests” for shared housing.	New York Foundation for Senior Citizens (n.d.)
HomeShare Vermont	Vermont, USA (statewide)	Nonprofit that screens and matches older hosts and homesharers; support can include chores, errands, and companionship.	HomeShare Vermont, (n.d.); Senior Solutions, (n.d.)
Wohnen für Hilfe	Germany (multi-city)	“Housing for Help” model: students receive low-cost rooms with older people and provide agreed help (some cities use 1 m ² = 1 hour/month rule).	Studierendenwerk München Oberbayern, (n.d.); Studierendenwerke Deutschland (DSW), (n.d.)
ensemble2générations	France (national network)	Association coordinating intergenerational cohabitation with structured support; 33 local branches and thousands of pairings since 2006.	Bettencourt Schueller Foundation (n.d.).
CONVIVE (Solidarios)	Madrid & other Spanish municipalities	NGO-run intergenerational cohabitation programme operating since 1995 with municipal/university partnerships.	SOLIDARIOS (Convive) (n.d.).
Life Shared (Home Share for Seniors)	Melbourne, Australia	Seniors-focused homeshare service matching older “home providers” with younger companions who contribute ~10 hours/week.	Life Shared (n.d.); (2025)
HANZA (Homeshare Australia & New Zealand Alliance)	Australia & New Zealand (peak body)	Peak body promoting, advising and capacity-building for homeshare services across ANZ; strategic plan 2023–2028.	HANZA (n.d.); (2023)
“Intergenerational Empathy Under One Roof” (Seoul)	Seoul, South Korea	City-supported intergenerational homeshare initiative, active across multiple districts near universities.	Homeshare International (n.d.); KoreaScience (2022); Seoul Mayor’s Blog (2013)



Initiative	Location	Description	Source
ValènciaConviu (formerly Viure i Conviure)	València, Spain (municipal)	Municipality-university programme pairing older people living alone with university students; relaunched and promoted in 2025.	Cadena SER (Radio Valencia) (2025).

Source: As per table

2.12 Secondary self-contained units or split capacity

While home modifications are currently only funded to meet people's disability needs, there is potential for a home modifications scheme to assist older people who want to convert their home to accommodate another self-contained dwelling for a form of homesharing that may be more attractive to a broader range of people.

This approach could be beneficial to older people who own a home that is too large for them but want to remain in their home and in their local community, where they have important social connections. The rent they could earn could help to pay for home help, eliminating the need to find someone they feel comfortable sharing their home with and who is also available to help them.

This type of initiative may not require funding for modifications, but many older people are likely to need advice and support to achieve the end result. Advisory services that help older people see what could be possible (e.g. design and rental income potential) and the likely cost (including access to loans), as well as support to engage tradesmen to undertake the work, would likely be needed.

One example of an initiative of this type is the Canadian Mortgage and Housing Corporation (CMHC) Residential Rehabilitation Assistance Program for Persons with Disabilities (RRAP) (Scotts et al. 2007), which offers:

- financial assistance to homeowners and landlords to modify main dwellings for occupancy by low-income people with disabilities
- assistance to low-income seniors and adults with a disability to convert or develop existing residential properties to accommodate a secondary self-contained unit.

The RRAP is means-tested.

Another example is the Irish model, Ava Housing (Age Friendly Ireland 2021). Ava Housing is an innovative scheme for older homeowners to reconfigure their family-sized home. Ava provides the design and construction services, screens and finds appropriate renters, and then serves as a rental agent if required.

Ava Housing is working on innovative approaches to make the modifications even more accessible and affordable to older people, including by working on specific initiatives (AARP 2021) such as:

- Homeowners can access a Housing Adaptation Grant through local government based on health needs. Ava is advocating for access to this fund at an earlier stage, when the homeowner is planning for retirement.
- Ava is also working on ways to help the homeowner secure their contribution toward the renovation cost through loans, which the homeowner can repay from the renter's payments, over five years. One example is loans through credit unions, which most



homeowners are already members of, so there is a credit history and often some savings.

- Energy saving programmes are being accessed for funding opportunities, such as green loans, which offer preferential interest rates if the renovation incorporates energy efficiencies.

Ava Housing is supported by the Department of Housing, Local Government and Heritage (Ava Housing, n.d.). It is one option presented in the Age-Friendly Guide to Right Sizing created by Age-Friendly Ireland. The booklet is intended for older people and their families who are considering their housing options in later life.

Table 7 Evidence on secondary self-contained units or split capacity initiatives

Initiative	Location	Description	Source
RRAP (Rental Residential Rehabilitation Assistance Program)	Canada	Means-tested financial support for the creation of a secondary self-contained dwelling within or adjacent to an existing home. Homeowners can receive up to \$60,000 in financial assistance	Government of New Brunswick (n.d.); Canada Mortgage and Housing Corporation, (n.d.)
Ava Housing	Ireland	Advice and support to assist older people to “right size” their home by modifying it to create a self-contained rental unit.	Age Friendly Ireland (2021); AARP (2021)
Age-Friendly Guide to Right Sizing	Ireland	Guide to right-sizing developed based on research carried out on behalf of Age Friendly Ireland in 2020.	Age Friendly Ireland (2021)

Source: As per table



3 Healthy ageing

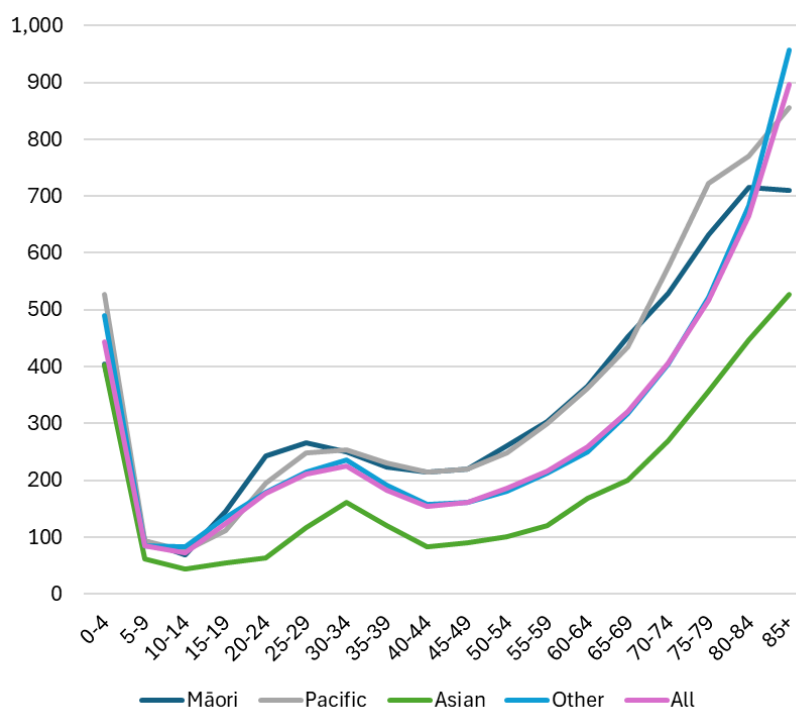
Healthy ageing is key to improved wellbeing later in life and to the financial sustainability of the services used by older people. Health New Zealand (Health New Zealand 2024) highlights that:

- While older people make up 15 percent of the population, they use 42 percent of health services.
- Over the last 10 years, spending on health services for older people has increased twice as fast as overall health expenditure (68 percent growth compared with 27 percent growth) and 5 times as fast as the consumers price index (CPI).
- Over 60 percent of health expenditure on support services for older people is currently allocated to aged residential care.
- Support in the home – a service that is key to avoiding costly aged residential care – increased in total expenditure by over 120 percent in ten years, compared with over 50 percent expenditure increase in aged residential care.

Health New Zealand data on publicly funded hospitalisations shows that, in our current system, the effects of ageing result in rapidly increasing hospitalisation rates in the second half of people's lives, with rates for Māori and Pacific New Zealanders being the highest.

Figure 2 Hospital discharges by age and ethnicity

Rate per 1,000 population, 2021/22



Source: NZIER, based on Health New Zealand publicly funded hospitalisations data



Healthy ageing requires a broad spectrum of interventions across the life course.

Some key interventions are:

- social supports for community-dwelling older adults to support ageing in place
- technology-enabled care to improve access to care for older people and support the sector to cost-effectively manage the increased demand for care that is expected with an ageing population
- adult vaccination to reduce rates of preventable illness
- oral health initiatives to support improved wellbeing, nutrition, and physical health
- vision and hearing screening
- programmes that reduce falls, frailty and loss of independence, which are often connected and result in significant wellbeing costs as well as health and disability system costs.

3.1 Social supports for community-dwelling older adults

Often, all older people need to be able to continue living at home and remain mentally well is simple home supports and visits. These services help to reduce the burden of house and garden work, provide social connections to older people who might otherwise not have much, and support greater connection with other services.

Better at Home (BH) is a home support programme in British Columbia (BC) that assists older adults with simple day-to-day tasks. Funded by the Government of British Columbia through its Ministry of Health, the programme is administered by United Way British Columbia (UNBC), a charity providing a range of social and community programmes.

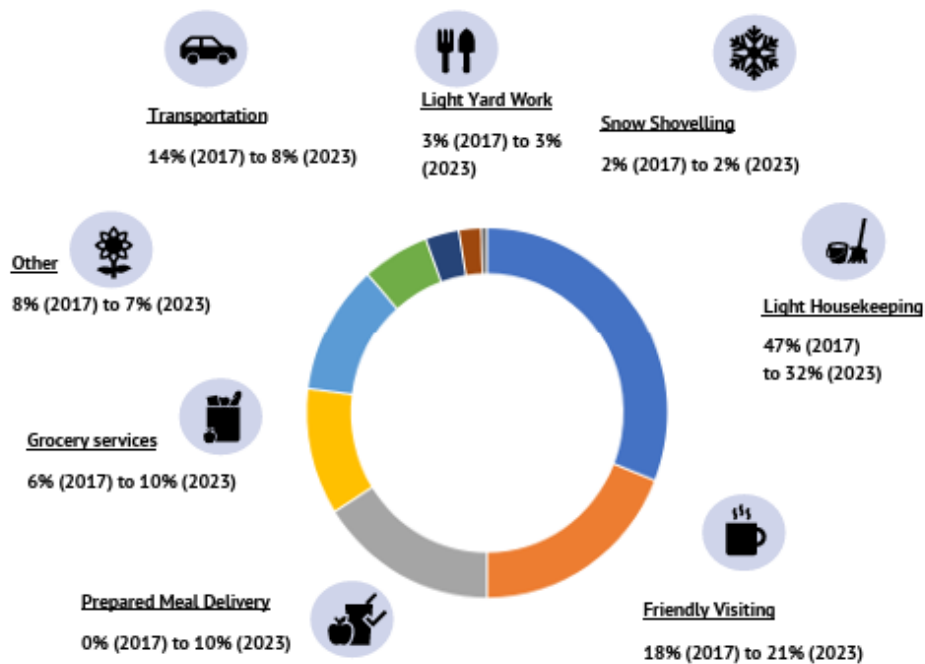
The goal of BH is to support older adults to continue living independently in their own homes and to remain connected to their communities. The programme offers non-medical supports, including light housekeeping, friendly visiting, medical transportation, grocery shopping, light outdoor work, minor home repairs, snow removal, and other non-medical supports as needed. A key feature of the programme is that it includes “friendly visiting”, incorporating wellness checks as one of the home supports offered (see the figure below).

In 2022–23, the programme was delivered by 92 local agencies in over 260 communities across BC through a mix of volunteers, contractors, and paid staff.



Figure 3 Components of Better at Home

2017–2023



Source: Ference & Company Consulting (2024)

The programme uses community-based approaches to be responsive to local needs and is integrated with other social supports and programmes for older adults, as well as with health services, often working with health services to ensure participants access the services they need.

An evaluation report (Ference & Company Consulting 2024) showed that 95 percent of community partners surveyed stated that the programme had become “an integral part of the continuum of care for older adults”. This is achieved in each community by designing the local programme through meaningful engagement with and input from the community, community organisations and partners, and older people. This approach allows the BH approach in each community to address specific service gaps, avoid duplication, and design services that meet the needs of local people. This approach includes developing local partnerships with indigenous communities and organisations to support cultural relevance and engagement.

Participants were reported to experience improved physical and mental wellbeing, better access to social supports both at home and within the community, and a sense of increased safety and support overall. As well as being better able to manage instrumental activities of daily living (IADLs), participants rated the programme highly (4.4/5) for helping them feel less isolated and lonely.

Caregivers also experienced important benefits. Caregivers were reported to experience less stress and anxiety, and more time for themselves and for their own or other family members’ needs. They also experienced feeling less alone and more supported.



As many caregivers were themselves older adults, the ability to share the responsibility for chores like shopping, housekeeping and meal preparation was highly valued and meant they could continue in their caregiver role longer than they otherwise might be able to.

An additional benefit the programme provides is improved communication, with programme staff often having a clearer picture of a participant's health and wellbeing than family members who may not live nearby and being able to communicate any significant changes.

The programme leverages the contributions of volunteers to minimise costs.

Two-thirds of the programme volunteers were aged over 61 and, for many of them, being involved in the programme provided a sense of purpose and connection that was needed at their life stage and allowed them to contribute their career skills to their local community.

"Many of us, me included, are from backgrounds of caring and service, and want to continue that in our retirement. It feels so good to give someone what they need, it is definitely a two-way street between volunteer and participant. I can't imagine not doing something that is so useful and fulfilling all around." (volunteer)

For some older volunteers, contributing to the programme directly supported their own social connections in retirement.

"As someone who moved into this community upon my retirement it was important to me to become connected locally to people here. [...] My family members have benefited from the kindness of community members in so many circumstances, it is lovely to feel that I can pass on that gift to others." (volunteer)

The value of social connection and purpose was revealed by the evaluation, which found that over 90 percent of the programme's volunteers emphasised their appreciation for the opportunity to take part in a meaningful, worthwhile, community-oriented programme. Eight percent felt valued by their community, and 92 percent felt connected to their community.

The evaluation indicated that it was likely the programme was reducing admissions to aged care facilities, with participants, staff and volunteers all indicating that the programme was helping older people to remain in their own homes, in many cases indicating that the programme was "needed" to make this possible. One outcome that correlated with this was improvement in "resilience for ageing in place", which was defined as a set of protective factors, including purpose in life, optimism, autonomy, social connectivity, and the ability to function independently.

Table 8 Social supports: Evidence reviewed

Initiative	Location	Description	Source
Community-based Integrated Care System (CbICS)	Japan	Municipal integration of medical, social, housing, and daily-living support to keep older people at home.	Ministry of Health, Labour and Welfare (Japan) (2024) ⁴
Reablement (Everyday Rehabilitation)	Denmark	National policy requiring a time-limited reablement course before long-term home-care eligibility, restoring independence.	Rostgaard and Szebehely (2022)



Initiative	Location	Description	Source
Better at Home	British Columbia, Canada	Province-wide non-medical supports (transport, housekeeping, social visits) enabling older adults to remain independent.	United Way British Columbia (2022)
Technology Enabled Care (TEC) Programme	Scotland, UK	National telecare and digital support infrastructure for independent living, spanning local authorities and social care.	Scottish Government (2022)
PACE (Program of All-Inclusive Care for the Elderly)	United States	Capitated community-based care model integrating social, medical, and transport services to prevent institutionalisation.	Williams and Chandrasekaran (2025)

Source: As per table

3.2 Technology-enabled care

Modern technologies now enable older people to access health services from home, including consultations and health monitoring.

Several examples of technology-enabled care initiatives for older people have progressed beyond pilot to full roll-out within health and social care systems, including Scotland's technology enabled care (TEC) programme, the NHS Virtual Wards, and VHA Telehealth.

The Scotland TEC programme

The Scottish Government's TEC Programme was set up to mainstream the adoption of technological solutions within service redesign. Its principal focus is on primary, community, and home-based care rather than acute specialities, with the general objective of improving outcomes for individuals in home or community settings through the application of technology as an integral part of quality, cost-effective care and support.

The TEC Programme is part of the wider Integrated Care Fund, a Scottish Government initiative designed to support the integration of health and social care, which is now a legal requirement in Scotland.

The programme aims to further embed the use of telecare, expand home and mobile health monitoring, and create a national digital platform framework. It is funded by the national government and delivered locally. National level support includes technical support, strategic planning support and service redesign support, with other expertise drawn on as required.

Although the programme is ongoing, to date it is beginning to show that sustained national support can provide the necessary impetus to introduce core budgets into mainstreaming previous small-scale approaches. By providing national focus, the profile and visibility of technology-enabled care have been significantly increased, leading to a greater cohort of individuals championing the use of TEC, above and beyond the usual enthusiasts. A significant part of this has been driven by the communications strategy, with specific events targeted to raise awareness, and a strong emphasis on embedding TEC into existing service redesign initiatives, rather than seeing TEC as a separate approach.



The NHS Virtual Wards

NHS England's Virtual Wards programme is one of the largest technology-enabled care initiatives in Europe. Launched nationally in 2022, it delivers hospital-level care at home for patients – primarily frail older adults with acute respiratory infection, heart failure, or post-surgical needs – by combining remote monitoring, daily clinical review, and rapid-response support (NHS England 2024). Each ward is run by an integrated multidisciplinary team of clinicians, nurses, pharmacists, and community staff. Patients are “admitted” virtually after referral from hospital or community care, equipped with digital devices to record vital signs and communicate through video or telephone. Their data feeds into secure dashboards in hospital command centres, allowing early detection of deterioration and timely intervention (NHS England 2023).

By March 2024, England had established more than 340 virtual wards, providing roughly 10,000 virtual beds and treating over 240,000 patients since inception (NHS England 2024). Around two-thirds of participants are aged 65 or older, demonstrating the model's focus on frailty and long-term conditions. The NHS target is for every Integrated Care System to maintain 40–50 virtual beds per 100,000 population, embedding the model as a permanent service.

