

Aging in New Zealand

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Like many other nations, New Zealand (also known as *Aotearoa*) grapples with what an aging population means for the delivery of good health services. Almost 16 percent of our small population of just over 5 million are age 65 and older, which is up significantly from about 11 percent a quarter of a century ago.

It's a good problem to have. It means New Zealand is providing opportunities to enjoy free time in retirement and voluntary service in communities after lifetimes of work. It means grandchildren and grandparents will share more precious time together.



Nevertheless, it creates a set of complex challenges for policy makers who seek to put equity at the heart of decision making as we do. The well-being of older New Zealanders is underwritten by one of the world's most universal non-means-tested pension schemes.



Older members of the Māori community in Hamilton, New Zealand.

Over-65s also enjoy free off-peak public transport, programs to assist with local government taxes, many free or copaid health and pharmaceutical services, and a no-fault system of accident compensation and other supports.

But aging and the well-being of older people sit in a context. It is not just about who pays for and who receives what and when.

Aotearoa has a unique history underpinned by a constitutional partnership between the indigenous Māori people and those who settled later, mainly Europeans from the

United Kingdom and Ireland. We also have a sizeable Pacific population, and our largest city, Auckland, has the world's largest Pacific community. More recently we have attracted global skilled migrants, especially from East and South Asia.

New Zealand has other forms of diversity: many faiths and nonreligious people, people living with disabilities, LGBT communities, and others. Visitors are often surprised by how large our land mass is relative to our population. If laid over North America, the main islands of New Zealand would stretch from Canada to Texas.

Our diversity is a strength, and equity for all is a fundamental value for New Zealanders — but the health and social indicators make it clear we have not always lived up to that value. For example, Māori and Pacific peoples have lower life expectancy and health outcomes than other New Zealanders.

Fortunately, there is broad political consensus about the need for our country to have high-quality publicly funded health care within a mixed public and private system. How we deliver on that consensus remains a topic of lively democratic debate, as it should be.

The publicly funded health system touches all of our lives and by international benchmarks has performed well on a range of measures. On average, New Zealand has been around or above those countries we like to compare ourselves with for key indicators such as life expectancy and avoidable deaths. Every two seconds one of us sees a general practitioner or nurse, and each year there are around 1.2 million hospitalizations, carried out in over 150 public and private hospitals, by some of the 220,000 people working in the sector. Health care is our largest employer and therefore a source of human capital and a major contributor to local economies.

But even before the onset of the COVID-19 pandemic, we knew our system was

under serious pressure and not delivering equitably to all. Around half of Māori and Pacific deaths are potentially avoidable, compared with under a quarter of those for other New Zealanders. We have had to focus on reducing child poverty because its effects have a long tail through individual lives and the communities in which children grow to adulthood. It is in that context that one of the first things our government did after assuming office was to set up a comprehensive review of the structures of our health system.

And then the global pandemic hit.

New Zealand came through the pandemic better than many countries. In part this is because the actions we took at the start of the pandemic were particularly strong, including stringent lockdowns, border closings, managed isolation requirements, mandates around testing, and widespread contact tracing.

These “go hard, go early” measures have been credited with saving thousands of lives by limiting the transmission of the virus until widespread population vaccination could be achieved, particularly among our most vulnerable groups. The measures also meant New Zealanders were fortunate to enjoy a year of relative normalcy and freedoms without COVID-19 when much of the world was in lockdown.

What tied all of those initiatives together was a relentless focus on equity. Equity does not mean just tailoring government approaches to the needs of communities; it also involves empowering and supporting those communities to lead their own responses.

And by that measure we didn't always do as well as we would have liked. Our mainstream public health system proved slow to facilitate vaccination uptake by some Māori groups, and it was ultimately Māori

themselves who, with support, took charge of the vaccination campaign through *kaupapa* Māori (culturally relevant) and *iwi*-led (tribe-led) health services.

The equity challenges we experienced in the pandemic response ultimately reinforced how the structures of our overall health system needed to change. So, as we responded to the pandemic, we also fundamentally changed the way our state delivers public health care.

Previously, New Zealanders received public health services from one of 20 local systems that struggled to share best practices and work together. The services and care individuals had access to depended more on where they lived than on what they needed. The result was sometimes significant differences of access within a town or even a suburb or street. In some regions people were twice as likely to die from potentially preventable causes than in others and three times more likely to be readmitted to hospitals for urgent needs. Some New Zealanders were twice as likely to get knee replacement surgery than others.

And the differences between population groups were stark. Only 50 percent of disabled people rated their health as good, compared with 89 percent of the remainder of the population.

New Zealand has been an international laggard in adopting modern interconnected data and digital systems to empower good decision making and make it easier for clinicians to provide care. The justification for real change was clear. So we pushed ahead with a once-in-a-generation reform to our health system.

On July 1, 2022, new legislation replaced the old disjointed system with a unified nationwide delivery agency, working in partnership with a new Te Aka Whai Ora/ Māori Health Authority that has policy and



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commissioning powers to address equity issues in the delivery of good health services for Māori.

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The new system is guided by shared principles of equity, of course, but also partnership, excellence, sustainability, and person- and *whanau*- (family-) centered care. It aims for everyone to have access to comprehensive support in their local communities to help them stay well, with emergency or specialist care when they need it.

This year we also have transformed our fiscal management of health. Parliament, for the first time, is appropriating money for health on a multiyear basis to provide more certainty and greater opportunities for long-term planning by hospitals and providers. Our companion economic response to the pandemic has allowed us to fund the highest combined health and disability budget we have ever had.

It is of course early days in a period of profound change. We are fortunate that our location in the South Pacific has already seen us through this year's winter respiratory illness spike, and now we look forward to warmer months in which to roll out changes.

But we have no illusions about the scale of the challenges ahead. There is a legacy of deferred maintenance for our hospital buildings that must be remediated. Mental health services are being built up from a low base. While New Zealand's health workforce has been growing — underpinned by rising wages, more training opportunities, and

streamlined immigration settings — we face the same competitive pressures as others in the globally mobile health labor market.

And through it all, the world economy in which we trade remains fragile, COVID-19 persists with its ever-evolving strains, and we must seek to be prepared for the next pandemic whenever it may come.

We will not get everything right the first time in all of the changes we are undertaking. We need to be transparent about the obstacles we encounter and share what we learn. We also need to learn from the experiences of friends around the world, because true equity is when all people can all live happier, healthier lives. There is a *whakatauki* (proverb) in our indigenous Māori language: "*Ehara taku toa i te toa takitahi engari he toa takitini.*" ["Our success is not mine alone; it is the strength of many."] ●



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