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Improving intergenerational equity in New Zealand

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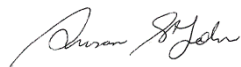
¹ Dr M.Claire Dale, Research Fellow, Retirement Policy and Research Centre, University of Auckland. This paper draws on the Workshop in Hong Kong in April 2016, funded as part of a travel grant by the Worldwide Universities Network (WUN) and the University of Auckland Faculty Research Development Fund (FRDF). Attendance at the 25th Annual Colloquium of Superannuation Researchers 6 – 7 July 2017, hosted by CEPAR and the School of Risk and Actuarial Studies, UNSW, was also funded by the WUN/FRDF grant. The presentation delivered at that Colloquium is the basis of this Working Paper.

The Retirement Policy and Research Centre

As the profound and enduring ageing of the population occurs in New Zealand and most of the rest of the world, consideration of intergenerational equity is increasingly urgent. Yet in New Zealand, little is being done, and where attention is being given, the focus is narrow and largely medical. The Retirement Policy and Research Centre is therefore pleased to publish this Working Paper, *'Intergenerational equity: policy and provision in New Zealand'*. It builds on a presentation by the Retirement Policy and Research Centre's M.Claire Dale at the 25th Annual Colloquium of Superannuation Researchers 6 – 7 July 2017, hosted by CEPAR and the School of Risk and Actuarial Studies, UNSW; and the workshop in Hong Kong in April 2016 with Worldwide Universities Network (WUN) partners in an 'intergenerational equity' research project, led by Eliza Lai-Yi Wong (Principal Investigator). The University of Auckland WUN collaborators were Kathryn Peri, Gary Cheung and Roy Lay-yee. Other collaborators were E.K. Yeoh, Roger Chung and Janice Lau (The Chinese University of Hong Kong), Christopher Etherton-Ber, Loretta Baldassa and Adele Millard (University of Western Australia), Bettina HusebØ (University of Bergen), Sweet Fun Wong (Alexandra Health System Singapore), Praveen Thokala (Sheffield University), and Chek Hooi Wong (Tokyo University).

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Abstract

The World Economic Forum 2015 ranked population ageing as one of the five top global risks in terms of likelihood and impact. When a population ages, intergenerational equity emerges as a critical issue. In addition to the rapidly rising costs of the universal age pension for the increasing numbers of those aged 65 and over, New Zealand's Ministry of Health projects the costs of health and care services for that age group will exceed 50% of Vote Health by 2026. Age pension and healthcare costs are met by current taxpayers. Will future taxpayers be willing to carry that burden? There is also the looming future cost of one child in four growing up in poverty and hardship and thus likely to suffer compromised health and reduced ability to contribute economically.

While New Zealand is not alone in having an ageing population, it is unusual in taking so little action to address this permanent and profound change. The New Zealand SuperFund will not solve the future problem of funding the age pension, and while KiwiSaver is a boon, its benefits flow to those who can afford to save.

Intergenerational equity can be looked at in various ways as discussed. Rather than a current generations versus future unborns approach, it is taken here to be simply the equity of treatment between the older and younger age cohorts. Existing and anticipated regional and ethnic variation in ageing and the issues arising are explored along with evidence of the prevailing intergenerational inequity in New Zealand. A survey of existing local and international measures aimed at increasing intergenerational equity and justice is followed by some concluding remarks. Actions that could be taken now to improve intergenerational equity include improving support for families and reducing child poverty; joining international organisations developing age-friendly communities; establishing a Parliamentary Commission for the Future; and introducing safe, fair, gender-neutral annuity products to enable intragenerational sharing of the costs of the ageing population.

1. Introduction

The Retirement Policy and Research Centre's (RPRC) Working Paper 2014-2 (revised April 2015), "Turning silver to gold: Policies for an ageing population" discusses:

the public policy-driven state costs of services and support for those aged 65+ and suggests possible policy options that could be applied in the future to... anticipate increasing numbers of older citizens with enthusiasm or at least equanimity rather than dread. (Dale, M.C, 2014, p. 2)

The impetus for that paper came from the realisation that the concept of an ageing population was conjuring fears of an increasing multitude of frail elderly dependent on decreasing numbers of young workers for provision of their care and support and income: primarily the age pension, the pay-as-you-go New Zealand Superannuation. "This is the source of the 'silver tsunami' metaphor, an unstoppable surge of grey-headed women and men, consuming or destroying everything in their path." (Dale, M.C, 2014, p. 23)

This paper suggests that much can be done and a different image can be conjured, 'turning silver to gold', if the potential for older adults' contribution to the community and the economy is enabled. There are public policy changes that are being introduced elsewhere, that could be introduced in New Zealand along with better policies for the young, to ensure improvements in intergenerational equity, and a smoother demographic transition.