There are two different types of virtual wards:

- Step-up wards that prevent admission from the community.
- Step-down wards that enable earlier discharge.

Technology partners supply remote-monitoring kits, analytic dashboards, and interoperability with the NHS Spine electronic record (NHS England 2024).

Key challenges from the experience of virtual wards indicate a need for careful attention to workforce capacity, local readiness, and ensuring digital inclusion for older or technologically inexperienced patients.

Early evaluation shows that average virtual-ward stays last about 7–10 days with 94 percent patient satisfaction and significantly lower readmission rates than comparable inpatient groups (University of Oxford and NHS England 2024). Resulting reductions in hospital bed-day use have been in the order of 15 to 20 percent (NHS England 2023). Rather than generating measurable fiscal savings, the benefits of virtual wards have been in improved patient experience and faster recovery, while reduced pressure on acute beds has freed up these resources for other uses (University of Oxford and NHS England 2024).

VHA Telehealth

The Veterans Health Administration (VHA) has operated one of the longest-running and most comprehensive telehealth systems in the world. Within the U.S. Department of Veterans Affairs (VA), telehealth is a standard component of medical benefits, available to any enrolled veteran and designed to improve access to care, especially for older veterans living with chronic illness or mobility limitations (U.S. Department of Veterans Affairs 2023). The system encompasses multiple modalities: secure video visits via the VA Video Connect app, telephone or tele-visits, remote patient monitoring (RPM–HT) using in-home devices to record vital signs, and asynchronous data sharing between patients and care coordinators (Heyworth et al. 2024).

The Remote Patient Monitoring Home Telehealth (RPM–HT) arm is particularly significant for older adults. Veterans with heart failure, COPD, diabetes, or hypertension receive



home-monitoring devices and training, and are paired with a dedicated care coordinator who reviews their readings daily and provides tailored self-management support (U.S. Department of Veterans Affairs 2025). The model aims to detect clinical deterioration early, prevent hospitalisation, and allow older veterans to manage their conditions safely at home—an approach closely aligned with ageing-in-place objectives.

Telehealth in the VA system has reached significant scale: by 2021, more than 2 million veterans had used telehealth services, including over 1 million home telehealth encounters (U.S. Department of Veterans Affairs 2023). To address inequities in device and internet access, the VA launched the Digital Divide Consult programme, which assesses veterans for digital access barriers and can provide loaned tablets or internet connectivity support through the Office of Connected Care (Ferguson et al. 2024).

Evidence shows this infrastructure has been especially beneficial for older veterans. A quality-improvement initiative in 2022 found that by offering device setup, test calls, and technical coaching in advance, telehealth completion rates for older participants increased from 56 percent to 100 percent, and overall telehealth usage among veterans aged 65 and over rose from 29 percent to 47 percent in just two months (Jerrett 2022).

In one large-scale analysis of over 17,000 veterans, home telehealth use was associated with 25 percent fewer bed days of care and 19 percent fewer hospital admissions, alongside greater patient satisfaction than standard care (Darkins et al. 2008). Remote patient monitoring alone is reported to have achieved a 41 percent reduction in hospital admissions and a 70 percent reduction in length of stay for veterans enrolled in RPM-HT (Dicks 2025).

Subsequent VA reports reaffirmed that remote monitoring supports better self-management of chronic conditions such as heart failure and diabetes, with improved medication adherence and early identification of deterioration (U.S. Department of Veterans Affairs 2023).

Table 9 Technology-enabled care: Evidence reviewed

Initiative	Location	Description	Source
Technology Enabled Care (TEC) Programme	Scotland, UK	National programme integrating telecare, remote monitoring, and video consultations (“Near Me”) across all local authorities. Serves >130,000 people (86% aged 65+).	Scottish Government (2022); Public Health Scotland (2025)
Digital Health and Care Strategy (Scotland)	Scotland, UK	Framework guiding adoption of digital tools, data platforms, and remote services across health and social care; TEC is its delivery arm.	Scottish Government (2021)
Telehealth Home Monitoring (NHS England)	England, UK	Nationwide use of remote health-monitoring devices and apps for chronic disease management (e.g. blood pressure, COPD, diabetes) through NHS Digital and “Virtual Wards.”	NHS England (2023)
My Health Record and My Aged Care Digital Integration	Australia	National digital health record system integrated with aged-care assessments and telehealth services to improve continuity and safety for older adults.	Australian Digital Health Agency (2023)



Initiative	Location	Description	Source
Telehealth Expansion under Medicare Benefits Schedule (MBS)	Australia	Federally funded telehealth model allowing older adults to access primary care, geriatric consults, and allied health remotely via MBS subsidies.	Department of Health and Aged Care (n.d.)
Virtual Wards (England)	England, UK	NHS initiative enabling hospital-level care at home for high-risk older patients using remote monitoring, daily clinician contact, and rapid-response teams. >10,000 virtual beds by 2024.	NHS England (2024)
Virtual Hospitals and Hospital@Home (Denmark)	Denmark	National scaling of remote clinical monitoring for frail older patients; connected to reablement and municipal care systems.	Danish Health Authority (2023)
Kaiser Permanente “Connected Care” Telehealth Network	United States	Integrated telehealth and remote-monitoring platform for chronic conditions and older adults.	Bernstein et al. (2023)
Veterans Health Administration (VHA) Home Telehealth	United States	Long-running national telehealth service for chronic disease management among older veterans; uses biometric monitoring and care coordination.	(Darkins et al. 2008)
Program of All-Inclusive Care for the Elderly (PACE) — Telehealth Integration	United States	PACE centres incorporating telemedicine and remote monitoring into integrated care delivery for frail older adults.	Williams and Chandrasekaran (2025)
eHealth Digital Care Coordination (“Lifecourse”)	Finland	National digital platform linking municipal care, social services, and hospitals; older adults can share data and coordinate care plans online.	Finnish Ministry of Social Affairs and Health (2022)
SilverConnect and Smart Senior Homes	Singapore	Smart-home programme integrating fall sensors, motion detectors, and emergency alert systems for seniors in public housing; linked to social service agencies.	Infocomm Media Development Authority (IMDA) (2023)
Japan ICT-Enabled Community Integrated Care (IoT Care Platform)	Japan	Digital infrastructure under the Community-based Integrated Care System: local “care data platforms” connect home-care providers, clinics, and monitoring devices.	Ministry of Health, Labour and Welfare (Japan) (2024)
Taiwan Long-Term Care 2.0 – Smart Care Networks	Taiwan	Community-based LTC with remote monitoring, teleconsultation, and assistive technologies deployed across community stations for older adults.	Ministry of Health and Welfare (Taiwan) (2023)
Ontario Telehomecare Programme	Ontario, Canada	Province-wide remote monitoring service for older adults with chronic conditions (COPD, CHF); combines devices, clinician dashboards, and phone coaching.	Ontario Health (2022)
Quebec Remote Monitoring and “Connected Seniors” Pilot (Connected Health Programme)	Québec, Canada	Provincial telemonitoring for chronic diseases and frailty among older adults, using home devices integrated with local CLSC clinics.	Gouvernement du Québec (2024)

Source: As per table



3.3 Adult vaccination

Vaccines are often referred to as the most important life-saving public health interventions ever provided.

Vaccination stands as one of modern medicine's greatest success stories, transforming global health and longevity. Childhood immunisation programmes have virtually eradicated diseases such as polio, smallpox, rubella, and tetanus, driving dramatic increases in life expectancy worldwide. A similar opportunity now exists to improve health and productivity in older adults through vaccines that protect against common and debilitating illnesses like shingles, influenza, and RSV. Expanding access to these vaccines can reduce healthcare costs, prevent hospitalisations, and support longer, healthier working lives. Many OECD countries already recognise this, making adult vaccination a cornerstone of preventative healthcare and healthy ageing strategies.

Vaccine-preventable diseases pose an elevated risk in older adults, particularly for those living with chronic conditions such as heart disease, diabetes, or respiratory illness. As immunity wanes with age and comorbidities stack, infections that might be mild in younger people can lead to serious complications in older populations. In New Zealand, modelling suggests that if all people aged 65 and over were routinely offered vaccines against illnesses such as influenza, shingles and RSV, more than 8,200 hospitalisations, 137,000 general-practice visits, and 2,400 emergency department presentations could be avoided over a four-year period (GSK 2025).

The burden of these illnesses is not only clinical but also economic: each hospital admission represents cost, disruption, and increased pressure on an already stressed health system. Preventing just a fraction of avoidable GP visits and acute admissions among older adults supports system resilience (especially during high-demand winter months), contributes to healthier, more active ageing, and can help maintain workforce and caregiving capacity.

Given this context, strengthening adult vaccination programmes becomes a pivotal strategy — not just from a public-health standpoint, but as an investment in the sustainability of our health system and the wellbeing of our ageing population.

Increased investment in these vaccines for older New Zealanders is needed:

- While there is an annual influenza vaccination programme for people aged 65+, the take-up rate is low
- The shingles vaccine is currently only funded if received in the year people turn 65, meaning the window of opportunity is narrow
- An RSV vaccine is available, and Medsafe-approved, but is not currently funded.

Shingles vaccination

Most adults carry the virus that causes shingles due to childhood chicken pox exposure. Shingles occurs when the virus that caused chicken pox, which has been dormant for many years, reactivates. This often happens when a person experiences a weakened immune system, such as due to cancer treatment, some health conditions and medication.

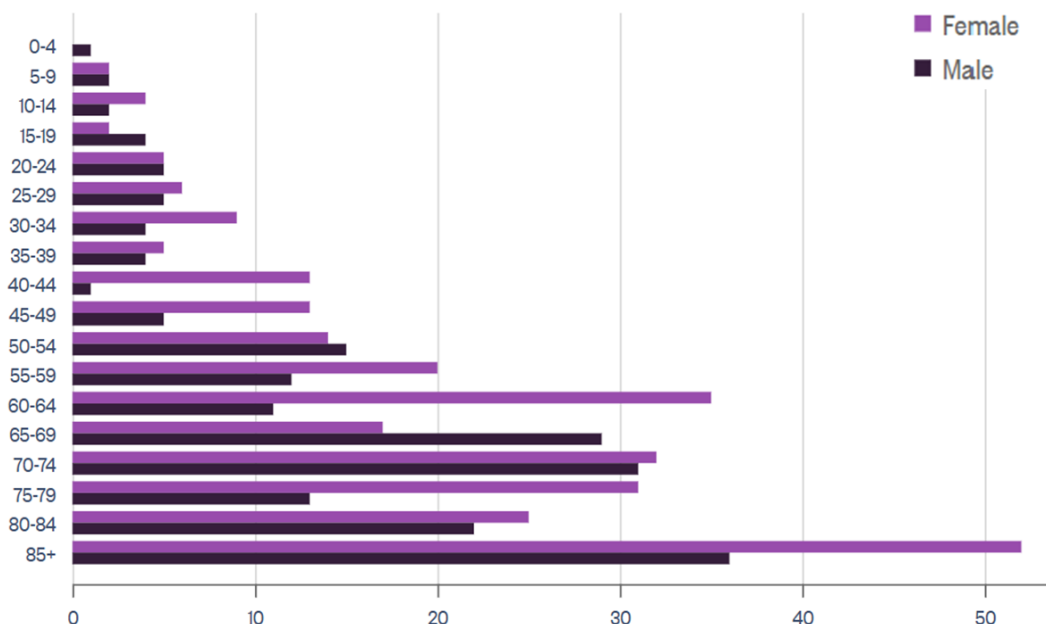
The result is a painful, blistering rash that can appear anywhere on the body but typically wraps around one side of the torso and is sometimes accompanied by fever, headache, fatigue and light sensitivity. Sometimes the pain is intense, and symptoms can be mistaken for more serious problems with the heart, lungs or kidneys (Mayo Clinic 2022), which



explains why older adults with shingles often go to the ED and/or are admitted to hospital for assessment.

Figure 4 Hospitalisations for shingles in New Zealand by sex and age group

2021/2022



Source: Figure.nz (Health New Zealand data)

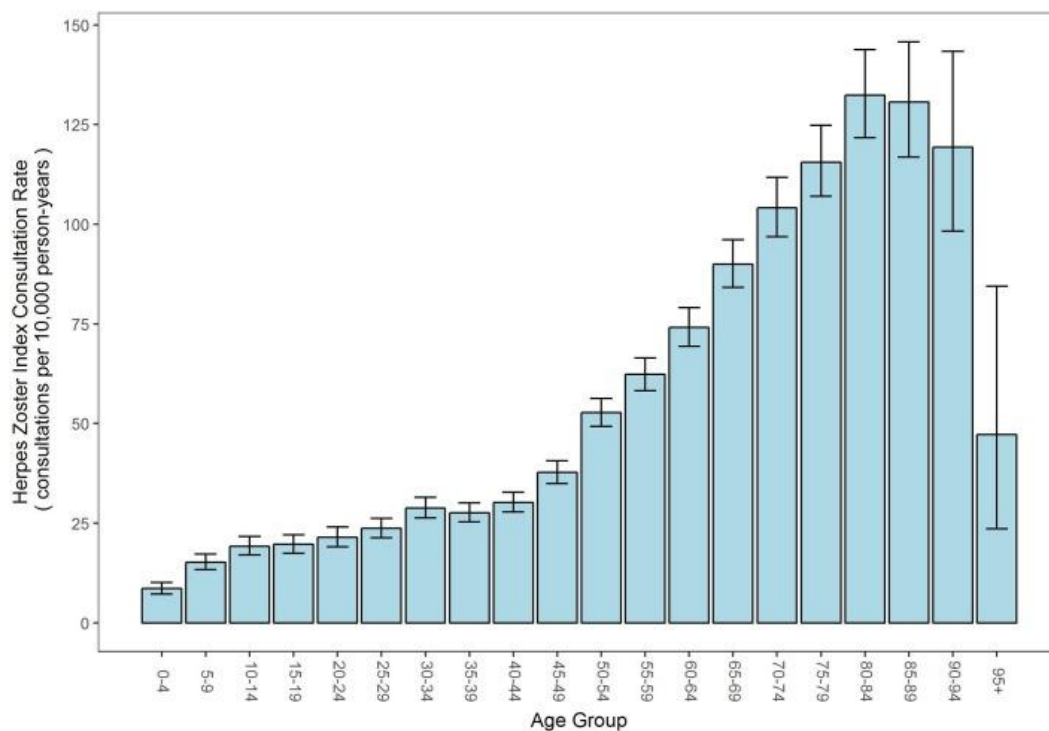
While shingles isn't life-threatening, it can be very painful, and complications, such as postherpetic neuralgia (PHN) (a long-lasting, painful condition), can occur. The risk of PHN is estimated to be 30 percent (New Zealand Doctor 2024). Other complications can result in vision or hearing loss, or skin infections. Older people are more likely to experience more significant complications.

Even without ED visits and hospitalisations, shingles results in additional use of primary care services – both initial consultations and follow-up consultations (see figures below).



Figure 5 Shingles-related primary care consultation rate in New Zealand by age group

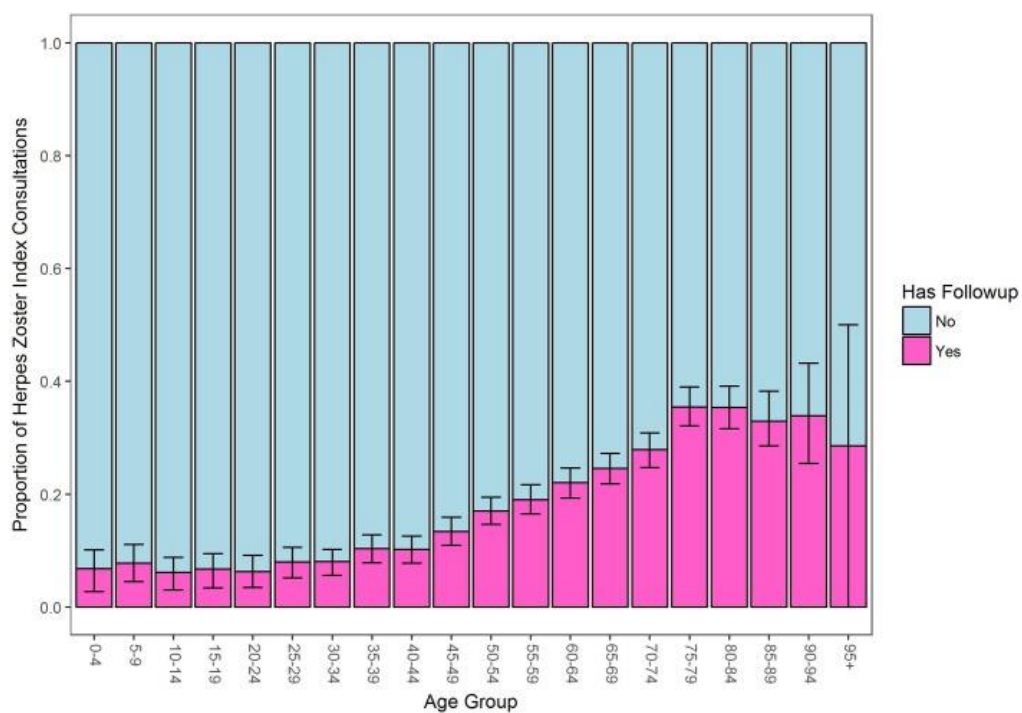
2005-2015



Source: Turner et al. (2018)

Figure 6 Shingles-related follow-up consultations in New Zealand by age group

2005-2015



Source: Turner et al. (2018)



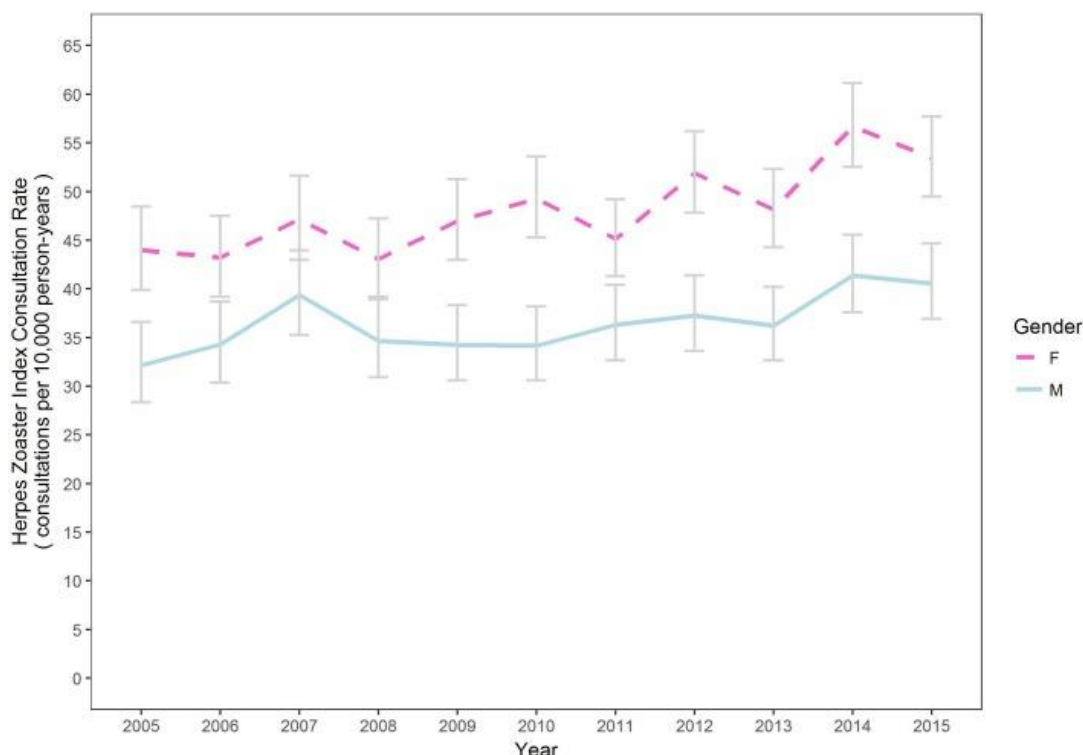
Around one in three people will develop shingles in their lifetime (Health New Zealand 2025b). People who received the chicken pox vaccine have a lower risk of shingles, but the best protection is offered by the shingles vaccine.