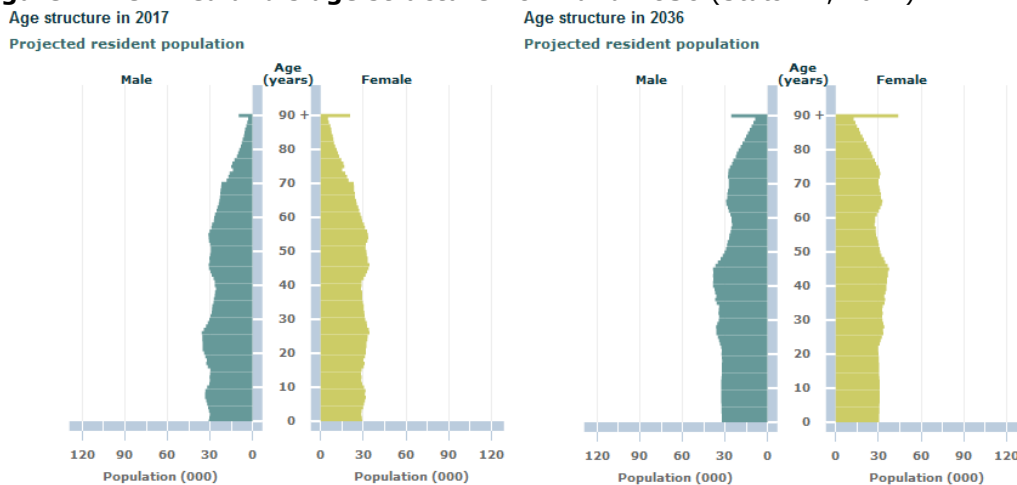
Critically, as stated at a government-level OECD conference:

Policies to prevent inequalities from building up and growing over the life cycle will need to take account of the new realities people are facing today in their families, in their workplace, in their careers and in their health and disability risks. Education, health and employment inequalities interact and compound. (Government of the Republic of Slovenia & OECD, 2018, p. 1)

2. Intergenerational equity – an overview

The World Economic Forum 2015 ranked population ageing as one of the five top global risks in terms of likelihood and impact (World Economic Forum, 2015, p. 12). In New Zealand, as in much of the western world including the US (Sheiner, 2018), in addition to the ageing of the population, the proportion of 'old' is increasing. In 2017, the 65+ population was 15% of the total population of 4,474,549; by 2036, the 65+ population is projected to comprise 20% of the total population estimated at 5,437,570. As Figure 1 shows, the proportion aged 75+, and thus more likely to be frail and in need of care and support, is projected to double in the next 30 years (Stats NZ, 2017).

Figure 1. New Zealand's age structure 2017 and 2036 (Stats NZ, 2017)



Population ageing occurs over an extended time period, and as Boston and Stuart (2015) note, the most formidable challenge when tackling policy problems with long time horizons

are conflicts regarding the proper allocation of benefits and burdens over extended periods of time:

... if governments do not invest adequately for the longer term, future citizens will be worse off. (Boston & Stuart, 2015, p. 61)

When a population undergoes a profound demographic change such as ageing, intergenerational equity emerges as a critical issue. Intergenerational equity is defined in multiple ways. Academic writings on intergenerational equity initially focussed primarily on the "dependency" or extended-family model of social contract, where working-age members of a society have an "obligation" to the current elderly who had supported them when they were too young to work (Foot & Venne, 2005, p. 5).

Rawls (1971) focusses on infrastructure, saying that each generation should put aside savings for the purpose of establishing and preserving just institutions and the fair value of liberty for their successors. For some commentators, intergenerational equity is as simple as "equality in treatment and opportunities for different generations" (Marshall, Cook, & Marshall, 1993). For Weiss (1992), sustainability is the issue: humans hold the natural and cultural environment of the Earth in common both with other members of the present generation and with other generations, past and future. In Padilla's (2002) definition, fairness is foregrounded: "to ensure a fair treatment to future generations, we should recognize and protect their right to enjoy at least the same capacity of economic and ecological resources that present generations enjoy".

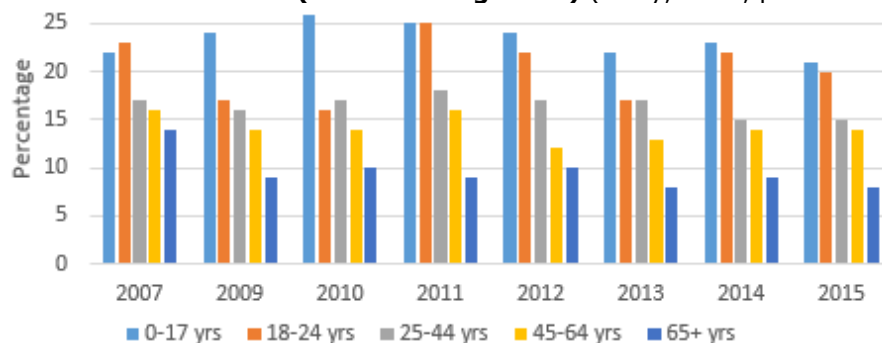
For others, for example Arrow, Dasgupta, Goulder, Mumford, & Oleson (2012), the definition devolves into something very modest: intergenerational equity occurs when the society is functioning sufficiently well to ensure that some measure of intergenerational wellbeing does not decline.

When intergenerational equity is framed in terms of current populations and future unborn generations it may distance the problem from the present power-holders and decision-makers. In contrast, intergenerational *inequity* is defined by Foot & Venne (2005) as "The distribution of the economic costs of an aging population, where the young are being deprived of opportunities for their well-being because of the excessive allocation of societal resources to the elderly." The evidence shows that this intergenerational inequity carries a high social and economic cost:

Underinvestment in children jeopardizes their rights and their future, as well as the economic and social development prospects of the countries in which they live. (International Labour Organisation, 2015, p. 4)

Intergenerational inequity, specifically the relative deprivation of the young, appears to be the case in New Zealand. New Zealand children have rated poorly in United Nations Children's Fund (UNICEF) reports. These reports use data from Statistics New Zealand, the Ministry of Social Development (MSD) and Organisation for Economic Co-operation and Development (OECD) reports to assess five aspects of children's lives: material well-being; health and safety; education; behaviours and risks; and housing and environment.

Table 1. Proportion of all individuals in low-income households by age, 60% of median "anchored" threshold (after housing costs) (Perry, 2016, p. 124 Table G2)



When compared with other developed countries, New Zealand is not delivering for the youngest generation, and is doing much worse than Australia: New Zealand statistics show 18.4% of children in poverty compared to 13% in Australia (UNICEF Office of Research, 2013). Table 1 shows that since 2009 those aged 0 – 17 have consistently had twice the rates of poverty of those aged 65+.

In the UNICEF (2013) report, out of 41 countries, New Zealand ranked:

- 38th for health and wellbeing for children, with 32% of 2 to 14 year olds overweight or obese, compared to the global average of 15.2%;
- 41st with the highest rate of adolescent suicide of any country in the report (15.6 suicides per 100,000 people); and
- 26th for reducing inequality and socio-economic disadvantage which impacts strongly on performance in reading, maths and science.

Research from the Dunedin Longitudinal Study confirms the immediate and long-term effects of poverty on children. Critically, relief from poverty later in life does not “mitigate or reverse the adverse effects of low childhood socio-economic status (SES) on adult health” (Poulton et al., 2002, p. 1640). The power of policy for positive change is clear:

Protecting children against the effects of socioeconomic adversity could reduce the burden of disease experienced by adults. (Poulton, et al., 2002, p. 1641)

The nation’s future economic and social health will depend on a population where one in five people were deprived in childhood, denied access to the economic and social assistance they are expected to provide as adults to others.

“Children who grow up in hardship in a comparatively wealthy nation are evidence of the failure of social and economic policies.” (Henare, Puckey, Nicholson, Dale, & Vaithianathan, 2011, p. 22)

In New Zealand, public healthcare, compulsory education and the universal age pension costs are all met by current taxpayers. The rapidly rising cost of the universal age pension, New Zealand Superannuation (NZS), reflects both the increasing numbers of those aged 65 plus, and the indexation of NZS to both prices and real incomes (Chapple, 2017), unlike other welfare benefits that are linked only to inflation. Projections show that, given the ageing population and the increased demand for healthcare, Government spending on healthcare will grow from 6.2% of Gross Domestic Product (GDP) in 2015 to 9.7% in 2060 and spending on NZS is projected to grow from 4.8% of GDP in 2015 to 7.9% in 2060 (The Treasury, 2016, Table 1.1). To meet the cost of NZS, the Government has been cutting spending on education and family support (see Table 2).

Table 2. ‘What if’ Fiscal projections (% of GDP) (The Treasury, 2016, Table 1.1)

	2015	2030	2045	2060
Healthcare	6.2	6.8	8.3	9.7
New Zealand Superannuation (NZS)	4.8	6.3	7.2	7.9
Education	5.3	5.4	5.5	5.7
Law and order	1.5	1.4	1.4	1.4
Welfare (excluding NZS)	4.2	4.5	4.7	4.7
Other (excluding finance costs)	6.3	6.7	6.7	6.7

Note: 2015 are actual results. Projections are from the “Historical Spending Patterns” scenario in Section Six. These projections represent a “what if” scenario and are not a prediction for how expense areas will actually grow.

It is noteworthy here that despite the language of ‘entitlement’, and ‘contribution’, Coleman’s (2012) estimates of net tax paid to fund pensions and the pensions received on average since 1976 indicate that New Zealanders have typically paid taxes during their

working (and retired) lives that amount to less than half the value of the pensions they receive. Under a PAYGO system (pay as you go) such as NZS, with increasing longevity and thus longer retirement, later generations have to commit a higher fraction of their incomes to support the previous generation (Gemmell, 2017). This raises the issue of lack of intergenerational equity.

However, some researchers suggest that *intragenerationally*, both inequality and redistribution remains much greater than that between generations, and its impact is growing. For example:

it remains the case that inequality within both the retired and non-retired groups is much greater than disparities between the two (Portes, 2014, p. F6).

Despite population ageing and population growth, the Treasury's Budget Economic and Fiscal Update (2017), projects almost halving state spending on housing and community development from \$943m in 2011 to \$508m in 2020, with health spending hardly increasing at all between 2017 and 2020: from \$16,214m to \$16,333m. Under current policy settings, the considerable increases in health care and NZS expenditure over time come at the expense of critical areas, particularly education and welfare spending that affects children and the working age population.