The rate of shingles-related primary care consultations has been slowly increasing over time for both males and females (see figure below). Additionally, new evidence suggests a link between COVID-19 infection and increased susceptibility to shingles (McCaul 2022), raising the possibility that rates will accelerate.

Health New Zealand recommends the shingles vaccine for anyone over 50, but it is only funded for those who are 65. People must have their first dose before they turn 66 in order for the vaccine to be funded. Otherwise, they will need to pay \$600 to \$800 for it (Health New Zealand 2025b), a cost unaffordable for many older New Zealanders. Older people's organisations have identified this as a significant barrier to take-up (Aged Plus 2024). Addressing this issue may return important savings to the health system.

Figure 7 Shingles-related primary care consultation rate in New Zealand over time

2005-2015, males and females



Source: Turner et al. (2018)

Health economic modelling of the shingles vaccine in the UK suggests that lowering the minimum age for a funded vaccine to 50 would be cost-effective (Sweeney 2025). In the UK, all adults' shingles vaccine subsidies have been extended to include adults aged 70-79 years who missed prior vaccines (NHS 2023b).

Australia offers even broader access to the Shingles vaccine, with the 2-dose course of Shingrix available for free to all adults aged 65+ as well as Aboriginal and Torres Strait Islander people aged 50 years and over (Australian Government Department of Health Disability and Ageing 2025).



In addition to increased funding to widen the eligibility for the funded vaccine, which could target lower-income older New Zealanders for full funding and offer part-subsidy for other older New Zealanders, the coverage of the programme should be monitored similarly to the childhood vaccination programme, which is monitored and publicly visible in a dashboard updated quarterly (Immunisation Advisory Centre 2023).

Influenza vaccination

Seasonal influenza imposes a substantial burden on older adults in New Zealand and thereby on the health system. Hospital discharge data for the year ended June 2022 show that people aged 65–69 had around 1,372 publicly funded discharges for influenza and pneumonia in that year alone; by age 85 and older, the number rose to approximately 2,576 discharges (Health New Zealand hospital discharge data).

In Auckland, a surveillance study of adults aged 20 and over found that influenza-associated acute respiratory infection hospitalisation rates per 100,000 increased from roughly 43.0 pre-pandemic to 54.4 in 2022 and 79.5 in 2023, with the highest rates among those aged 80 and older, Māori and Pacific peoples, and people living in more deprived areas (Lindsey 2024).

Similarly, the 2024 Acute Respiratory Illness Surveillance Report notes that, among people aged 65 and older, weekly hospitalisation rates for influenza are consistently higher than for any other age group except very young children (Public Health Focus Science 2024).

These evidence sources demonstrate that older people are at considerably greater risk of hospitalisation with influenza, placing sustained pressure on hospital beds, staff, and overall health services during peak winter illness seasons.

Downstream impacts include longer recovery periods, higher risks of frailty and functional decline, and increased need for post-hospital rehabilitation or long-term care. A factsheet from the Immunisation Advisory Centre (IMAC) highlights that older adults hospitalised after influenza may experience new or worsened difficulty with activities of daily living (10–63 percent depending on ICU admission) and that survival at 12 months may drop to around half among those admitted to intensive care (IMAC (Influenza Advisory Centre) 2024). Thus, the system cost extends beyond acute hospitalisations and includes costs associated with rehabilitation and home support, as well as the morbidity and mortality burden.

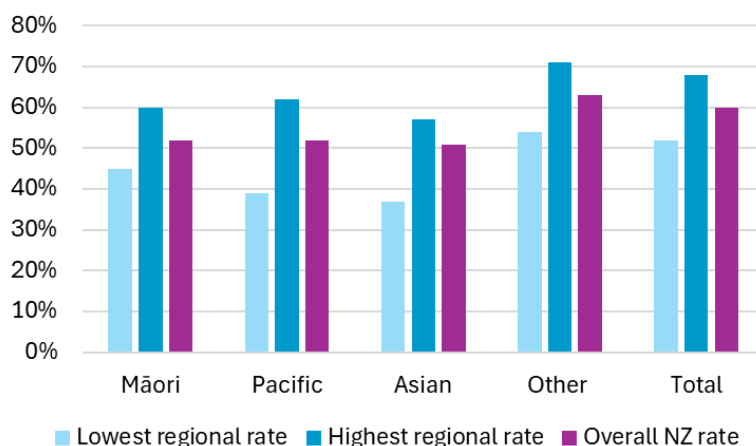
Influenza vaccination in community-dwelling older adults may be around 58 percent effective (range 34 percent to 73 percent) in preventing laboratory-confirmed influenza and is associated with reduced hospitalisation for pneumonia, severe illness, and death (IMAC (Influenza Advisory Centre) 2024). Vaccination substantially reduces hospitalisations and severe outcomes, helping to flatten seasonal peaks, preserve hospital capacity, and prevent long-term functional declines that contribute to further health and social-care costs. Preventing influenza-related disability and dependence also supports caregivers and reduces pressure on aged-care services.

Current rates of influenza vaccination in older people are low at 60 percent overall, with the most successful region achieving an overall rate that is still under 70 percent, and the least successful regions having rates barely over 50 percent. These rates indicate that while influenza vaccination is funded for people aged 65+ and for people with a long-term health condition, the vaccination programme is inadequately reaching older people and may require alternative approaches to delivery.



Figure 8 Rate of influenza vaccination in adults aged 65+

% of estimated population, as of September 2025



Source: NZIER, based on Health New Zealand National Influenza Vaccine Data (2025a)

Evidence shows that one of the key barriers to adult vaccination is missed opportunities (i.e. eligible people seeing a clinician but not being offered the vaccine). Many older adults face access barriers: transportation difficulties, mobility issues, or may not regularly attend a primary care clinic. For these reasons, offering vaccinations in alternative settings, such as retirement villages, churches or by mobile vaccination service (including potentially home visits where appropriate) could provide cost-effective approaches to increasing vaccination rates.

Lower vaccine uptake amongst Māori, Pacific and Asian people also indicates that culturally appropriate information campaigns aimed at older adults (and their whānau/caregivers) explaining their elevated risk from influenza, the benefits of the vaccine, and addressing common myths may be needed. These should be developed with community leaders, older-adult groups, Māori and Pacific health providers, and Asian services.

RSV vaccination

Respiratory syncytial virus (RSV) is a common viral illness in New Zealand, particularly in the winter months. It is very infectious, spreading easily from person to person through coughs and sneezes or by touching contaminated surfaces.

RSV poses a significant health risk to older people due to a naturally declining immune system with age and because it can lead to serious respiratory illnesses and complications in older adults, such as:

- Pneumonia
- Bronchiolitis
- Exacerbation of pre-existing conditions like COPD or congestive heart failure
- Prolonged hospital stays and, in some cases, intensive care admission
- Increased risk of mortality.

While many adults experience only mild, cold-like symptoms, older adults, especially those with underlying conditions, are at much higher risk for severe illness, hospitalisation, and



death. Older Māori and Pacific peoples have a higher independent risk of RSV-associated hospitalisation, especially when living in areas of high deprivation.

Seasonal RSV poses a growing health burden for older adults in New Zealand. Although detailed hospitalisation or mortality rates by age for RSV are sparse in publicly-released data, official sources note that “each season, RSV causes substantial morbidity and mortality in older adults, including lower respiratory tract disease, hospitalisation, and death.” (IMAC (Influenza Advisory Centre) 2024) The vaccine Arexvy, registered in New Zealand in May 2024, marks a significant step (Scoop NZ 2024).

The implications for the health system are meaningful. A recent economic modelling exercise produced for GlaxoSmithKline (GSK) estimated that a publicly funded adult vaccination programme in New Zealand for people aged 65+ (including protection against RSV) could, over four years, prevent around 8,253 hospitalisations, 137,878 GP visits and 2,468 emergency-department presentations (GSK 2025).

Vaccination against RSV for older adults, therefore, holds considerable value, both for individuals and the health system. According to Immunisation Advisory Centre (n.d.), Arexvy is indicated in New Zealand for adults aged 60 years and older (and for 50–59 years with increased risk) for the prevention of symptomatic lower respiratory tract disease caused by RSV sub-types A and B. International trial data suggest the vaccine offers substantial protection, and newer meta-analyses, including a major recent Cochrane review (KM Saif-Ur-Rahman et al. 2025), indicate RSV vaccines are safe and effective in protecting people most at risk, especially older adults and young children, with benefits in older adults including:

- reduction in RSV-associated lower respiratory tract disease, such as pneumonia and bronchitis, by 77percent
- reduction in RSV-associated acute respiratory disease by 67 percent.

By reducing symptomatic RSV, hospitalisations and complications, vaccination contributes to improved wellbeing outcomes (less severe illness, less disability) and supports system-level benefits (fewer acute episodes, less downstream care, preserved functional independence in older people and reduced need for supports).

Currently, the RSV vaccination is fully funded by:

- the NHS (UK) for people aged 75 to 79, and will be funded for people turning 75 going forward
- the province of Ontario, Canada, for adults aged 75+
- the state of Victoria, Australia, under a pilot for aged care residents.



Table 10 Adult vaccination: Evidence reviewed

Country	Shingles (Herpes Zoster)	Influenza	RSV
United Kingdom (England/NHS)	Fully funded by the NHS (free on the NHS for eligible adults) (NHS 2023b) Eligibility age: From 1 Sep 2023: all adults who turn 65 on or after that date; or adults aged 70-79 years who missed prior vaccine (NHS 2023c). Adults aged 50+ with a severely weakened immune system are eligible (two doses) (NHS 2023c) Vaccination rate: 30% for individuals turning 65. 41% for individuals turning 70 (UK Health Security Agency 2025) Service delivery: Delivered via GP surgeries, opportunistically during other appointments; call/recall letters sent; some pharmacy involvement; local immunisation programmes.	Fully funded by the NHS (free for eligible groups) (NHS 2024a). For Winter 2025-26: all adults aged 50+ are eligible for free flu vaccine via the NHS. Also adults ≥ 18 with a serious long-term health condition, pregnant people, people in long-stay residential care, carers, and people living with those at risk (NHS 2024a). Vaccination rate: For older adults, historically flu vaccine uptake in the UK among those ≥ 65 has been around ~75 % (Nuffield Trust 2025) Service delivery: Via GP surgeries, community pharmacies participating in NHS programme, outreach in care homes, mobile clinics in community.	Fully funded by the NHS (free for eligible groups). Eligibility age: Adults aged 75-79 since September 2024 and going forward, funded for adults turning 75 (NHS 2024b)
Canada (Ontario)	Fully funded 2-dose Shingrix[®] vaccine for adults aged 65 to 70 who have not previously received the publicly-funded live vaccine (Zostavax[®] II) (Government of Ontario 2016)	Fully-funded for all residents aged >6 months. Service delivery: Primary care, community pharmacies, aged care facilities, public health units, Indigenous healthcare organisations (Government of Ontario 2025)	Fully funded for adults aged 75+ Service delivery: Primary care, public health units, aged residential care, Indigenous healthcare organisations (Government of Ontario 2025)
Australia	Fully funded under the National Immunisation Program (NIP) for free vaccination for all adults 65 years and over; Aboriginal & Torres Strait Islander people aged 50 years and over; and certain adults (18+) with immunocompromise or high risk (Australian Government Department of Health Disability and Ageing 2025) Service delivery: GP clinics, community pharmacies, aged-care services; recorded in the Australian Immunisation Register.	Fully funded under the National Immunisation Program (NIP) for free vaccination for adults 65 years and over, Aboriginal & Torres Strait Islander people aged 50 years and over; and certain adults (Australian Government Department of Health 2025) Vaccination rate: 75–80 % among ≥ 65 years (AIHW 2024) Service delivery: GP clinics, pharmacies, workplace programmes, mobile and community vaccination events.	Fully funded under a pilot in Victoria for aged care residents (Premier of Victoria 2025)
New Zealand	Fully funded for adults aged 65 only (first dose must be before age 66). At-risk groups and younger individuals may be	Fully funded for free influenza vaccination, adults 65+ and other high-risk groups are eligible for fully funded	Not funded



Country	Shingles (Herpes Zoster)	Influenza	RSV
	eligible, e.g. long-term conditions. Vaccination rate: Uptake in NZ in 2023 among people aged 65+ eligible for funded shingles vaccine is estimated to be 10-20% (PMAANZ, n.d.). Service delivery: Delivered through general practices, pharmacies.	vaccine (Health New Zealand, n.d.) Vaccination rate: Around 60% of those aged 65+ (Health New Zealand 2025a). Service delivery: Delivered via GPs, community pharmacies, aged-care facilities, outreach to Māori and Pacific older adults.	

Source: As per table

3.4 Oral health

The World Health Organization suggests that people should retain a minimum of 20 natural teeth for life (Petersen and Yamamoto 2005). But, as people accumulate a lifetime of dental wear and tear and repairs, they can often arrive in their senior years with few to no teeth, or heavily filled teeth and complex dentistry requiring a high level of maintenance.

Many older people who have maintained their teeth well but have become frail or are living with dementia rely on caregivers to support them with daily oral care and to attend regular dental visits. This can result in an accelerated decline in oral health. Research suggests that dental health can cause, exacerbate or complicate other health conditions through its impact on nutritional intake. Severe tooth loss has been shown to increase the risk of nutritional deficiency in older adults by 21 percent (Zhao and Kim 2024)

Evidence shows that oral health is more important than previously believed and that it does not decline in importance as people reach advanced age; in fact, it can become a major health issue. Recent research has indicated a compelling link between oral health and dementia:

- a large-scale population-based study involving over 2.5 million people (Je et al. 2023) revealed that professional dental cleaning and frequent tooth brushing were associated with a decreased risk of dementia
- other studies have shown a connection between periodontal disease, dental caries, and a high number of missing teeth with an increased risk of dementia (see, for example, Beydoun et al. 2024; 2020a; Fu et al. 2023a)
- a longitudinal study of ageing nuns found that severe tooth loss was associated with a 6.4-fold increased risk of dementia compared to those with fewer tooth losses (Stein et al. 2007).

Evidence also shows that retaining natural teeth contributes to older people's quality of life, physical and mental health, due to the role of teeth in:

- supporting people's ability to chew food and allowing them to enjoy different tastes and textures, which encourages a healthy and diverse diet
- helping to maintain clear speech and appearance-related self-esteem, which supports social connection and independence
- contributing to overall physical health by helping to reduce harmful bacteria and infections in the mouth, which can lead to other health issues.



(New Zealand Dental Association 2010)

Poor oral health is common in New Zealand and becomes highly visible in later life. National surveys show that older New Zealanders, and especially those with higher support needs and those in the highest socioeconomic deprivation groups, bear a heavy disease burden.

The 2023/24 New Zealand Health Survey reported that only 36 percent of people in the highest deprivation quintile (NZDep5) had visited a dentist in the past 12 months, 72 percent did not attend for regular preventive and maintenance reasons (attending only when there was a problem), and 52 percent had avoided dental care in the past 12 months due to cost.