The fiscal risk is not unique to New Zealand. For example, Sheiner (2018) reports that ageing poses a US federal budgetary challenge because much of that budget is allocated to old age entitlement programs such as Social Security and Medicare. She shows the debt path is unsustainable without significant changes in policies, including some combination of spending reductions and tax increases. She suggests that changes in policies should be focused on tax increases and consumption spending, in addition to improvements in the efficiency of the health sector. Importantly, Sheiner argues that cutting government spending that has long-run returns, such as investments in education, infrastructure, and poor families—will not improve the long-run fiscal outlook (Sheiner, 2018).

Unfortunately, in New Zealand, despite the shift to a 'social investment' approach by the National-led government, and over a decade after child poverty was acknowledged as a real and growing problem (Perry, 2004), public spending on families and welfare actually reduced (Johnson et al., 2017) as a proportion of government spending. The emerging social distress around child poverty, increasing inequality and unaffordable housing suggests that current fiscal policies are unsustainable, and may increasingly prove to be intergenerationally inequitable.

Inequity can be ameliorated by redistribution, and fiscal policy can be a powerful redistributive instrument.

Fiscal policy can help enhance redistribution by reducing both disposable (post-tax-and-transfer) and market (pre-tax-and-transfer) income inequalities. Taxes and income-related transfers affect disposable income inequality, whereas in-kind transfers such as health and education spending influence the inequality of market incomes. (International Monetary Fund, 2017, p. 1)

A key feature distinguishing education and health policies from other redistributive fiscal instruments is that they have the potential to promote both growth and equity. Closing education and health gaps through better allocation of public spending "would improve equity and efficiency by enhancing human capital and productivity" (International Monetary Fund, 2017, p. 21). Perhaps the most remarkable fact is the continued inaction as this inequity is played out in the real lives of the children of New Zealand.

Economic and public policy decisions are intertwined in determining a viable future for an ageing society, as a recent Treasury paper stated: "The ultimate purpose of public policy is to help people live better lives, now and into the future." (Karacaoglu, 2015, p. ii) In his discussion of 'anticipatory governance', balancing rights and claims of the present with rights of the near and distant (unknown, unknowable) future, Boston (2016) proposes that policy settings need to be consistent with principles of intergenerational justice:

While there are many different principles of intergenerational justice, there is wide support for the view that current generations should not inflict serious, widespread or irreversible harm or act in ways that compromise the capacity of future generations to meet their needs. Ideally, current generations should act in ways that ensure that future generations are better off ... (Boston, 2016, p. 18)

Herein lies the problem. This generation of young people have not and will not enjoy the 'entitlements' accessed by the baby-boomer generation. As Eaquib (2016) writes:

Older voters believe they are entitled to superannuation, health and other public spending – as they were promised these benefits and they paid into the tax system for that promise. The wrinklies are right to believe in their entitlement. The young are right to be angry for being worse off.

At the 2012 conference 'Affording our Future', the 27 young participants, self-styled LongTermNZ, stated:

We will inherit the consequences of today's decisions and we cannot afford not to care.... Young people are willing to make trade-offs which recognise that the system must develop with changing demographics and rising health costs. Generations need to work together on this issue. Although spending may be fiscally constrained, the future we want requires active investment in smart long-term options – like a low-carbon economy, lower imprisonment rates, and decreased child poverty. These options are often cost-effective in the big picture and over the long term. (LongTermNZ, 2012, p. 12)

Younger people are also increasingly aware of not just the climbing future costs of health and pensions for the ageing population, but also of the reduced working-age population that will be confronted with those costs. The dependency ratio, the ratio of working age (15 to 64 years) to those aged 65+ years, was just over 5 to 1 in 2010, but by the 2060s the ratio will be closer to 2 to 1 (see Figure 2). With increasing longevity, and consequently more than an average 20 years per person of entitlement to NZS, and given its universality, the system appears neither realistic nor equitable.

Figure 2. Dependency Ratio 15-64 to 65+ (Karacaoglu, 2013, p. 55)



A further associated problem is the high numbers of unemployed youth, particularly since the GFC. While the official unemployment rate from 2013 to 2016 has been around 5%, for those in the 15 to 19 age group, unemployment has hovered around 20%; for those aged 20 to 24 the rate has been around 10%; and for those aged 25 to 29 the rate has been around 7%.²

Post-GFC, young people aged 15-24 were particularly hard hit: the unemployment rate rose to 17.5% by the end of 2009 and has not dropped below 12.5% since then. This age group experienced a decline in the employment rate of 8 percentage point to 50%, and by 2017

² See Statistics NZ at: http://archive.stats.govt.nz/browse_for_stats/snapshots-of-nz/nz-social-indicators/Home/Labour%20market/unemployment.aspx.

the pre-GFC employment level had not been regained. Recent research published assessments of unemployment and psychosocial outcomes (mental health, substance abuse/dependence, criminal offending, adverse life events and life satisfaction), using data from the Christchurch Health and Development Study. An increasing duration of unemployment was associated with significant increases in the risk of all psychosocial outcomes. "The findings of this study suggest that exposure to unemployment had small but pervasive effects on psychosocial adjustment in adolescence and young adulthood." (Fergusson, McLeod, & Horwood, 2014).

The experience of young people contrasts sharply with consistently rising employment rates for older workers throughout the 2000 to 2017 period.

The employment rate of 60-64 year olds rose from 42% in 2000 to 74% in 2017. At age 65, New Zealanders are eligible for a universal, non-means-tested pension ("NZS"), but the strong rise in employment rates is evident even for workers above this age. Employment rates for 65-69 year olds rose from 16% to 44%, and for workers over the age of 70, from 4% to 13%. (Maré, 2018, p. 3)

As Maré (2018) notes, as population aging continues, the employment patterns for older workers will have an increasingly strong impact on the labour market. Seniors currently make up around 6.2% of the workforce. By 2033 the number of seniors at work will nearly double and they will make up 10.6% of the workforce. It is estimated that by 2061 seniors will contribute \$31 billion to the economy through paid and unpaid work, up from \$6.5 billion today.

In the UK, it appears that apart from the government appointing a Minister for Loneliness research and policy development on intergenerational issues has devolved largely to non-government organisations. Very active in this space is the Resolution Foundation,³ an independent thinktank, who convened the Intergenerational Commission, because:

Questions of intergenerational fairness are rising up the agenda.... Today's younger generations are finding it more difficult to get on the housing ladder, experience more uncertainty and slower pay progression as they begin their careers, and can expect less from the welfare state when they fall on hard times.

But the problems go even deeper. The risk is that young people today fail to achieve the growth in living standards that their predecessors enjoyed. That matters ... for all of us no matter our age, and for the state.

We welcome the intergenerational debate that has now opened up. But it needs to go much further, in three key respects:

- *We need more robust analysis of what is actually happening. Is the fact that millennials are earning £30 a week less than generation X-ers were at the same age a recession effect or something more long term?*
- *The government needs to better understand the intergenerational consequences of its decisions. Tax and benefit policies planned for this parliament will redistribute billions from young to old; taking £1.7bn from millennials and giving £1.2bn to the baby boomers.*
- *Too often the debate is framed as an intergenerational war, which doesn't reflect how people feel about the issue or live their lives as families.⁴*

The intention of the Intergenerational Commission was to bring together experts from the worlds of work, academia and public policy to seek better understanding of these issues and propose changes to strengthen the intergenerational social contract. Dismally, the final report states:

³ See <http://www.resolutionfoundation.org/>.

⁴ See <https://www.intergencommission.org/about/>.

We have shown that generational progress has indeed stalled. Moreover, we face significant challenges in providing the health and care that older generations expect. This report brings our findings together and the evidence is compelling. No longer can anyone deny the challenge facing us as a country in maintaining a fair deal between the generations. If the evidence is so powerful then that means there is an obligation to act. (Intergenerational Commission, 2018)

Without the introduction and adoption of new values and policies, intergenerational justice and intergenerational equity are unlikely to improve.

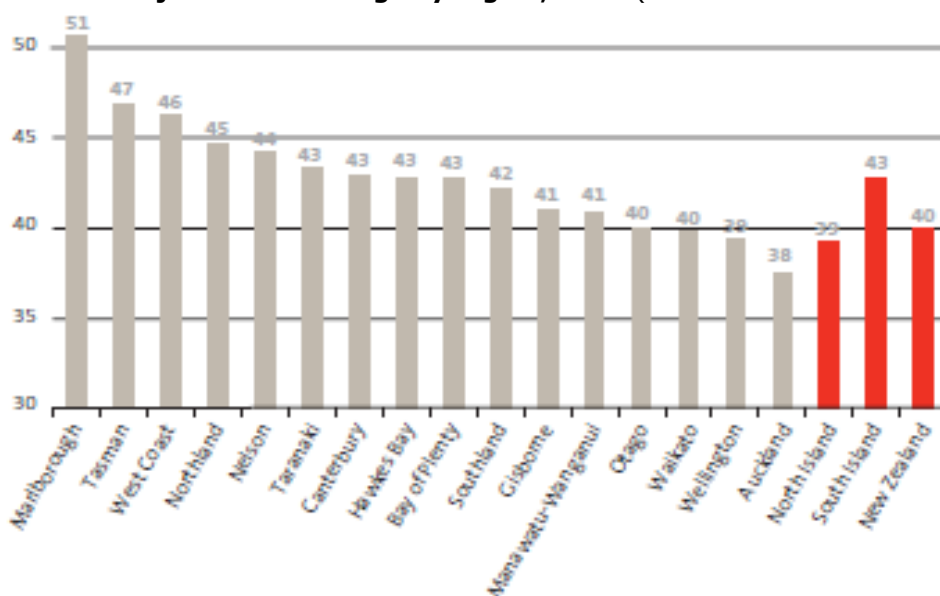
2. Geographical variation in ageing and deprivation

Uneven geographical distribution of the aged population adds complexity to demographic change and equity issues. Regional variation in ageing impacts on the young and old in need of care, and on the caregivers. New Zealand's Auditor General reported (2013, p. 3):

Some regions will have older populations and age more quickly than others. When an increasing proportion of the population is on a fixed income, local authorities with the oldest populations are more likely to be the first to face challenges in paying for community services and maintaining, repairing, and replacing infrastructure. One way or another, many public resources will be committed to responding to our ageing population.... We expect governments will spend more on superannuation, healthcare, and social support care (such as home-based support services and aged residential care). Spending on other services might decrease.