Older people's oral health is rarely investigated at a national level, but in the 2012 Older People's Oral Health Survey (OPOHS), which examined people aged 65+ living in aged residential care or receiving home-based support:

- just over half of the participants were fully edentulous (had no teeth)
- the dentate participants (those who had some teeth) averaged:
 - 24 teeth decayed, missing or filled, with 15 to 16 teeth missing on average
 - roughly two in five needs at least one restoration
 - one in three (residential care) to one in five (home-based) needing one or more extractions
 - high plaque and calculus levels and substantial prosthetic need, signalling ongoing risk even where treatment has occurred.

(Ministry of Health 2016).

The survey also documented inequities for Māori older adults, including fewer natural teeth present and a lower likelihood of a functional dentition or replacement of missing teeth, indicating a higher burden of disease and unmet need (Ministry of Health 2016).

These patterns sit alongside contemporary evidence of access barriers across the adult population, with cost-related unmet dental need common and concentrated among Māori and Pacific peoples (McKenzie et al. 2024).

Oral disease can be particularly severe in older age because people are living longer and with more natural teeth than in the past. Gingival recession, which increases with age due to lifestyle and quality of oral care factors, exposes root surfaces that are highly susceptible to root caries. Underlying causes can include:

- polypharmacy contributing to xerostomia (dry mouth), which impairs saliva's protective effects
- difficulties with dexterity and cognition, which can hinder daily oral care
- denture use, which, when not well maintained, can add to mucosal and caries risk.

(Ministry of Health 2010; 2016).

Taken together, these age-related risk factors explain why oral conditions are both common and complex in later life, with implications for chewing ability, pain, infection and quality of life (Ministry of Health 2010; 2016).



Non-traumatic dental presentations to emergency departments (EDs) remain a preventable burden: a Christchurch tertiary-centre study estimated a cost of \$370 per ED visit and a minimum annual cost of NZ\$344,470 to the Christchurch Hospital ED alone for dental presentations in 2020 (Fisher et al. 2023). The study also identified that Māori and Pacific people with dental concerns are over-represented among ED attenders. The authors noted that despite the high cost of these events, people receive sub-optimal management in the ED, further highlighting the low cost-effectiveness of the current approach.

Public investment in later life oral health should start in childhood, as this lays the foundation for good oral health throughout life (New Zealand Dental Association 2019). However, beyond direct investment in dental services for children and adolescents, improving oral health in later life can include interventions across the life course, such as:

- fluoridated drinking water
- targeted subsidised dental care for low-income New Zealanders
- caries management in older adults
- oral hygiene support for frail older adults and those living in aged residential care.

Fluoridated drinking water

Fluoridated drinking water is one of the most powerful population-level oral health interventions because it provides continuous, passive exposure to protective fluoride to everyone who uses the supply, regardless of income, age, or access to dental care. The New Zealand Dental Association (2025) notes that dental decay is a chronic, cumulative disease, and that the Dunedin Multidisciplinary Health and Development Study showed that people with the worst dental health at age 45 had more decay at age 5. The impact of water fluoridation across the life course and across all socioeconomic groups makes it the fundamental oral health intervention for healthy ageing and equitable later-life outcomes.

Authoritative reviews conclude that community water fluoridation (CWF) is safe and effective, reducing both the incidence and severity of dental decay across the life course, and contributing to equity gains for groups with the highest burden of disease (including Māori and Pacific peoples) (Royal Society Te Apārangi & Office of the Prime Minister's Chief Science Advisor 2014; Office of the Prime Minister's Chief Science Advisor 2021; Ministry of Health 2024).

A New Zealand-specific economic evaluation (Moore and Poynton 2015) found substantial clinical benefits in adults, with lifetime exposure offering:

- an estimated 21 percent reduction in decay for those aged 18–44
- an estimated 30 percent reduction in decay for those aged 45+.

These adult benefits complement well-established gains in children and adolescents, underscoring CWF's role as a true life-course intervention that maintains natural dentition, supports function and nutrition in older age, and reduces treatment need at every stage (Moore and Poynton 2015; Ministry of Health 2024).

Cost-benefit analysis in the New Zealand context has estimated a net discounted saving of NZ\$1.401 billion over 20 years from fluoridating plants serving populations of at least 500, translating to around NZ\$334 per person in net savings (Moore and Poynton 2015). A subsequent peer-reviewed study by New Zealand authors reached the same conclusion: CWF remains highly cost-effective for all but very small communities, with modest per-



person gains compounding into substantial national savings and quality-of-life benefits (Moore et al. 2017).

These findings have underpinned policy moves to expand fluoridation as a health intervention, reflecting the strength and consistency of the local evidence base (Office of the Prime Minister's Chief Science Advisor 2021; Ministry of Health 2024).

Compared with other high-income countries, New Zealand has historically had low access to fluoridated water, so many older people are experiencing poor oral health from a lifetime of inadequate fluoride protection. The Health (Fluoridation of Drinking Water) Amendment Act 2021 sought to change this by amending the Health Act 1956 to enable the Director-General of Health to direct local authorities to fluoridate drinking water supplies and establish nationally consistent decision-making on this issue.

According to the Ministry of Health, if the Director-General were to direct local authorities to fluoridate all drinking water supplies servicing populations over 500, over 80 percent of New Zealanders would have access to fluoridated drinking water; however, as of 2025, only around half the population has fluoridated drinking water (Ministry of Health 2025) leaving 30 percent of the population using unfluoridated water from networked supply.

Targeted subsidised dental care for low-income New Zealanders

A policy report published by the New Zealand Dental Association (NZDA) in 2019 estimated that providing basic dental services for low-income adults in New Zealand would generate a return of \$1.60 for each dollar invested, due to reduced health care costs, increased employment, and increased tax revenue (New Zealand Dental Association 2019).

In 2019, the New Zealand Dental Association published a report that set out a roadmap to improve access to oral health services (New Zealand Dental Association 2019).

The report also described a cost-benefit analysis of subsidised dental care for a cohort of 380,000 low-income adults, showing that public investment of \$900 per eligible person would be cost-neutral from a fiscal perspective. It also set out the priorities for implementation:

- Extending urgent dental grants. These grants, available from Work and Income New Zealand, provide three mechanisms for adults facing financial hardship to meet the cost of necessary dental work and are in high demand. The NZDA recommended increasing funding for these grants, simplifying the application process, ensuring a more consistent grant approval process, and negotiating a fee schedule with participating dental care providers to remove the need for a quote before people can obtain care.
- Funding dental care for vulnerable young adults. Recognising that funding dental care for all adults was a fiscal challenge, the NZDA proposed extending funded dental care beyond the 18th birthday for young adults on a main benefit. This was proposed to begin as a programme for 18- to 24-year-olds with future expansion to older age groups. The cost was estimated to be between \$10 million and \$25 million per annum.
- Funding and evaluating demonstrator projects to identify the most effective service delivery design for reaching disadvantaged populations, including integration with Whanau Ora, the use of primary care pre-assessment and referral, and inclusion in intensive wraparound services. This initiative would ensure that funding of adult dental care delivers the best value for money.



Canada provides an example of a targeted approach to adult dental care. The Canadian Dental Care Plan (CDCP) is a national income-tested scheme started in 2024/25 to help low- and middle-income adults who don't have private dental insurance. Administered by a private insurance company, the scheme pays dentists, hygienists and denturists directly for eligible services at CDCP pre-set fee rates.

The income test determines eligibility based on adjusted family net income of less than CA\$90,000. Co-payments apply and depend on income level (no co-payment for those with income below CA\$70,000, with steps of 40 percent and 60 percent co-payments at higher incomes)(Government of Canada 2023). The CDCP is expected to ease financial barriers to accessing dental care for up to 9 million Canadian residents (Government of Canada 2025a) and has already approved over 5.5 million people in its first year (Government of Canada 2024).

The Canadian scheme covers dental exams, diagnostics, cleanings, fluoride, fillings, root canals, extractions, and other clinically necessary services, with potential coverage subject to pre-authorisation for certain crowns, endodontics, and dentures. Cosmetic and orthodontic services aren't covered (Government of Canada 2023).

Table 11 Targeted subsidised dental care: Evidence reviewed

Initiative	Location	Description	Source
NHS Low Income Scheme (HC2/HC3)	UK	Free or reduced NHS dental charges for people who meet income and asset tests, restricted to NHS dentists. Administered by NHS Business Services Authority/NHS.	NHS Business Services Authority (2025a; 2025b)
Dental Treatment Services Scheme (DTSS) for Medical Card holders	Ireland	Adults (16+) with a Medical Card receive free core care (exam, cleaning, two fillings/year, extractions; some dentures/gum care as needed) delivered by contracted private dentists.	Health Service Executive (Ireland) (2023); Citizens Information (2025). (HSE.ie)
Canadian Dental Care Plan (CDCP)	Canada (federal)	National, income-tested plan for people without private insurance. Administered by an insurance company; 0–60% co-pay on CDCP fees by income band; covers exams, hygiene, fillings, etc. Some items require pre-authorisation.	(Government of Canada 2023; Brondani et al. 2025; Government of Canada 2025b)
Federally Qualified Health Centers (FQHCs) Sliding Fee Discount Program	United States	Community Health Centres must operate the programme and provide dental care within scope; charges adjusted by income/family size.	HSE (Health Service Executive 2025; Henry J. Austin Health Center (2025)
Public dental clinics for concession-card holders	NSW	Adults with a Health Care Card/Pensioner Concession Card eligible for free care at public dental clinics; states/territories administer and set eligibility/waiting lists.	NSW Health (2025a; 2025b)
“100 % Santé” (dental basket at zero out-of-pocket) and Complémentaire santé solidaire (CSS)	France	Defined prosthetic items (crowns/bridges/dentures) provided with no patient charge when combined with statutory + complementary coverage; CSS is the low-income complementary plan.	Assurance Maladie (2025); DREES (Direction de la recherche (2024)



Initiative	Location	Description	Source
Hardship rule (Härtefallregelung) within statutory health insurance	Germany	For very-low-income adults, statutory insurance pays 100% of standard prosthetics (higher subsidies also available with good check-up history).	How-to-Germany (2025)(overview of GKV dental benefits).
Municipal assistance (Bijzondere bijstand) and local low-income dental help	Netherlands (municipal)	Municipal social assistance can pay necessary dental costs for low-income residents; often channelled via city schemes or collective municipal policies.	Gemeente Amsterdam (2025); KNMT / Allesoverhetgebit.nl (Netherlands) (2025)
National dental subsidy & high-cost protection (ATB + caps)	Sweden	Universal subsidies (annual allowance) plus high-cost protection that sharply reduces out-of-pocket costs above thresholds; particularly protective for extensive adult treatment. New subsidy being introduced in 2026 for people aged 67+, covering 90% of dental care costs.	Försäkringskassan (2025)
Helbredstillæg (health supplement) for pensioners	Denmark (municipal)	Income/asset-tested municipal subsidies for dental care (incl. dentures) for pensioners; some municipalities add extended supplements.	borger.dk (2025)
Public dental care + Kela reimbursements	Finland	Adults can use publicly funded dental services or receive reimbursement for private dental services. All funded or reimbursed services have some level of co-payment. Oral and dental check-ups every 2-3 years, x-rays, treatment (including urgent treatment), and some orthodontic treatment. From 1 May 2025, the government expanded coverage to include up to 2 oral hygienist appointments per year.	Kela (Finland) (2025); Suomi.fi (Finland) (2025); European Observatory on Health Systems and Policies (2025)
National Health Insurance (NHI/SHI) dental coverage with reduced senior co-pays	Japan	Universal coverage includes most routine dental with standard co-payments (often 30%, lower for many older adults); national fee schedule controls prices.	MHLW (Japan Ministry of Health (2025); World Health Systems Facts (2019)
Elderly dentures/implants coverage expansion under NHI	South Korea	NHI expanded coverage of dentures (2012) and implants (2014) for ≥65s to address unmet need and significant burden of poor dental health resulting in chewing difficulties and nutrition-related poor health; Studies show the policy change increased utilisation among older adults, along with significant reductions in severe chewing difficulty	Zhao and Kim (2024)

Foreign language sources were translated by ChatGPT.

Source: As per table



The New Zealand Dental Association notes that oral health outcomes are multifactorial:

“Many oral conditions are theoretically preventable, but they are also complex multifactorial conditions with socio-economic, environmental and biological determinants. Oral conditions have risk factors in common with other chronic conditions, such as diabetes, heart disease and respiratory diseases. Oral health is integral to general health, and oral health needs to be included within health policy decisions for people of all ages, ethnicities and abilities.” (New Zealand Dental Association, 2025)

Rather than indicating that specific oral health interventions are not worthwhile, this means that achieving many of their potential benefits requires complementary investment in general physical health and social determinants.

Oral hygiene support

Oral hygiene support is an intervention designed to ensure that, as people age, oral hygiene is maintained through adequate support, particularly targeting older adults who are frail, have activity limitations that impair their ability to maintain oral health, are living with dementia, or are living in aged residential care facilities.

A 2016 report (Kelsen et al. 2016) reviewed the use of Oral Health Care (OHC) policies in aged care facilities and found that written policies were in place in only 36 percent of facilities, and only 15 percent of facilities had an OHC policy that had been drafted with input from a dental professional. It also found that only 14 percent of facilities had ever had a dental professional give a demonstration, despite over 90 percent of facilities expressing that this would be beneficial. Baseline oral examinations were identified as a low priority for facilities, with only one in nine providing them on admission.

According to the New Zealand Dental Association, there is a need for national protocols for dental hygiene care and inclusion of oral care criteria as part of aged care facilities’ compliance with standards (New Zealand Dental Association n.d.). The Healthy Mouth, Healthy Ageing oral care training programme run by the NZDA with funding from the Ministry of Health aims to improve the skillset of care workers in the aged care sector beyond the basics to include assessment, planning and implementation of oral care plans.

Oral hygiene support should be offered to older people in residential care as well as those in the community who are already receiving help with personal care, indicating a need for adequate training for all aged care workers working across both contexts.

Table 12 Targeted subsidised dental care: Evidence reviewed

Initiative	Location	Description	Source
Caring for Smiles	Scotland	National oral health improvement programme for residents in care homes. Provides staff training, resident oral assessments, personalised care plans, and daily mouth-care protocols. Delivered by NHS Boards’ oral health promotion teams, integrating dental professionals with aged-care staff. Evaluations show improved oral health knowledge and consistent	NHS Health Scotland (2017); MacEntee (2020)



Initiative	Location	Description	Source
		mouth care in facilities since implementation in 2010.	
Mouth Care Matters (MCM) and Oral Health in Care Homes Toolkit	England	A Health Education England programme delivering comprehensive oral care training to non-dental staff in hospitals and aged-care facilities. Includes screening prompts, escalation to dental teams, and a national toolkit aligned to CQC and NICE guidance. Demonstrated improved oral assessment practices and awareness in non-dental settings.	Newton et al. (2019); Care Quality Commission (2019)
Better Oral Health in Residential Care (BOHRC)	Australia	Nationally funded initiative providing standardised tools for oral health assessment, care planning, and referral pathways in residential aged care. Includes training modules and resources for dementia and complex needs. Integrated into Australia's Aged Care Quality Standards.	Chalmers et al. (2016); Australian Government Department of Health (2021)
Preventive Dental Services for People in Long-Term Care (§22a SGB V)	Germany	Statutory health insurance benefit providing entitlement to regular dental examinations, preventive treatments, and individual oral care plans for residents in long-term care or with care grades. Dentists deliver domiciliary care; programme includes caregiver instruction. Evidence indicates increased preventive service uptake and improved oral outcomes.	Deutscher Bundestag (2018); Nitschke et al. (2021)
Annual dental care allowance, high-cost protection, ROAG-J and Senior Alert System	Sweden	All adults in Sweden receive an annual dental care allowance plus high-cost protection that limits out-of-pocket costs. Those in aged residential care receive fully funded dental care. A nationwide quality register for age-related risks (including oral health risks) supports standardisation of care in nursing homes. The Revised Oral Assessment Guide (ROAG-J) supports consistent high quality oral health assessment and preventive oral care interventions by nursing staff, as well as referrals to dental professionals. Research shows improved detection of oral problems and preventive follow-up.	Andersson et al. (2020); Bellander et al. (2024)
Long-Term Care Insurance Oral Care Reimbursement	Japan	Since 2009, Japan's LTC insurance reimburses dentist-supervised oral hygiene programmes in nursing homes. Includes regular oral care, dysphagia prevention, and staff coaching. Studies show improved	Matsuo and Takahashi (2019); Ministry of Health Labour and Welfare (Japan) (2023)



Initiative	Location	Description	Source
		swallowing function and reduced pneumonia incidence among participants.	
“Brushing Up on Mouth Care” Programme	Canada	National training package for LTC and home-care staff developed by the Canadian Dental Hygienists Association. Provides practical videos and guides on daily mouth care and dementia-sensitive communication. Delivered by hygienists in collaboration with care teams; demonstrated improved caregiver competence and oral hygiene compliance.	Jablonski et al. (2018); Canadian Dental Hygienists Association (2020)
“Mondverzorging in de langdurige zorg” Guideline	Netherlands	2023 national guideline on oral care in long-term care facilities. Requires screening at admission and on indication using the OHAT-NL tool, detailed daily care protocols, and integration with professional dental oversight. Aims to standardise practice and ensure continuity between nursing and dental care.	KNMT (Royal Dutch Dental Association) (2023); de Visschere et al. (2022)
Healthy Mouth, Healthy Ageing	New Zealand	NZ Dental Association initiative training aged-care staff to assess and deliver daily oral care. Identifies large variation in practice and limited dental professional input across NZ facilities. Calls for national standards and inclusion of oral health in aged-care quality audits.	New Zealand Dental Association (2024); Ministry of Health (2023)

Foreign language sources were translated by ChatGPT.

Source: As per table

3.5 Vision and hearing screening

Hearing and vision impairment are highly prevalent in ageing individuals and are significant public health concerns.