District Health Boards (DHBs) are particularly challenged by shrinking, ageing populations. For example, while Auckland arguably has the best facilities and support for aged care, as shown in Table 3, it has the lowest regional proportion of superannuitants at 10.5% compared to the New Zealand average of 13.9% (Jackson 2012, p. 28). In contrast to Auckland, Marlborough has a population with 33% aged 65 or older, exceeding even Japan's proportion of 26.7% aged 65+ (Yoshida, 2016). Given the population structure in Marlborough, obtaining the necessary support to 'age in place' is increasingly difficult.

Table 3. Projected median age by region, 2031 (Controller & Auditor General 2013, Figure 3)



Regional variation also occurs in deprivation, and: "Income poverty and material deprivation are by definition unacceptable states of affairs." (Perry, 2015, p. 69). Individuals can experience multiple forms of deprivation and they may have a cumulative effect (Townsend, 1987). The researchers behind the recently developed New Zealand Index of Multiple Deprivation (IMD) found geographic variations in the distribution of the

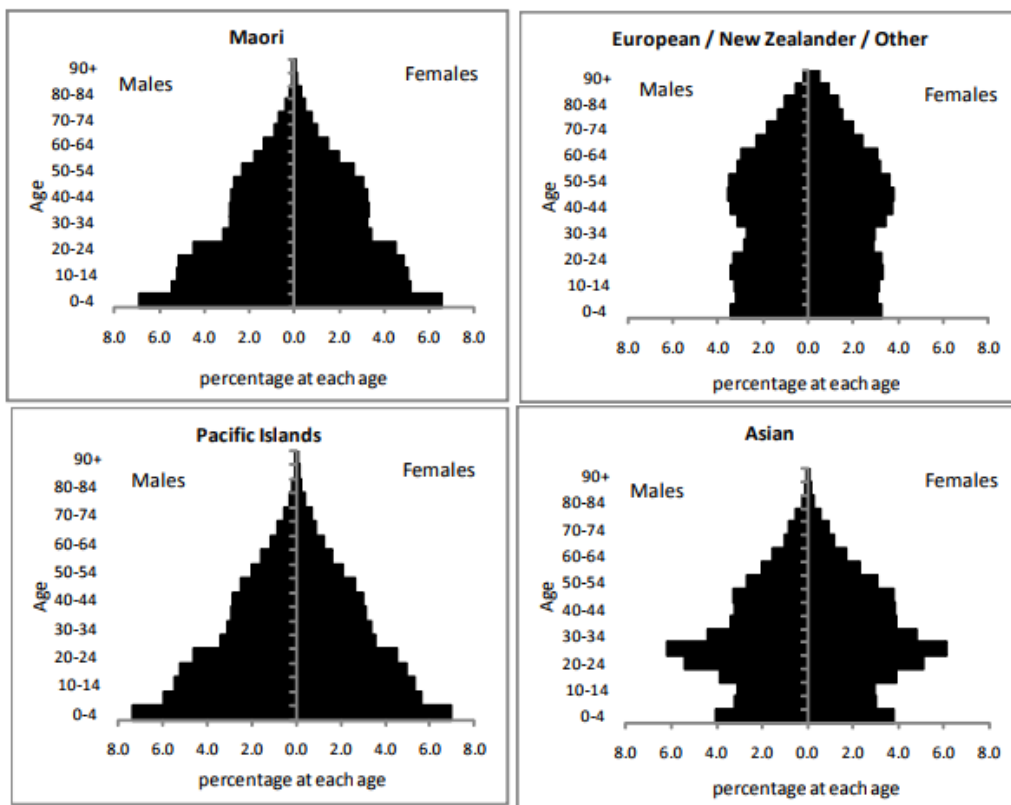
IMD and its Domains among the District Health Boards in New Zealand, suggesting that factors underpinning overall deprivation are inconsistent across the country.⁵ Importantly:

There is an unequivocal graded association between area-based deprivation, health and social outcomes in New Zealand. (Exeter, et al., 2017, p. 2)

Exeter et al. (2017, pp. 11 – 12) examine the populations associated with DHBs and show Capital and Coast DHB (Wellington) has among the lowest levels of Income and Education deprivation; South Canterbury and Canterbury DHBs have the lowest employment deprivation; Auckland, Counties Manukau, and Tairāwhiti DHBs have the worst Housing deprivation; Auckland, Lakes, and Tairāwhiti DHBs have the most Crime deprivation; West Coast and Northland are the DHBs with the worst Access deprivation (and Auckland has the best); and Nelson/Marlborough DHB has by far the lowest Health deprivation. These results emphasise that assumptions cannot be made and evidence is crucial: Marlborough has the oldest mean population age, but the lowest health deprivation.