A systematic review of 23 studies on adults with sensory impairment found a significant association with lower quality of life (Tseng et al. 2018). The prevalence of sensory impairments like vision and hearing loss rises with age, and according to data from the Global Burden of Disease Study (Institute for Health Metrics and Evaluation, n.d.), in adults over 70 years of age, hearing loss and vision impairment are the leading and third-leading causes of Years Lived with Disability, respectively.

Hearing loss has been identified as one of the modifiable risk factors for cognitive decline and dementia, and the New Zealand Audiological Society recommends that all people with hearing loss be encouraged to address it to minimise the impacts (NZ Audiological Society 2024).

A recent New Zealand study (de Ribot et al. 2025) analysed 48,038 interRAI assessments from 2019 and 2020, and found prevalence rates of moderate difficulty or worse in 19 percent for hearing loss and 10 percent for vision impairment. Dual sensory impairment



(vision and hearing) was found in seven percent of the sample. The study also found that regular hearing examinations were undertaken by 31 percent of community-dwelling older adults, but only 21 percent of those living in aged care facilities. For vision loss, regular testing decreased from 55 percent amongst community-dwelling older adults to 32 percent amongst those in aged care facilities. The study also found relatively low use of hearing aids amongst older adults living in aged care (20 percent). It concluded that people in aged residential care had reduced access to both hearing and vision screening compared with community-dwelling older adults, and that visual impairment was more likely to be associated with the use of aids than was hearing impairment.

The main causes of blindness and moderate to severe vision impairment in New Zealand are cataracts, macular degeneration, glaucoma, uncorrected refractive error and diabetic retinopathy, and although these primarily affect older adults, diabetic retinopathy is the leading cause of vision impairment in working-age New Zealanders (Rogers et al. 2021). With higher rates of diabetes, Māori and Pacific people are likely also to experience higher rates of diabetic retinopathy.

Despite the increasing burden of these issues and their significance for older people's loss of independence and quality of life, reports note that there is a shortage of eye health services, inconsistent access to treatment across the country,

The Royal Australian and New Zealand College of Ophthalmologists notes that timely access to eye healthcare can prevent more than 80 percent of permanent visual impairment and blindness and calls for a National Eye Health Plan, including a funded means-tested biennial eye health check from age 65, and from age 55 for Māori and Pacific New Zealanders (Royal Australian and New Zealand College of Ophthalmologists n.d.).

Hearing loss is also identified as needing solutions in New Zealand: The Office for Disability Issues (Office for Disability Issues 2021) identified that many New Zealanders see cost as a major barrier to accessing hearing loss services, with 67 percent stating they cannot afford a hearing aid. While subsidies are available through different government agencies, depending on the cause of hearing loss, hearing aids are not fully funded. Cultural factors and stigma attached to disability are also identified as barriers, particularly for Māori and Pacific people. The report identified a need to expand access to screening for hearing loss and argued that, despite NGOs providing some services, a significant contribution from government funding would be necessary to achieve universal access nationally.

The World Health Organisation (WHO) goes even further than these, recommending that the best current available evidence indicates that vision screening be offered at least annually to adults aged over 50 years and hearing screening be offered every 5 years to adults aged 50–64 years, and every 1–3 years to adults aged 65 years or older (Chadha et al. 2023).

There is evidence that New Zealand's progress to achieving best practice is behind other countries, with a review of 76 eye health services for older adults across eight high-income countries noting that "New Zealand was the only country without a programme that provided this care without requiring out-of-pocket payments from groups least able to pay" (Goodman et al. 2022).

In contrast, Singapore offers a comprehensive national screening programme called Project Silver Screen, which includes annual functional screening (vision, hearing and oral health) for people aged 60 and above. While not universally fully-funded, the programme has zero to low co-payments (up to SGD\$5) based on means-tested eligibility rules. Vouchers



subsidising the cost of assistive devices are also provided regardless of household income for those who need them (Singapore Ministry of Health 2023).

The UK National Screening Committee does not recommend national screening programmes for hearing loss in adults, with a key reason being that it was unclear at the time of the last review (2021) that people identified as needing hearing aids would actually use them (UK National Screening Committee 2021), highlighting the importance of addressing non-financial barriers to the use of hearing aids. It does not offer any recommendations regarding screening for vision loss.

Similarly, the Canadian Task Force on Preventive Health Care does not recommend vision screening in community-dwelling asymptomatic older adults due to low-quality evidence of benefits, recommending primary care referral for vision screening instead; however, it notes that the recommendation itself is “weak” due to low certainty (Canadian Task Force on Preventive Health Care 2018).

A national screening programme for hearing and vision loss in older people is not likely to be an appropriate solution. However, a national strategy and framework for referrals, access to services, possible screening in aged care, and means-tested funding for hearing aids and vision correction should include measures to address non-financial barriers to the use of aids. The Australian Government committed AUD\$5 million to a National Hearing Health Awareness and Prevention Campaign launched in 2023 as part of its Roadmap for Hearing Health. The campaign focused on the prevention of avoidable hearing loss, promoting practices to prevent hearing damage, destigmatising hearing loss and encouraging people experiencing hearing loss to seek treatment (Australian Government Department of Health 2021b).

Table 13 Hearing and vision screening: Evidence reviewed

Country	Hearing and vision screening programme for older adults	Source
Australia	The Hearing Services Program offers fully funded standard hearing aids and partially funded premium hearing aids, as well as fully funded fitting, maintenance, and follow-up appointments every five years for lower-income older Australians and veterans. An independent review of the programme identified that over half of eligible adults were not using it due to non-financial barriers (lack of information about services, limited range of service providers, stigma, lack of culturally appropriate services, poor access to services in rural and remote areas). AUD\$5 million government funding for a National Hearing Health Awareness Campaign to raise awareness and destigmatise hearing loss. Medicare subsidises optometry services with a referral from a GP and covers one bulk-billed eye test annually for people aged 65 and over. Various state-level fully-funded or partially subsidised refractive error correction, primarily means-tested, some co-payments	Australian Government Department of Health (2024); Woods and Burgess (2021); Australian Government Department of Health (2021b); Services Australia (2025)
UK	No national hearing screening for older adults. GP/self-referral to audiologist and online tests. GP-referred hearing tests are fully funded by the NHS. National fully funded ophthalmic service available every two years (England, Northern Ireland, Wales) or annually (Scotland)	UK National Screening Committee (2021) NHS (2017) NHS (2023a)



Country	Hearing and vision screening programme for older adults	Source
	to those >60 years of age, and optical vouchers for refractive error correction.	
Canada	Hearing aids are funded by provincial programmes, with caps on percent of subsidised cost and/or amount. Some fully funded services with means-testing or for adults receiving means-tested benefits, and for First Nations/Indigenous people. Vision testing for older adults is funded by some provincial programmes, with most covering the full cost of a routine vision test at least every 2 years for people aged 65 and over (some annually). Vision aid coverage is means-tested.	HearingLife (n.d.)
Ireland	No national screening programme for hearing loss in older adults. Hearing services provided and funded through the Health Service Executive by referral. Some means-tested subsidies for hearing aids and hearing aid repairs through the HSE and National Hearing Aid Repair Centre. Fully funded vision testing for people aged 60+ every 2 years, more often if clinically necessary. Diabetic retina screening national service with annual recall from national register. Screening and all necessary treatment and follow-up provided to user free of charge.	Citizens Information Ireland (2025); Irish College of Ophthalmologists (2021)
Singapore	Project Silver Screen includes annual functional screening (vision, hearing and oral health) for people aged 60 and above. Free or co-payment up to SGD\$5 based on means-tested eligibility rules. Non-means-tested vouchers for assistive devices.	Singapore Ministry of Health (2023)
Hong Kong	Capped funding for optometry services HK\$2,000 per 2 years covering eye care and refractive error correction.	Government of the Hong Kong Special Administrative Region (2021)

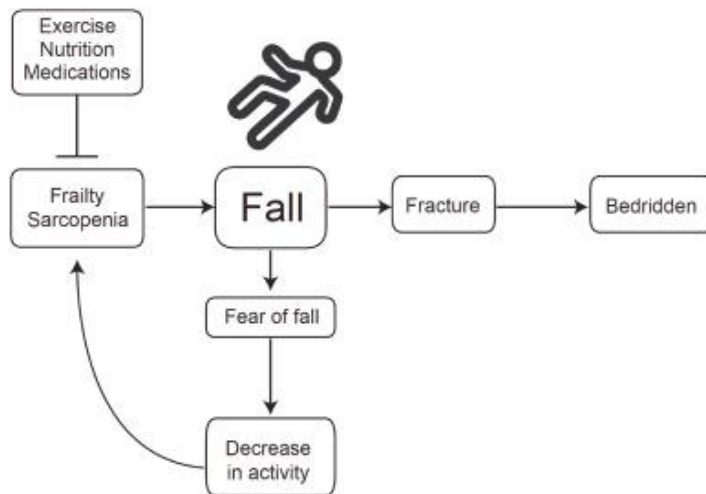
Source: As per table

3.6 Frailty, falls, and loss of functional independence

Frailty, falls, and loss of functional independence are related and can be part of a vicious cycle.



Figure 9 Vicious cycle of frailty, falls and loss of functional independence



Source: Hashimoto et al. (2025)

Regardless of whether the presenting issue is frailty, experience of falls or loss of functional independence, similar interventions are typically required, and these can be across a spectrum from risk assessment to prevention and rehabilitation.

Falls, which are common in older people, especially as they become frail, are a leading cause of injury-related hospitalisation for older people, driving loss of independence, long rehab, and premature entry to long-term care. Without intervention, the risk of falls and the severity of injuries and impacts on quality of life increase with age (ACC 2019). One in three adults aged over 65 in New Zealand falls each year (Osteoporosis New Zealand n.d.).

The Health Quality and Safety Commission produces a dashboard for the Falls & Fractures Outcomes Framework (Health Quality & Safety Commission New Zealand 2023), which shows that in 2022-2023, there were over 300,000 claims to ACC for falls injuries in people aged 50 and over, including nearly 35,000 fracture claims. The data also shows an increasing trend in the number of these claims and a constant or increasing rate, depending on the specific measure. For example, the rate of fracture claims has remained relatively constant at around 20 per 1,000 population, while the rate of repeat claimants (people in this age group who have experienced more than one injury claim due to a fall) has increased since 2011-2012.

The HQSC dashboard also shows that total expenditure on falls claims was over \$859 million in 2022-2023, compared with \$277 million in 2011-12.



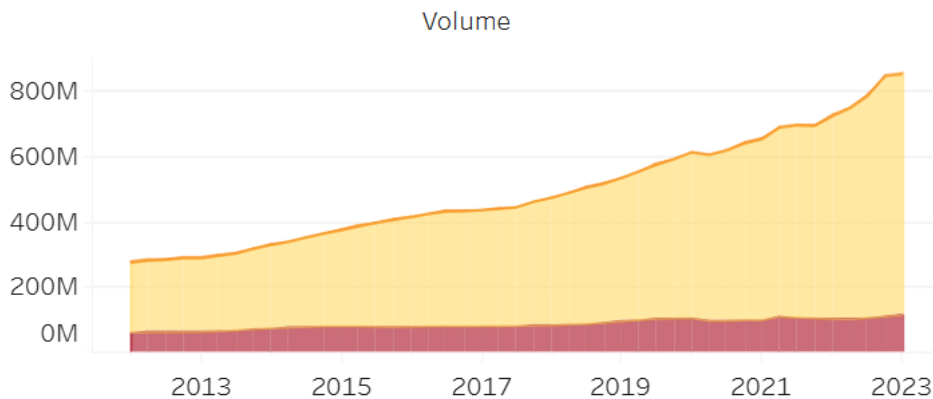
Figure 10 Total expenditure on falls claims for adults aged 50+

2011/12 to 2022/23

\$859,173K total expenditure

86% **entitlement**

13% **medical**



Source: Health Quality & Safety Commission New Zealand (2023)

A systematic review of older people presenting to an ED after a ground-level fall found the incidence of intracranial bleeding was around 5 percent (de Wit et al. 2020). This highlights how serious even a low-level fall can be.

Risk of falls typically accumulates silently as people age through:

- Declining balance and strength
- The use of multiple medications (polypharmacy), which introduces postural hypotension or sedation effects. Orthostatic hypotension is a common falls risk factor and can be tested for. A systematic review and meta-analysis of nearly 25,000 older people living at home and over 2,500 living in aged care facilities found that the prevalence of postural blood pressure drop was 22 percent in the community and 24 percent in residential facilities (Saedon et al. 2020).
- Vision or hearing loss
- Footwear and home hazards
- Low confidence after minor slips, which result in decreased activity, compounding the problem of declining strength and balance and contributing to other problems like social isolation.

As with other ageing risks, health systems often only have visibility of falls **after** an ED visit —when costs and harms are already high.

Falls that result in hip fractures are particularly costly due to the need for orthopaedic surgery and the high rate of admission to aged residential care or increased need for home support services that these injuries precipitate.

Falls and injuries from falls can be a cause of loss of functional independence. Challenges with maintaining functional independence with age (the ability to undertake activities of



daily living, such as bathing, dressing, and getting in and out of a chair), which can be negatively impacted by injuries, are often the root cause of older people's withdrawal from social participation, further injuries, and declining physical and mental health.

Older people's functional independence – whether lost suddenly due to a fall and serious fracture or lost slowly over time – is critical to their ability to remain in their own homes as they age.

One Australian and New Zealand study found that amongst 437 hip fracture patients aged 50+, 29 percent of those who had been living in private residences were discharged to a residential aged care facility after the event (Siminiuc et al. 2024).

Aged care facility residents face significant additional risks from deconditioning and cognitive impairment. Falls among older people in aged care facilities are common and can cause loss of independence, injuries, and sometimes death (Dyer et al. 2025).

Significant fractures are most common in older people who have osteoporosis, a condition that causes fragile bones and is most prevalent in older women. The risk of fragility fractures can be reduced by interventions that prevent or reduce the extent of osteoporosis.

Evidence shows that many single interventions (exercise interventions, vitamin D supplementation, increased dairy/calcium intake, medication review, etc.) may all have some beneficial effect, but benefits are most robust when interventions are combined, as individual interventions often have complementary effects. Similar multifactorial approaches are needed in aged care contexts where there is a need for leadership, staffing, and the facility environment to be integrated into intervention design (Dyer et al. 2025).

Some interventions focus on activities of daily living, while others focus more specifically on falls prevention.

Falls prevention in New Zealand

New Zealand has, over the past decade, attempted to coordinate a national programme of “Reducing Harm from Falls” under the Health Quality & Safety Commission (HQSC), along with ACC and the Ministry of Health.

The “Reducing Harm from Falls” programme was established in mid-2012, as part of the national patient safety campaign “Open for better care,” led by HQSC, in partnership with ACC and others. Its aim was to reduce falls and harm in older people across hospitals, aged residential care (ARC), and eventually community settings (Health Quality & Safety Commission 2025b). The programme was structured around 10 topics, a learning and resource set designed to guide clinicians, managers and the sector (HQSC “10 Topics”) (Health Quality & Safety Commission 2025a). These topics covered awareness, risk assessment, care planning, safe environment, post-fall care, medicines, hip fracture focus, strength & balance, and integration.

The programme initially focused on hospital settings, with a modest extension into ARC (from 2013) and later into primary care and community (Synergia 2015). One of the programme's explicit early targets was a 20 percent reduction in fractured neck of femur (hip fracture, FNOF) arising from inpatient falls over the period July 2013 – June 2015.

The programme also supported the development of tools (e.g. “Ask, Assess, Act” algorithm via the Best Practice Advocacy Centre (bpac)) to guide systematic falls risk enquiry in primary care (based on STEADI concepts) (bpac falls risk tool). In aged residential care, the



HQSC also ran a “mini-collaborative” evaluation of falls prevention work in several ARC facilities, with case studies illustrating local efforts. HQSC also published a Quality Improvement Toolkit (2016) for using falls prevention as a project topic in health care (e.g. in care facilities), to build capacity in QI methods (Health Quality & Safety Commission 2021).

By June 2015, there had been a sustained, statistically significant reduction in in-hospital FNOF from falls: The reduction corresponded to a roughly 25 percent reduction in falls with FNOF (Social Investment Agency 2018). According to HQSC’s Topic 10 and associated documentation, over the three initial years, the programme may have prevented an estimated 67 fractured hips in hospitals, saving \$2.8 million in avoidable costs (Health Quality & Safety Commission 2022).

Despite these achievements, the programme has been wound back. The HQSC website states that the “Reducing Harm from Falls” programme ran from 2012–13 until 2017–18; by 2025, it is no longer active as a centrally driven programme. The 10 Topics (though still available as resources) are no longer planned to be further updated; they continue to reflect the evidence landscape as of their last revision in 2020 (Health Quality & Safety Commission New Zealand 2021)

Many of the elements originally under the programme (e.g. direct funding, mandated adoption) have not persisted as national mandates; rather, progress now relies more on a “movement” model through the likes of ACC’s Live Stronger for Longer, a directory of funded strength and balance classes and resources for health professionals which is itself a successful model (a social impact evaluation estimated that it provides a social return on investment of \$5.20 per dollar invested).

While the recent approach could be seen as more flexible, a qualitative evaluation (Pirouzi et al. 2024) of district programmes noted that:

- Where funding was withdrawn, implementation of some in-home components was variable and dependent on linking to empowering private physiotherapy organisations, and there were concerns about sustainability.
- Inconsistent approaches to patient identification resulted in variations in the Fracture Liaison Service, highlighting the importance of primary care engagement and the use of standardised protocols.
- Districts with lower primary care engagement and a lack of well-planned awareness sessions had less successful implementation.

This evidence indicates a need for a return to a nationally coordinated programme to ensure that all New Zealanders can benefit from these initiatives. There is scope within a nationally coordinated approach for local approaches and individually tailored programmes, but national funding, protocols and standards, and monitoring and reporting would ensure that a consistent and evidence-based approach is taken.

Comparison with overseas models

Within New Zealand’s overall approach to falls and fractures in older people, there has been a strong focus on evidence-based interventions.

New Zealand’s current national approach under Live Stronger for Longer includes:

- ACC-accredited Community Strength and Balance classes



- digital self-management (e.g. through the Nymbl balance app)
- fracture liaison services (FLS) and clinical pathways (ACC 2024).

In primary care, the “Ask–Assess–Act” toolkit, adapted by bpac from CDC’s STEADI, supports systematic risk identification and referral into exercise, home safety, vision and medication reviews (bpac (Best Practice Advocacy Centre) 2014; Health Quality & Safety Commission 2018).

Compared with other high-income countries, New Zealand’s emphasis on progressive strength and balance training is strongly evidence-aligned. Similar programmes overseas, including UK programmes such as FaME (Skelton et al. 2005; 2019), Australia’s LiFE (Clemson et al. 2012; Jansen et al. 2021), and the US SAIL model (National Council on Aging 2023) are largely based on the same principles.

Where New Zealand diverges is in system-level policy infrastructure. The UK provides a model that could be adopted, with national guidance through NICE (2025b) and related quality standards, which specify what services should do across community, hospital, and residential care, and emphasise sustained participation and multifactorial assessment (NICE 2025b; 2014). England has also specified community-based falls response requirements for integrated care boards (ICBs), focused on rapid response to falls, “long lie” avoidance, and clear onward referral into prevention and rehab pathways (NHS England 2022; Office for Health Improvement and Disparities 2022). This approach has a lot in common with New Zealand’s previous approach, led by HQSC, with a strong national framework and standards.

On secondary fracture prevention, many other high-income countries have Fracture Liaison Services (FLS) embedded as standard, with published evidence of reduced subsequent fractures and signals of improved survival (Li et al. 2021). UK and European systems often audit FLS performance and publish coverage maps and KPIs (Li et al. 2021). For New Zealand, fully specifying minimum FLS standards and publishing outcomes would align with international best practice and improve accountability (Li et al. 2021; NICE 2025b).

In aged residential care (ARC), Australia’s SUNBEAM cluster-RCT demonstrated that physiotherapist-led progressive resistance plus high-level balance training can cut fall rates substantially in long-term care, with supportive economic results (Hewitt 2018; Hewitt et al. 2018). International syntheses also show hip protectors reduce hip fractures in institutions, depending on adherence (Da et al. 2024). New Zealand has pockets of activity in aged residential care, but no nationally specified exercise dosing standard for this context and no national policy on hip-protector adoption strategies. Adopting SUNBEAM-style supervised training specifications and defining when and how to use hip protectors could improve New Zealand’s approach (Hewitt et al. 2018; Da et al. 2024; NICE 2025b).

For home safety and targeted modification (HSAM), New Zealand provides highly effective and cost-effective OT-led home safety assessment and modification (Campbell et al. 2005; Keall 2016b; 2016a). However, delivery remains uneven and not guaranteed nationwide.

Assessment is similarly patchy. The bpac Ask-Assess-Act intervention is largely based on the CDC STEADI pathway, which continues to be expanded with coordinated care plans and provider training for outpatient, inpatient, and pharmacy settings (bpac (Best Practice Advocacy Centre) 2014; Centers for Disease Control and Prevention 2025a; 2025b). But this is not consistently implemented. Embedding falls quality metrics and referral targets in PHO



contracts and hospital quality frameworks (similar to NHS expectations for ICBs) could strengthen uptake (NHS England 2022; NICE 2025a; Office for Health Improvement and Disparities 2022).

Table 14 Falls and fracture prevention: Evidence reviewed

Initiative	Location	Description	Source
FaME (Falls Management Exercise)	United Kingdom	24–36-week progressive, group-based strength and balance programme (plus home exercises) for frequent fallers; RCTs and follow-ups show improved function and reduced falls.	Skelton et al. (2005; 2019)
LiFE (Lifestyle-integrated Functional Exercise)	Australia	Individually coached programme embedding balance/strength into daily activities; landmark RCT shows reduced falls by 31%.	Clemson et al. (2012)
Lifestyle-integrated Functional Exercise (LiFE), gLiFE (group-based LiFE)	Germany	Data from the one-to-one delivered LiFE and gLiFE demonstrated cost-savings for both compared with standard care when provided to individuals at high risk of falls, with gLiFE being most cost-effective.	Jansen et al. (2021); Dams et al. (2024)
SAIL (Stay Active & Independent for Life)	United States	Public-domain, community strength-balance classes for 65+ delivered via senior/community partners; evidence-based designation and multi-state dissemination.	National Council on Aging (2023); SAIL Fitness (2025)
STEADI (Stopping Elderly Accidents, Deaths & Injuries)	United States	CDC clinical toolkit to screen, assess, and manage fall risk in primary care/ED settings; national implementation materials and evaluation guidance.	Centers for Disease Control and Prevention (2025)
SUNBEAM Programme	Australia	Cluster RCT in residential aged care: physiotherapist-led progressive resistance + balance training; ~55% fall-rate reduction at 12 months; economic evaluation supports value.	Hewitt (2018); Hewitt et al. (2018)
Hip protectors (institutional settings)	International (especially care homes)	Wearable pads to dissipate impact at the greater trochanter; umbrella review of meta-analyses shows reduced hip-fracture risk in institutions (adherence critical).	Da et al. (2024)
Fracture Liaison Services (FLS)	United Kingdom/Europe/Canada (global spread)	Coordinated secondary prevention after fragility fracture; systematic review/meta-analysis shows fewer subsequent fractures and signals for lower mortality in pre/post analyses.	Li et al. (2021)
Home safety assessment & modification (HSAM)	New Zealand/Australia/International	OT-led assessment with targeted modifications; RCTs (e.g., low-vision cohort) and modelling show reduced falls and strong cost-effectiveness when targeted to high-risk groups.	Campbell et al. (2005); Keall (2016a; 2016b)
National guidance/standards (NICE QS/NG)	United Kingdom	National guidance for assessment and prevention (e.g., strength-balance training; home hazard assessment; multifactorial risk assessment) implemented across NHS services.	NICE (2025a)



Initiative	Location	Description	Source
National strategy (Falls & Fragility Fracture Prevention)	Scotland (UK)	Whole-system strategy (2019–2024) to coordinate national falls/fracture prevention across health and social care, including community programmes and FLS.	Scottish Government (2019)
Community falls response & commissioning tools	England (UK)	NHS/OHID resources to strengthen community falls pathways (e.g., response models, commissioning aids) and scale strength-balance services.	Office for Health Improvement and Disparities (2022); NHS England (2022); NIHR ARC SWP (2025)

Source: As per table



4 Financial resilience and employment

A supportive environment in a longevity economy is designed to help people achieve the life they want in their later years. Two key aspects of this are financial resilience in later life and employment. These are the focus of this chapter.

4.1 What does retirement mean to New Zealanders?

A 2019 study (IPSOS 2019) explored what retirement means to New Zealanders. The study revealed how New Zealanders think about retirement, with 12 emergent themes. These are described in the table below.

Table 15 What retirement means to New Zealanders: Themes and issues

Theme	Issues
Home ownership	Home ownership was seen as a key part of a financially secure retirement. People are concerned about those who spend their entire retirement without the security of home ownership and are concerned about how this will impact on younger people. Moving to other regions was seen as one way of making home ownership more affordable.
Family	Families are a key driver of retirement outcomes. Families were seen as the primary influence on financial literacy and financial planning, and parenthood was the trigger for many people to start thinking about their financial future. People are concerned about the wellbeing and care of their parents as they age.
Work	New Zealanders have a range of attitudes towards work, with many seeing retirement not as a withdrawal from work but a transition to different types or amounts of work. While for some, work was a “daily grind” that retirement offered an escape from, others viewed their work as central to their sense of self, mana and purpose.
Financial education	People see a need for practical financial education starting early in life and identify changes in life circumstances, such as employment, buying a home, becoming a parent, etc., as requiring new financial learning relevant to the specific life stage and situation.
Cultural views about money	New Zealand culture is characterised by the belief that money should not be discussed openly, by a relaxed attitude towards planning, and by a tendency to expect the “welfare state” to ensure an adequate retirement income, although younger New Zealanders did not share that expectation.
Planning	Awareness of how to plan and what to plan for was low, and younger people were unlikely to factor into their expectations any unforeseen events that could negatively affect their retirement, even though many older people had experienced such events.
Health	Health was seen as critical to retirement, being a positive life stage, with independence and mobility being especially important. Health insurance was seen as desirable but not affordable to many at a time in life when it would be most needed.
Incentives to save	People expressed a need for help and encouragement to save, including a range of needs from advice and coaching to financial incentives and compulsory saving. Rent-to-own schemes were seen as one such intervention.
Poverty/low income	Pre-retirement wealth and income determine the information and support needs of people with regard to retirement planning, and their susceptibility to risk.

Source: NZIER based on IPSOS (2019)

Importantly, New Zealanders participating in the study saw retirement as a social construct that we opt into, rather than a right or entitlement. This means the concept of retirement is malleable. It can be socially reconstructed to better meet the needs of a longevity society.



4.2 New Zealand's retirement income system

New Zealand's retirement income system is the primary and most direct way of supporting the retirement that people want. The system comprises three key parts:

- NZ Superannuation
- KiwiSaver
- Private savings, including assets such as cash, shares, property and other assets.

According to the Brookings Institution (John and Levine 2010), New Zealand stands out among wealthy countries for its high reliance on a single, universal flat-rate pension paid out of general revenues as the primary government-sponsored retirement income mechanism.

While the OECD (2023) confirms the important role that such schemes play in reducing retirement inequities, the Treasury notes that New Zealand's high reliance on an income-tax-funded universal pension scheme raises sustainability concerns (The Treasury 2025).

Internationally, governments facing similar demographic shifts have begun to raise the age of eligibility for a universal flat rate pension, which has been widespread, and some countries have put in place mechanisms that will increase pension ages or reduce benefits automatically in the future if life expectancy continues to grow or if economic growth slows (OECD 2023).

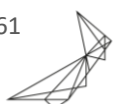
4.3 Our current retirement income system exposes the long-term impacts of inequities

A wide range of research reports have provided important insights into the issues and challenges in New Zealand's retirement policy landscape, which impact the ability of NZ Superannuation to ensure an adequate standard of living or the adequacy of support to New Zealanders to build and manage savings for retirement.

Equity concerns have been central to these issues and challenges. Inequitable outcomes in retirement require a range of solutions, not all of which would be part of the retirement income system. However, left unaddressed by other systems, these inequities are then magnified in retirement, undermining the ability of the retirement income system to perform as expected.

Key issues highlighted include:

- Equity concerns for women – the impact of gender pay gaps, differences in use of parental leave and share of parenting responsibility on women's retirement outcomes, as well as system design features such as access to government contributions to KiwiSaver being lost during parental leave. A 2025 report (Martin Jenkins 2025) reveals that, on average, men's KiwiSaver balances are 25 percent higher than women's, and the gap widens to about 37 percent among the 56–65 age cohort. Women's trajectories are shown to diverge from men's across key life events (education and training, work, relationship status, parenting and care responsibilities, housing tenure, and retirement), which together contribute to cumulative disadvantage. For example, women are more likely to have interrupted or part-time employment due to caregiving, lower earnings, less asset accumulation via housing, and fewer opportunities for KiwiSaver savings growth.



- Equity concerns for Māori and Pacific people – the impact of earlier life disadvantage and housing outcomes, the higher burden of disease and disability and its impact on working lives, shorter life expectancy. These disadvantages mean Māori and Pacific New Zealanders rely more heavily on NZ Superannuation and enter retirement with fewer assets. Cultural and systemic barriers, such as lower trust in mainstream financial institutions, lower access to KiwiSaver, and intergenerational financial obligations, further constrain savings opportunities (Te Ara Ahunga Ora Retirement Commission 2022b). Māori and Pacific people are also overrepresented in physically demanding occupations, meaning that proposals to raise the age of NZ Super eligibility would disproportionately harm them, given their lower life expectancy and reduced capacity to continue working later in life.
- Equity concerns for disabled people – while less commonly considered, these relate to the lower incomes, reduced employment opportunities and consequent reduced retirement savings of this population. Similar to other groups affected by inequities, disabled New Zealanders also have lower rates of home ownership and are more reliant on NZ Superannuation to provide an adequate income. They also face higher living costs, reducing their ability to save and increasing their retirement income needs. Te Ara Ahunga Ora Retirement Commission (2023) notes that many disabled New Zealanders experience financial stress, low confidence, and limited access to tailored advice.

Economic abuse is a significant contributor to inequitable financial resilience outcomes

Economic abuse can include a range of harmful behaviours that focus on economic resources, such as:

- exerting control over income (including disability benefits) or employment choices, spending, bank accounts, bills and borrowing (including forcing a person to take on debt)
- controlling access to and use of transport and technology, which affect people's ability to work and access financial information
- controlling property and access to daily essentials like food and clothing (this can include destroying items of value)
- refusing to contribute to household and childcare costs
- hiding income to avoid paying child support after a relationship has ended
- refusing to allow spending on needed medical and other care.

Economic abuse is typically part of a larger pattern of coercive and controlling behaviour, often co-occurring with psychological, physical, or sexual abuse. People experiencing economic abuse become more vulnerable to other forms of abuse due to the economic insecurity or dependence that economic abuse creates. New Zealand evidence indicates that economic abuse compounds the impacts of other forms of abuse (Mellar et al. 2024).

Reduced access to financial resources makes it more difficult for people to escape abusive relationships. Those who do ultimately escape economic abuse often have:

- little to no financial resources and even significant debt



- a long history of reduced or no employment, reducing their future employment prospects
- no ownership stake in the home they have left
- poor mental health, including due to the other forms of abuse they have experienced.

People most at risk of economic abuse include women, disabled people, young adults/adolescents, and older people.

Amongst women, Māori women have the highest prevalence of economic abuse at 22.1 percent compared with 15 percent of all women who have ever experienced economic abuse. Impacts of this abuse on women's long-term economic outcomes reveal significantly higher financial insecurity, including higher dependence on government benefits and food insecurity (Mellar et al. 2024).

Currently, the Family Violence Act 2018 recognises financial or economic abuse, but only as a form of psychological abuse instead of as a separate and distinct form of abuse.

Traditional service delivery being replaced by digital services presents risks

As acknowledged by the government's Better Later Life Action Plan (Office for Seniors 2025b), the shift to increasing replacement of traditional modes of service delivery for financial services has exposed older people to increased risk of economic abuse due to the frequent need to rely on others to access and use services. The Action Plan indicates that older people will be able to access banking services in ways that work for them, including being able to access money in a timely manner.

But even without needing to rely on others to access and use digital services, older people are at risk of economic abuse. It is essential to protect older people from economic abuse in all its forms. Protection would be strengthened by:

Justice Connect also recommends that banks should develop and enhance earlier, preventative measures against financial elder abuse, including:

- continued efforts to increase the financial literacy of older people, including for digital banking, coordinated with public awareness campaigns
- clear and consistent financial industry standards and requirements for financial products that may have a significant impact on older people's housing security (e.g. reverse mortgages and guarantor loans)
- employees of banks, government agencies, and other institutions dealing with older people's incomes and savings, having training and up-to-date resources on economic abuse, including how to identify it and how and when to raise concerns
- continued research into effective interventions to prevent economic abuse.

(Based on OECD (2020a) and Justice Connect (2025))

4.4 Carers are disadvantaged in retirement after providing an essential service

Unpaid carers are people who care for family members, whānau and others who have a disability, health condition, or who have lost functional independence with age. Unpaid carers improve the wellbeing of the people they care for, while sacrificing their spare time, and often their employment and personal incomes, as well as their own wellbeing. In 2023 the carer population was estimated to be at least 530,000 and 63 percent female, with 20



percent being aged 65+ (Ministry of Social Development and Office for Seniors 2025). The New Zealand Longitudinal Study of Ageing also found that women and Māori provide higher levels of care than other groups, with women's high share of caring explained by gendered role expectations as well as their own longevity and the fact that their spouses or partners tend to be older and die younger on average.

While some financial support is available for some unpaid care work (e.g. the Supported Living Payment and Carer Support subsidy), full-time unpaid carers have very low incomes with direct benefits to the health system in the form of avoided care costs, and in some cases, avoided health service use and delayed or avoided use of aged residential care. The financial support received by unpaid carers does not compare to the value they provide, which has been estimated at \$17.6 billion based conservatively on the wages of paid carers and the number of unpaid carers counted by the 2018 Census (Infometrics 2022).

The 2023 Census indicates that 1 in 7 adults is an unpaid carer (a figure that has remained consistent with the 2013 and 2018 Censuses), with two-thirds being women. Due to women's traditional role in childcare, caring for an older person or a disabled adult often means the duration of unpaid care work is longer for women than it is for men. These factors compound women's financial disadvantage at retirement and have led to calls for the government to make KiwiSaver contributions for people engaged in unpaid care work (Retirement Commission 2024a, Infometrics 2022) to assist in building up assets for retirement, or to implement a universal basic income or similar approach.

The recent Supreme Court decision (Fleming v Attorney-General) that reinstated the Employment Court's finding that parents providing full-time care for adult children with disabilities could be classified as "homeworkers" under the Employment Relations Act recognises that formal hiring processes are not determinative where the practical reality reflects an employment relationship (Duncan Cotterill 2025). However, the precise implications of this ruling remain unclear. Even with some minimal remuneration, family carers may be at a significant disadvantage, and will likely only apply to carers of people with recognised disability for a number of hours assessed as eligible for funded care.