In addition to regional variation in deprivation and in ageing, there is ethnic variation in ageing as shown in the age pyramids in Figure 3.

Figure 3. Age-sex structure by major ethnic group (multiple count ethnicity), 2011 on 2006 Base (Jackson, 2011, Fig. 10)



Source: Statistics New Zealand (2006) Projected Ethnic Population of New Zealand, by Age and Sex, 2006 base - 2026 Update

While the European-origin population has a 2006 median age of 38 years, the youthful Maori population has a median age of just 23 years; and despite comprising only 14% of the total population, Maori at 0-14 years account for 21% of all 0-14 year olds (Jackson, 2011, pp. 17 - 18). As Jackson writes:

⁵ The researchers identified 28 indicators of deprivation representing 7 Domains of deprivation: Employment; Income; Crime; Housing; Health; Education; and Geographical Access. "The IMD is the combination of these seven Domains. The Domains may be used individually or in combination to explore the geography of deprivation and its association with a given health or social outcome." (Exeter, Zhao, Crengle, Lee, & Browne, 2017, p. 1)

Clearly young Maori will play a significant role in New Zealand's future labour force, and attention to their specific educational, training, and social needs must be a paramount consideration. (Jackson, 2011, p. 18)

There is also significant ethnic variation in life expectancy at birth. The increases in life expectancy between 2014 and 2038 for 'European or Other' are from 80.7 to 85.0 years for males, and from 84.2 to 88.3 years for females; for Māori the increases are from 73.4 to 81.3 years for males, and from 77.3 to 84.7 years for females; for the Asian population from 84.8 to 88.7 years for males, and from 87.2 to 91.1 years for females; and for Pacific peoples, from 74.6 to 82.1 years for males, and from 78.8 to 85.8 years for females.⁶

A University of Auckland longitudinal study, the first in the world of an indigenous population in advanced age (Kerse, Lapsley, Moyes, Mules, & LiLACS NZ, 2017), reports that the New Zealand Māori population aged 80+ in 2010 is projected to increase by 74% by 2026. The number aged 80+ who are independent and the number needing long interval care are also estimated to increase by 74% by 2026 (from 50,605 in 2010 to 93,161 in 2026). Study leader Ngaire Kerse says the findings are significant because planning for future service provision is needed to allow people to manage at home. While the greatest numbers of 80+ are in the older non-Māori population, "It is clear from this report that the rate of change in the population is greatest for Māori, and this will present challenges for Māori society."

The challenges are great for all society, and it is important to remember that our ageing society is actually one of our greatest achievements:

Older people are key contributors to our economy, our communities and families across New Zealand. They are our skilled workers, volunteers, caregivers, mentors and leaders. They are part of our families, and social fabric.... Older people make a significant economic contribution as business leaders, employees, taxpayers and consumers. (Office for Seniors, 2016, p. 5).

Jackson (2015) emphasises that while little can be done to alter the demographic future, much can be done to ensure policies are fit for purpose:

It is essential that regions, territorial authorities (TA's) and organisations revisit their policies and plans and the principles on which they are based, to ensure they are appropriate for ageing populations – but also importantly, one within which there are markedly younger and older populations, such as Maori and European, each with different needs and opportunities. Choice of strategy in how to engage with these trends and circumstances will very much determine whether regions, TA's and organisations will be successful going forward.

As New Zealand is coming so late to the realisation that a successful transition to the new and inevitable 'older' future, we also have the opportunity to ride on the coat-tails of those countries that are planning and preparing their age-friendly futures. Some of these exciting innovations are discussed in section 4.

3. Health and care provision: intergenerational inequity

Within New Zealand, "serious inequalities in health outcomes persist between different genders, generations, ethnic and socioeconomic groups" (Ministry of Health, 2016b).⁷ In

⁶ See Stats NZ:

http://archive.stats.govt.nz/browse_for_stats/population/estimates_and_projections/projections-overview/nat-ethnic-pop-proj.aspx.

⁷ Importantly, serious inequalities in health access and health outcomes also persist *within* different genders, generations, ethnic and socioeconomic groups. For example, the 2017 Commonwealth Fund International Health Policy Survey of Older Adults (2017) comparing the challenges faced by older people in Australia, Canada, France, Germany, the Netherlands, New Zealand, Norway, Sweden, Switzerland, the UK and the US, found that while older Kiwis had the least waiting time to see a doctor, around 11% could not afford healthcare, and only Switzerland, Australia and the US (23%) had more elderly in this position.

2017, almost a quarter of estimated Core Crown Expenses of \$80.5 billion was allocated to health costs for the aged of residential care, other services and support (\$6,343 billion), and New Zealand Superannuation (NZS) (\$12,912 billion). By 2020, without including any provision for cost increases in the health sector, projected health costs for the aged of residential care, other services and support are \$6,719 billion, and NZS \$14,916 billion, so those two expenditures will exceed \$21.6 billion of estimated Core Crown Expenses of \$84.8 billion (Dale, M C, 2016). In short, over 25% of Core Crown Expenses will continue to be allocated to around 15% of the population.