4.5 Key trends are changing how we live – and expect to live – in later life

The IPSOS (2019) retirement study showed that there was an awareness of changes in New Zealand's social and economic landscape that would have an impact on retirement, particularly:

- Changes in the way people work and the trajectories of working lives. Long-term careers are now less common, and flexible working solutions have increased in popularity with both workers and employers. The skills needed from workers are also changing with technological change and the types of jobs now available.
- New Zealand's demographic mix is changing, including our ethnic mix and the growing proportion of older people.
- Declining rates of home ownership mean more people are renting later in life, including in retirement.
- Family and living situations are changing, with more sole and shared location parenting and blended families. Intergenerational households are becoming more common due to housing pressures that cause many young adults to stay at home longer and the



changing ethnic mix of the population towards cultures where this household structure is the norm.

Many of the same challenges affect other countries' retirement income systems

The OECD report *Pensions at a Glance 2023: OECD and G20 Indicators* (2023) reveals wide diversity in the structural designs for retirement income systems, although it notes that most high-income countries have a layered system comprising some public pension (either flat rate or earnings-related), mandatory or incentivised earnings-related pension schemes, and voluntary private savings. The report provides an overview of the key challenges facing retirement income systems and the varied approaches to dealing with them.

Labour market trends are challenging traditional retirement income system design

The report notes that coverage and adequacy vary markedly across countries but that many countries are dealing with inequitable outcomes owing to the “one-size-fits-all” approach that many systems have been based on. The emergence of non-standard work and increased self-employment has led to more people being affected by contribution gaps.

Equity concerns for women remain despite efforts to address them

Women's outcomes are also a concern, with average pensions being 25 percent lower for women across the OECD (ranging from 10 percent lower in Nordic countries to 40 percent lower in some others). The report notes that the gender gap is narrowing but only slowly, even in countries with long-established gender equity policies. The report stresses that women's longer life expectancy creates a need for higher retirement savings, and suggests that addressing gender inequity requires both labour-market reforms (closing pay gaps, ensuring access to full-time and formal employment) and pension-system design reforms (such as care credits, survivor benefits, and non-contributory minimum pensions) to prevent cumulative disadvantage and ensure women can maintain adequate living standards in old age.

Nordic countries demonstrate some solutions to reducing gender inequity

The OECD highlights several policy and structural features of Nordic countries that help explain their relatively low gender pension gaps compared with most other OECD nations. The report doesn't provide a single “Nordic model,” but it identifies a combination of design and labour-market factors common to countries like Sweden, Norway, Denmark, Finland, and Iceland, which collectively reduce women's disadvantage in retirement:

- Nordic countries have high female labour-force participation rates and smaller gender pay gaps, which means women accumulate more continuous work histories and earnings-based contributions.
- Nordic pension systems combine universal and earnings-related tiers in ways that enhance equity:
 - They feature a substantial non-contributory or residence-based basic pension (such as Sweden's and Denmark's national pensions) that guarantees a minimum income floor regardless of career length or earnings.
 - Earnings-related schemes are designed to credit or compensate for periods of parental leave and caregiving, so women do not lose contribution years while raising children or providing unpaid care. In Sweden and Finland, for example, pension entitlements continue to accrue during parental leave, financed by the state.



- Nordic countries have integrated gender-responsive policies throughout their social and economic policy frameworks. Affordable childcare, generous and gender-neutral parental leave, and public care services enable women to maintain full-time or near-full-time employment across the life course.

As the OECD notes, this alignment of social, labour-market, and pension policy, not just pension design alone, explains why Nordic countries record some of the smallest gender pension gaps (often below 10 percent) in the OECD.

Equity concerns for disadvantaged population groups across the OECD mirror New Zealand's issues facing Māori and Pacific retirement outcomes

Unlike gender, income, or employment-type disparities, which are systematically tracked across all OECD countries, ethnicity is not consistently captured in international pension datasets. However, the report acknowledges related structural inequities that tend to overlap with ethnicity in many member countries. It notes that migrants, low-income workers, and individuals with incomplete contribution histories are disproportionately likely to face lower pension entitlements and higher poverty rates in later life. The OECD highlights that these groups frequently rely on minimum or basic pensions and are more vulnerable to economic shocks in later life.

The report emphasises the role played by structural mechanisms that tend to magnify disadvantage and emphasises the key role of public pensions as a safety net providing an adequate income in retirement. Many OECD countries have increased their public pensions in recent reforms, particularly to support people who retire after low or interrupted contributory histories and are at risk of falling below minimum living standards. For example, it notes that Canada, Chile, Estonia, France, Italy, Lithuania, Spain, Sweden and Türkiye substantially increased the universal component of their public pensions.

The OECD report also notes that many disadvantaged people are employed in hazardous and arduous jobs, which can result in poor health outcomes and shorter working lives. It recommends that solutions should be primarily focused on working conditions (e.g. health and safety regulations, information about risks) and employment transitions to enable people to move out of hazardous and arduous work well before retirement. For the latter, the OECD recommends governments develop a professional training framework providing opportunities for reskilling and upskilling to reduce exposure to hazardous and arduous work and support longer working lives as well as better health outcomes in later life.

4.6 Solutions

The retirement income system has a range of objectives

In 2020, the Retirement Commissioner released a statement describing the purpose of New Zealand's retirement income system. The purpose statement was produced with assistance from the Retirement Commissioner's Expert Advisory Group (EAG), which consists of iwi leadership, academics, and policy specialists with expertise in a range of areas relevant to retirement policy (Te Ara Ahunga Ora Retirement Commission 2020).

The purpose statement is:

"A stable retirement income framework enables trust and confidence that older New Zealand residents can live with dignity and mana, participate in and contribute to society, and enjoy a high level of belonging and connection to



their whānau, community and country.” (Te Ara Ahunga Ora Retirement Commission 2020)

Along with the purpose statement, two specific objectives were outlined:

- 1 To provide NZ Superannuation to ensure an adequate standard of living for New Zealanders of eligible age. NZ Super is the Government’s primary contribution to financial security for the remainder of a person’s life.
- 2 To actively support New Zealanders to build and manage independent savings that contribute to their ability to maintain their own relative standard of living.

The statement also recognised that the retirement income system sits within the broader policy landscape supporting New Zealanders to live well, including health care, housing and transport.

The objectives set out by Te Ara Ahunga Retirement Commission have clear implications:

- NZ Superannuation must be available to those who need it and must provide an income that is adequate for those who have no other retirement income. This means the current generation of older people must have an adequate retirement safety net provided by NZ Superannuation. Even if the scheme, as it stands, is not financially sustainable, any changes must prioritise maintaining an adequate income for those who rely on it.
- The government must address the systemic issues that hinder people’s ability to contribute to their own standard of living in retirement. In doing so, reliance on NZ Superannuation will be reduced, and the overall financial sustainability of providing an adequate safety net will be assured.

4.6.1 Solutions announced in Budget 2025

In Budget 2025, the government announced a range of changes to KiwiSaver. The changes are intended to strengthen New Zealanders’ retirement savings adequacy while supporting the long-term sustainability of the overall retirement income system (e.g. by reducing reliance on NZ Superannuation and reducing the cost of KiwiSaver to the government).

The changes announced are:

- From July 2025, the Government contribution (previously the member tax credit) will be halved from 50c for every dollar contributed to 25c, reducing the maximum annual top-up from \$521.43 to \$260.72.
- Means-testing will be introduced so that members earning more than \$180,000 annually will no longer be eligible for the government contribution.
- The government will gradually increase the default employee and employer contribution rates – from 3 percent to 3.5 percent in April 2026 and 4 percent in April 2028 – thereby shifting the balance of savings responsibility toward individuals and employers.
- Eligibility for government and employer contributions will also be extended to younger workers aged 16 and 17 from 2025–26.

Te Ara Ahunga Ora Retirement Commission conducted some analysis of these changes (Te Ara Ahunga Ora Retirement Commission 2025a). The modelling shows that the changes are



a mixed bag when considered against the existing equity challenges in our retirement income system:

- Higher default contribution rates are expected to increase retirement balances for most members over the long term, improving the adequacy of private savings and reducing future reliance on New Zealand Superannuation.
- The halving of the government top-up means that around one-fifth of members, particularly those on low or variable incomes, may accumulate less overall, as their ability to benefit from the change depends on stable employment and employer contributions.
- Low-income workers, Māori, Pacific Peoples, women, and self-employed or irregular workers are most at risk of being disadvantaged by the changes because these groups tend to contribute less consistently and derive greater relative benefit from the government's contribution. Without targeted mitigation, reducing the government contribution could widen existing disparities in retirement savings.
- The distributional effects of the new contribution settings may depend on employer remuneration models, especially where KiwiSaver contributions are absorbed within total remuneration packages rather than added on top of wages, effectively leaving some employees no better off.

4.6.2 Previously recommended KiwiSaver improvements not yet implemented

Overall, the changes provide a shift towards greater system sustainability by increasing employee and employer contributions, but as Te Ara Ahunga Ora Retirement Commission (2025a) notes, a targeted government contribution towards lower-income earners would still support fiscal objectives while also minimising equity concerns, for an improved distributional impact. And, because the impacts are uncertain, there is a need for monitoring and an openness to potential future targeted solutions to fine-tune these adjustments.

Key policy changes that were previously recommended by Te Ara Ahunga Ora Retirement Commission (Te Ara Ahunga Ora Retirement Commission 2024a) and are yet to be implemented include:

- Requiring employer contributions to KiwiSaver for people aged 65+ who are still working.
- Extending government contributions to those on paid parental leave.
- Removing total remuneration packages whereby employers may include all cash and non-cash benefits in determining gross pay, allowing employers' contributions to be offset against the employee's gross pay, and reducing the amount of take-home pay received.
- Increasing government contributions for people who are self-employed and do not benefit from employer contributions to increase incentives to enrol and contribute.

The Treasury also recommends that sustainability gains can be achieved with small adjustments that compound over time, including introducing contribution rate auto-escalation with an opt-out option (The Treasury 2023), which could help nudge New Zealanders into progressively higher contribution rates.



4.6.3 Solutions for gender equity

Based on the gender equity issues identified and the life-course analysis that reveals the key points where women's trajectories lead to later disadvantage, the evidence points to a need to address structural factors across the life-course. Proposed solutions are summarised in the table below.

Table 16 Proposed solutions for retirement equity for women

Key life stage	Problem	Solution	Rationale
Formal education & training	Women and girls are less likely to receive targeted financial education, and when they do, it often arrives too late to influence early saving and investment behaviours. This contributes to lower financial confidence and knowledge.	Provide gender-responsive financial education that reaches girls and women at appropriate life stages (school, tertiary, early career). Use behavioural prompts, relatable content, and accessible delivery channels.	Early, relevant financial capability building helps women engage with saving and investment earlier, build confidence, and close long-term wealth and retirement gaps.
Work	Women's work patterns are more likely to be part-time or interrupted due to caregiving; they are concentrated in lower-paid sectors and roles, leading to smaller KiwiSaver balances.	Improve KiwiSaver equity by enabling voluntary and flexible contribution options; allow top-ups from government or partners; revisit the default KiwiSaver fund strategy to better suit intermittent contribution patterns; expand outreach to sole traders and low-income earners.	Aligning retirement savings mechanisms with women's real work lives reduces structural disadvantage, supporting continuous accumulation even through non-linear career paths.
Relationship status	Women often lose access to assets or KiwiSaver savings during separation or divorce and may not fully understand their entitlements. Financial impacts are magnified when they have lower lifetime earnings.	Raise public awareness of the financial and retirement implications of relationship separation; automate equitable division of KiwiSaver balances when couples separate; ensure access to tailored financial advice and support during relationship transitions.	Improved awareness and automatic entitlement processes protect women from losing retirement savings due to relationship changes and information asymmetry.
Parenting & caregiving	Women disproportionately take time out of paid work for parenting or caregiving, reducing their earnings, KiwiSaver contributions, and long-term savings growth.	Extend Government KiwiSaver contributions during parental leave (including for women not actively contributing); simplify and incentivise employer contributions during parental leave; formally recognise unpaid caregiving in retirement income settings through credits or top-ups.	Recognising and compensating caregiving contributions ensures that women are not penalised for fulfilling essential social roles, reducing the cumulative financial penalty of unpaid care.



Key life stage	Problem	Solution	Rationale
Housing tenure	Women are more likely to rent in later life, have lower housing equity, and are less likely to access housing support such as the Accommodation Supplement, leaving them more exposed to poverty in retirement.	Review uptake and eligibility of housing support for older women; improve awareness of the Accommodation Supplement; raise the cash-asset limit or adjust eligibility criteria to better support renters.	Housing stability is fundamental to wellbeing in retirement; ensuring equitable access to assistance reduces gendered poverty risks and enhances financial resilience.
Retirement	Women retire with smaller savings yet live longer than men, meaning their resources must stretch further; they are more reliant on NZ Super and vulnerable to cost-of-living increases.	Maintain NZ Super eligibility age and stability; explore topping-up retirement savings for caregivers; ensure gender-disaggregated data collection to monitor outcomes; secure cross-party agreement to preserve system certainty and equity.	A stable and inclusive retirement income system protects women from compounding disadvantage, while recognising caregiving and longevity differences, strengthens long-term fairness.

Source: NZIER based on Martin Jenkins (2025)

4.6.4 Addressing economic abuse

New Zealand research (Milne et al. 2018) identified the solutions needed to respond effectively to economic abuse:

- affordable and safe housing
- effective workplace policies and procedures
- front-line support that can help to identify economic abuse
- a comprehensive referral network
- access to interim financial remedies
- coordinated and effective government policy and practice responses
- a 'trigger' system to identify and apply interim protections for credit law breach and fraud
- stable employment for victims of economic abuse.

The author of another New Zealand study (Fanslow 2024) has called for the implementation of the SASA! An evidence-based community mobilisation approach designed to address the root cause of power imbalances between men and women. It has been shown to reduce different types of intimate partner violence (IPV), including the controlling behaviours associated with economic abuse.

The study author also called for new tools to engage institutions such as banks, citing work done in Australia, as well as insurance companies and other financial institutions, to provide protection for people experiencing abuse. These have emerged in response to an Australian federal parliamentary inquiry into financial abuse in the financial services industry. The inquiry report made 61 recommendations to tackle the issue (SBS News 2024). The recommendations include:



- requiring lenders and insurers to ensure customers are not experiencing financial abuse
- improving reporting mechanisms between financial institutions and police
- Implementing more effective safeguards and support for victim-survivors.

4.6.5 Solutions for Māori equity

Proposed solutions for the inequities facing Māori, focusing on the retirement income system, relate to:

- System-level solutions (policy and governance)
- Solutions to reduce the savings and KiwiSaver gap
- Housing solutions.

These are summarised in the table below.

Table 17 Solutions for Māori equity: Evidence reviewed

Focus area	Problem	Solution	Rationale
System level (policy & governance)	Government retirement income policy does not sufficiently reflect Māori worldviews, nor fully recognise shorter life expectancy, lower asset accumulation, land-loss effects and whānau/collective obligations.	Establish a Māori advisory rōpū to co-design retirement income policy; embed kaupapa Māori frameworks in policy design and delivery; explicitly consider Māori demography, life-course and cultural roles.	Without governance and design that reflect Māori realities, universal settings risk reinforcing inequities—tailored oversight and culturally grounded policy increase fairness and relevance.
Savings & KiwiSaver	Savings and contribution-based retirement vehicles (like KiwiSaver) risk increasing inequity for groups with lower incomes, irregular employment, and lower employer-matched contributions—a situation that disproportionately affects Māori.	Target the government contribution or employer match so that lower-income, irregular-employment and Māori savers receive proportionally greater support; monitor and model impacts by ethnicity/region.	If universal changes favour standard full-time employment paths, Māori who are over-represented in non-standard work may fall further behind; targeted support helps prevent outcome gaps from widening.
Housing	Many Māori enter retirement with lower housing tenure, have experienced land-loss or housing instability, or live in intergenerational/whānau housing which may reduce individual asset accumulation.	Review and adapt housing and asset-related support for older Māori: for example, strengthen home-ownership pathways, recognise whānau/collective tenure, update asset rules for housing supports; ensure retirement income policy aligns with Māori housing realities.)	Since housing and assets underpin retirement income security, addressing the disparity in asset accumulation and tenure for Māori is essential for equitable retirement outcomes.

Source: NZIER based on Te Ara Ahunga Ora Retirement Commission (2022; 2025)



4.7 New Zealand evidence

Table 18 New Zealand’s retirement system and policies: Evidence reviewed

Report	Focus	Key points	Recommendations	Source
Pensions at a Glance(2023) . OECD and G20 Indicators	Retirement income systems in OECD countries and emerging issues	Challenges across the OECD are similar: Population ageing, equity issues, sustainability of pension schemes, persistent inequities, labour market trends. Pension reforms to address these vary.	Align age and eligibility with changing demographics and life expectancy gains. Improve coverage and adequacy for workers with interrupted or non-standard employment. Re-design pension provisions for hazardous and arduous work (consider job transition, disability and sickness insurance rather than lower retirement age). Monitor socioeconomic inequities in pension outcomes.	OECD (2023)
Review of Retirement Income Policies (RRIP) (2022)	System-wide review of NZ retirement income settings (NZ Super, KiwiSaver/decumulation, housing), including equity for Māori, Pacific Peoples, and women.	Women: part-time work, gender pay gaps, and lower KiwiSaver balances; Māori and Pacific Peoples: structural inequities in housing, shorter life expectancy; Low-income: heavy reliance on NZ Super; Disabled: concerns about inequitable impacts of eligibility changes.	Address gender and ethnic pay gaps, maintain KiwiSaver contributions during parental leave; establish a Māori advisory group; improve KiwiSaver access for Pacific and low-income workers; avoid changes disadvantaging those with shorter life expectancy.	Te Ara Ahunga Ora Retirement Commission (2022a)
What does Retirement look like for Māori? (2022)	Retirement equity issues facing Māori	Māori face multiple, cumulative structural disadvantages that undermine retirement security, including shorter life expectancy, “accelerated ageing”, lower home ownership, higher rates of low-paid or insecure work, and historical loss of land and resources, reducing inter-generational wealth transfer.	Embed Te Tiriti o Waitangi and kaupapa Māori frameworks in the design and governance of the retirement income system. Ensure Māori advisory guides retirement income policy. Recognise shorter life expectancy and accelerated ageing in policy settings. Strengthen culturally relevant financial education/information resources. Support Māori housing and land solutions.	Te Ara Ahunga Ora Retirement Commission (2022b)



Report	Focus	Key points	Recommendations	Source
New Zealand Financial Capability: Focus on People with Disabilities and Long-Term Health Conditions (2023)	Retirement equity issues facing disabled New Zealanders and those living with long-term health conditions	People with disabilities and long-term health conditions have lower incomes, reduced employment opportunities, and fewer retirement savings. High living costs and health-related expenses limit their ability to save. Many report financial stress, low confidence, and limited access to tailored advice.	Improve accessibility of financial services and KiwiSaver for disabled people; provide targeted financial capability education and tools; enhance coordination between income support, health, and retirement policy; address barriers to workforce participation and employer discrimination; collect better data on disability status in financial and retirement surveys to monitor equity outcomes.	Te Ara Ahunga Ora Retirement Commission (2023)
Money Matters: How New Zealanders Are Feeling Financially in (2024)	National sentiment on financial wellbeing amid cost-of-living pressures.	Women report higher financial discomfort; low-income households most vulnerable; inequities evident across demographic groups.	Target financial capability initiatives at women and low-income groups; continue collaborative efforts under the National Strategy to address inequities.	Te Ara Ahunga Ora Retirement Commission (2024b)
Older People's Voices 2024 (Part 1: Financial Sentiment)	Financial experiences of people aged 65+, supporting RRIP 2025.	37% report worsening finances; older renters, low-income, Māori and Pacific Peoples are more vulnerable; women are over-represented among those struggling.	Tailor policies to support older renters and financially uncomfortable older cohorts; focus on Māori and Pacific Peoples' housing insecurity.	Te Ara Ahunga Ora Retirement Commission (2024d)
National Strategy for Financial Capability — Annual Report 2023–2024	Sector progress and equity priorities in financial capability.	Highlights 900+ partner engagement; prioritises women, Māori, Pacific Peoples, and youth; aims to build inclusive financial capability.	Maintain cross-sector partnerships; target women, Māori, Pacific Peoples, and low-income groups for measurable impact 2025–2027.	Te Ara Ahunga Ora Retirement Commission (2024c)
Money Matters 2025: The Power of Emergency Savings (Aug 2025)	Role of emergency savings in financial resilience.	Women: 62% report financial discomfort vs 51% of men; low-income and minority households are the least likely to have savings.	Promote emergency fund creation, especially among women, Māori, Pacific Peoples, low-income and disabled New Zealanders; align campaigns around resilience.	Te Ara Ahunga Ora Retirement Commission (2025d)
KiwiSaver Government Contribution: Distributional	Distributional equity of government	Women, self-employed and low-income earners benefit less from contributions;	Retarget government contributions toward low-income, self-employed, Māori, women and disabled	Te Ara Ahunga Ora Retirement Commission (2025c)



Report	Focus	Key points	Recommendations	Source
Analysis (2025)	KiwiSaver contributions.	Māori and disabled people are under-represented in KiwiSaver participation.	groups; ensure equitable access to KiwiSaver.	
Analysis of KiwiSaver Changes: Budget 2025 (May 2025)	Impacts of Budget 2025 changes to KiwiSaver settings.	80% of contributors gain, 20% lose—especially low-income, self-employed and women; risks widening equity gaps.	Retarget government contributions to mitigate adverse effects on vulnerable groups; ensure future changes maintain inclusiveness.	Te Ara Ahunga Ora Retirement Commission (2025a)
Review of Retirement Income Policies (RRIP) (2025)	Comprehensive review to ensure NZ's retirement system remains equitable and sustainable.	Women's balances 25% lower than men's; self-employed and low-income groups at risk; Māori, Pacific and disabled groups face compounded disadvantages.	Strengthen equity measures for women and self-employed; adjust default contribution settings; account for shorter life expectancy among Māori and disabled groups.	Te Ara Ahunga Ora Retirement Commission (2025e)
Improving Women's Retirement Income (30 June 2025)	In-depth analysis of gendered retirement outcomes.	Men's KiwiSaver balances 25–37% higher; compounded disadvantages from pay gaps, care work, housing, and financial literacy; wāhine Māori and Pacific women especially disadvantaged.	Apply a life-course policy lens: expand parental-leave KiwiSaver contributions, improve financial education, review default fund settings, and enhance data collection by gender and ethnicity.	Martin Jenkins (2025)
Improving the Retirement Savings of the Self-Employed (Aug 2025)	Examines persistent retirement savings gap for self-employed New Zealanders.	Self-employed contribute irregularly, have lower balances, less access to employer contributions; higher financial discomfort rates; inequities linked to income volatility.	Simplify KiwiSaver access; explore auto-enrolment or opt-out models; design tax-deductible or matched incentives; collect data on self-employed savings to track equity.	Te Ara Ahunga Ora Retirement Commission (2025b)
Aotearoa New Zealand in 2050: Preparing Our Retirement Income Policies for the Future (Mar 2025)	Long-term foresight report on demographic and economic trends to 2050.	Ageing population, more diverse society, widening disparities for Māori, Pacific, low-income and disabled people if policies remain static.	Plan gradual policy adjustments; use disaggregated data to monitor inequality; address intergenerational and ethnic disparities in housing and income security.	NZIER (2025)

Source: As per table



4.8 Supporting longer working lives

Concerns about income adequacy in retirement often highlight the groups of people who

- are engaged in employment types that are not sustainable for several decades due to the hazardous or arduous nature of the work
- cannot continue in their employment after the onset of a health condition or disability
- look forward to retiring as early as possible to escape the “daily grind”.

All of these are examples of situations where people would benefit from some form of support to enable them to continue working.

The solutions need to address the underlying cause of the issue. For example, people engaged in hazardous work might be better supported by workplace health and safety regulation, people who experience a health condition or disability may benefit from workplace adjustments or a change of job, which might require retraining, and people who feel their work is a grind they look forward to escaping from may need advice and support to find alternative opportunities.

Any solution that keeps New Zealanders engaged in employment will improve financial resilience in retirement by supporting higher levels of savings.

This has been recognised in a number of other jurisdictions, with various solutions implemented. The World Economic Forum (2025) highlights these examples:

- In France, the Compte Personnel de Formation (CPF) system empowers employees to take charge of their professional development by letting them accumulate training credits over the course of their careers. Many private-sector employers have built on this public model by adding their own company-funded credits and customised upskilling opportunities. Each year, workers earn credits that can be used to pay for approved training programmes, qualifications, or career-change initiatives. Under the scheme, around 28 million full- and part-time employees receive €500 to €800 (about \$520 to \$830, depending on income level) annually in their personal skills accounts to support lifelong learning, up to a lifetime cap of €5,000 and €8,000 respectively (about \$5,200 to \$8,300). Employers often top up these credits with organisation-specific learning budgets, focusing on developing industry-relevant capabilities and individual growth (World Economic Forum 2025).
- Denmark’s Flexicurity model blends labour-market flexibility with strong social protection, supporting people through different life stages — from education and work to caregiving and retirement. As of January 2025, Denmark’s unemployment rate was around 2.9 percent, reflecting in part the system’s effectiveness in promoting job creation and mobility. The Danish welfare system provides generous unemployment benefits, healthcare, and pensions. But the government also invests heavily in training and reskilling, helping workers adjust to changing labour-market needs. In 2023, over 20 percent of the workforce participated in adult education, underscoring Denmark’s commitment to lifelong learning. The Flexicurity framework brings together job placement, training, and financial guidance within an integrated system. Through the Danish Agency for Labour Market and Recruitment, job seekers receive coordinated support from career counselling to training access, ensuring smoother and more secure career transitions (World Economic Forum 2025).



- The UK’s “returnerships”, a government-funded programme providing skills bootcamps, sector-based work experience and training programmes, apprenticeships and accelerated apprenticeships, all geared towards people aged 50+ who want to re-enter the workforce or embark on a second career by leveraging and tailoring existing skills. Training programmes were designed in partnership with employers to help fill vacancies in specific areas. To help people navigate the programme, the government has created training portals and job-centre advisors as well as a Returnership Toolkit that helps match prior experience and interests to available courses. The UK government has announced additional funding of £63.2 million to increase the availability of Skills Bootcamps, helping up to 8,000 more people to benefit from this transformational scheme, with an aim of delivering 64,000 training places from next year. The increased funding will also expand the Sector-Based Work Academy Programme (SWAPs) scheme to increase the number of places available and make the programme more accessible. This will create around 40,000 new SWAPs placements (Gov.UK 2023).

A programme providing New Zealanders with apprenticeship and training options could be an important investment for all ages. Currently, only 6 percent of school leavers go into apprenticeships (Foster 2025). While arguments are often made that these options present a “poor cousin” to university education for young people (Johnston 2025), they could be more appropriate for people at later stages in life who want to adapt existing skills and may be less disposed to return to academic study. However, if this were to be implemented in the New Zealand context, many of the known problems in the current apprenticeship model would need to be addressed, including:

- The funding model, standards-setting and monitoring of apprenticeships and training programmes have been criticised as inconsistent. For instance, apprentices/trainees sometimes do not receive the same support (financial, mentoring, workplace training, recognition) as other educational pathways.
- The vocational education and training sector in New Zealand has been undergoing large-scale reform, which critics argue is causing uncertainty and disruption. For example, the merger of ITPs (Institutes of Technology & Polytechnics) into the mega-organisation Te Pūkenga and then the proposed dis-merger, changes in how apprenticeships are governed, etc. To engage older workers, it will be essential that the system is stabilised and can provide confidence that the investment is worthwhile.
- Research indicates that many apprentices/trainees fail to complete their qualification/training in the industry-training organisations (ITOs). Factors include inconsistent employer or provider support, a mismatch between fully workplace-based training and academic/training standards, and variable quality of training provision (Alkema 2016).



Table 19 Supporting longer working lives: Evidence reviewed

Initiative	Location	Description	Source
Compte Personnel de Formation (CPF) – Personal Training Account	France	Individual learning account that lets workers accumulate training rights (in euros) over their careers to fund accredited courses and certifications; a leading international model of individualised training finance.	OECD (2020b)
Flexicurity (integrated flexibility + security model)	Denmark	Labour-market model pairing easy hiring/firing with robust unemployment benefits, active labour-market policies, and lifelong learning supports to smooth job transitions across life stages.	Ministry of Foreign Affairs of Denmark (n.d.)
Returnerships (50+)	United Kingdom (England)	Campaign bundling Skills Bootcamps, adult/accelerated apprenticeships, and Sector-based Work Academy Programmes (SWAPs) to make second careers and returns to work more accessible for over-50s.	Department for Education (2023)
Lifelong Learning Entitlement (LLE)	United Kingdom (England)	From 2027, a flexible loan entitlement equal to four years of post-18 study that can be used modularly for approved level 4–6 courses and modules, enabling mid-career reskilling.	Department for Education (2025b)
Midlife MOT (digital & Jobcentre offer)	United Kingdom	Career, skills, health and money “MOT” for people in their 40s–50s to plan longer working lives and target retraining routes such as Bootcamps or apprenticeships.	Department for Work and Pensions (2023)
Skills Bootcamps	United Kingdom (England)	Employer-designed, flexible courses (typically up to ~16 weeks) aligned to local skills gaps; participants often receive an interview offer on completion; funding model and allocations set out for 2025–26.	Department for Education (2025a; 2025c)
Sector-based Work Academy Programme (SWAPs)	United Kingdom	Short, sector-specific training plus work experience linked to a real vacancy, aimed at rapid (re)entry; guidance for employers and providers updated in 2025.	Department for Work and Pensions (2024; 2025)
“Employment up to 70” measures (Elderly Employment Law amendment)	Japan	2021 amendment created a “best-efforts” duty for employers to secure work opportunities up to age 70 via measures such as raising/abolishing retirement age or continued employment systems.	Anderson Mori & Tomotsune (2021); JILPT (Japan Institute for Labour Policy and Training) (2025)
SkillsFuture Credit	Singapore	Universal lifelong learning credit for adults (with periodic top-ups) to fund approved courses, strongly signalling shared responsibility for continuous upskilling across the life course.	SkillsFuture Singapore (n.d.)
Springboard+	Ireland	Government-funded higher-education upskilling programme (certificate to master’s), including options suitable for returners and career changers; emphasis on labour-market demand.	Government of Ireland (Department of Further and Higher Education)(2023); Citizens Information (n.d.)
Qualifica Programme &	Portugal	National adult-learning system with a countrywide network of centres and Recognition, Validation and Certification of	UNECE (United Nations Economic Commission for



Initiative	Location	Description	Source
Qualifica Centres (incl. RVCC)		Competences (RVCC) to credit prior learning and support later-life qualifications.	Europe) (2021); ANQEP (Agência Nacional para a Qualificação e o Ensino Profissional) (n.d.)
Compte Personnel de Formation (CPF) – Personal Training Account	France	Individual learning account that lets workers accumulate training rights (in euros) over their careers to fund accredited courses and certifications; a leading international model of individualised training finance.	OECD (2020b)

Source: As per table



5 Further considerations

Building the foundations of a longevity economy

New Zealand stands at a demographic crossroads. The policy choices made now will determine whether ageing becomes a driver of wellbeing and productivity or a source of fiscal strain and inequity. The evidence points clearly to the former path if government, business, and community actors coordinate around shared objectives of participation, independence, and health across the life course.

Strengthen leadership and coordination

The longevity agenda spans multiple portfolios. If investments across the three pillars in this report are to be effective, some coherent national strategy is needed to ensure alignment and maintain momentum. Shifting to a longevity economy is not a one-off investment. Many initiatives will require robust data and evaluation to ensure they deliver value for money and support continuity across political cycles.

Embed age-friendly solutions in homes and communities

Policy should require age-friendly design and planning in housing and communities, but a meaningful change in the overall environment will take a generation or more to achieve. In the meantime, home modifications still play an important role and should be well planned and adequately resourced with additional targeted funding for those most at risk from their home environment.

New solutions to housing older people who retire without the benefit of home ownership are needed. These could include shared ownership and other innovative solutions that leverage what older people have to offer and improve housing affordability, quality, and connection to community for older people.

Expand community and preventive health supports for a pro-active approach

Healthy ageing needs a pro-active approach and actions should focus on keeping older people at home and within their community with social supports and technology that enables health tracking, remote monitoring and falls prevention. Preventive interventions to support healthy ageing should include universal interventions like water fluoridation, targeted interventions like dental care for low-income adults and increased adult vaccination, increased awareness of vision and hearing loss and destigmatisation of vision and hearing aids, as well as interventions delivered to those already receiving support or in residential care (e.g. oral hygiene support) to ensure their health and wellbeing are as good as they can be.

Enable longer, fairer working lives

Reforms to employment and retirement systems should focus on flexibility and targeting. Supporting people to re-skill, re-train or find alternative employment later in life will help mitigate some of the need for retirement income support, but as the retirement income system shifts towards greater personal responsibility, it must still support those who have been disadvantaged, including those who take on a caring role for society's most vulnerable.



Advance equity and cultural inclusion

Policies must actively address the intersectional inequities that shape ageing. Co-design with Māori, Pacific, Asian, disabled, and migrant communities is essential for culturally safe services, such as dementia-friendly initiatives, but also to ensure the needs of

New Zealand already has the evidence, and the solutions, but needs investment, coordination and integration

The longevity economy offers not only a fiscal imperative but a social opportunity: to design systems that enable all New Zealanders to live longer, healthier, and more purposeful lives.

New Zealand already has many of the critical enablers in place. Relatively modest, well-targeted investments have the potential to generate human and fiscal returns. The opportunities identified by the evidence review are:

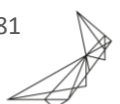
- Increased monitoring and evaluation of age-friendly community initiatives and improved systems to share learnings across communities.
- Resources and support to embed culturally relevant approaches in dementia-friendly communities initiatives.
- Increased development of housing solutions, including shared ownership models to increase the supply of affordable age-friendly housing, potentially with a greater role for local councils in housing for seniors, home safety assessment and targeted subsidies for higher risk older people to enable them to age in place safely.
- Increased social supports based on a combined professional and volunteer model and including older people in the social support workforce to help community-dwelling older people age in place and avoid loneliness and social isolation.
- Health system initiatives to harness the power of technology to help keep older people at home by remote monitoring of community dwelling older people who are at risk of or have experienced acute health events, increased investment in adult vaccination (shingles, influenza and RSV), a range of oral health interventions from universal to highly targeted supports, vision and hearing loss awareness and destigmatisation of vision and hearing aids, and increased investment in multifactorial falls prevention integrated with home safety assessment and modification.
- Improvements to the retirement income system to address structural barriers across key life stages that disadvantage women, target support to Māori and other disadvantaged New Zealanders who are dependent on government contributions and Superannuation, and increasing incentives for private saving.
- Funded support for retraining, re-skilling, up-skilling, and job matching to support New Zealanders working in hazardous, arduous or other work that becomes unsuitable as they age to continue participating in the workforce.

The Government and key partners should develop a national strategy to support a coordinated, nationally consistent approach based on prioritisation of the most cost-effective solutions, and including support for local councils to strengthen community-based approaches.



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