Although most children under age 13 have had access to free GP visits since July 2015 (Kirk, 2015), underinvestment in children is also revealed in health spending per age group as shown in Table 7. DHBs are funded per head of population out of Vote Health. The older a person gets, the more likely they are to spend time in hospital. The higher the proportion of older people, the greater the demands on the health system.

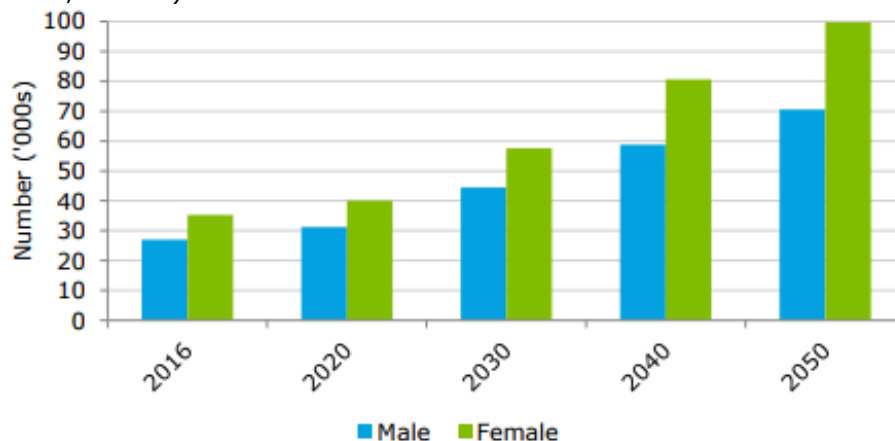
We may be living longer, and living longer in good health, but we are also living longer in poor health. Put another way, only 70–80% of the years of life gained over the past quarter century have been years lived in good health: our health system and wider society have proved more adept at preventing early death than at avoiding or ameliorating morbidity. (Ministry of Health, 2016b)

At least 10% of older people receive government-funded, home-based support. The qualifying criteria are needs-based, tested by a Needs Assessment Service Coordination (NASC) organisation, rather than means-tested (Ministry of Health, 2016c). The Ministry of Health contracts service providers to deliver Home and Community Support Services.

A further estimated 5% of older people live in institutions providing either resthome or hospital-level care. The means-tested Residential Care Subsidy (RCS) is generous. As at 1 July 2017, the asset threshold in order to qualify for the RCS was \$224,654, and there is a cap on the cost of private hospital care (Dale, M.C, St John, & Hanna, 2012; Ministry of Health, 2017). The maximum contribution that can be charged for care is set annually for each Territorial Local Authority region by the Director-General of Health. In 2017, the maximum weekly contribution (including GST) ranged from \$977.90 to \$1,035.58 (Director General of Health, 2017).

As part of the ageing in place policy (and a cost-reduction strategy), the age-adjusted population proportion in rest home care has decreased while the proportion in hospital level care has stayed steady. In Auckland, for example, absolute numbers in residential care beds have stayed roughly constant for 20 years but dependency levels have increased (Boyd et al., 2011; Ministry of Health, 2016d). Declining use of rest home care is matched by increasing use of home support services (New Zealand Home Health Association 2011). These increases have impacted on formal and informal careworkers.

Table 5. Dementia prevalence projections by gender, New Zealand, 2016 to 2050 (Deloitte, 2017, Chart b)



An added concern is the projected exponential increase in the incidence of dementia as the population ages (particularly aged 60+) as shown in Table 5 (Prince et al., 2015).

In 2016, the prevalence of dementia in New Zealand was higher among females (35,254 people, or 56.6%) than males (27,033 people, or 44.4%) as a result of both the higher longevity for women compared to men, and the higher population of females to males.

It estimates there has been a 29% increase in numbers of people with dementia in five years – from 48,182 people in 2011 to 62,287 in 2016. It is predicted 170,212 people will have dementia by 2050....The costs associated with dementia are estimated to have increased by 75% from \$955 million in 2011 to \$1,676 million in 2016. In today’s dollars, this could be more than \$2.7 billion by 2030. (Deloitte, 2017, p. 8)

The Healthy Ageing strategy recognises that adequate provision of support and care services is critical to older people ageing well for longer in their communities.

The Healthy Ageing Strategy vision is that "older people live well, age well, and have a respectful end of life in age-friendly communities". It takes a life-course approach that seeks to maximise health and wellbeing for all older people. (Associate Minister of Health, 2016)

However, in New Zealand, since 2011, despite the increased costs imposed by the ageing population, and despite significant increases in the total population, state health spending relative to GDP has reduced (Table 6). Nevertheless, spending on services for older people is increasing faster than other expenses, and over the last 10 years, DHB spending on services for older people has increased by 68% vs 27% for their overall expenses, and 5 times as fast as the consumer price index (CPI). Since 2005, while payments to DHBs have increased less than 25%, expenditure on support in the home has increased by over 120%, while expenditure on residential care, as a consequence of applying the ‘ageing in place policy’, has been contained to around a 50% increase (Ministry of Health, 2016d).

Table 6. Health spending relative to GDP (Johnson, et al., 2017)

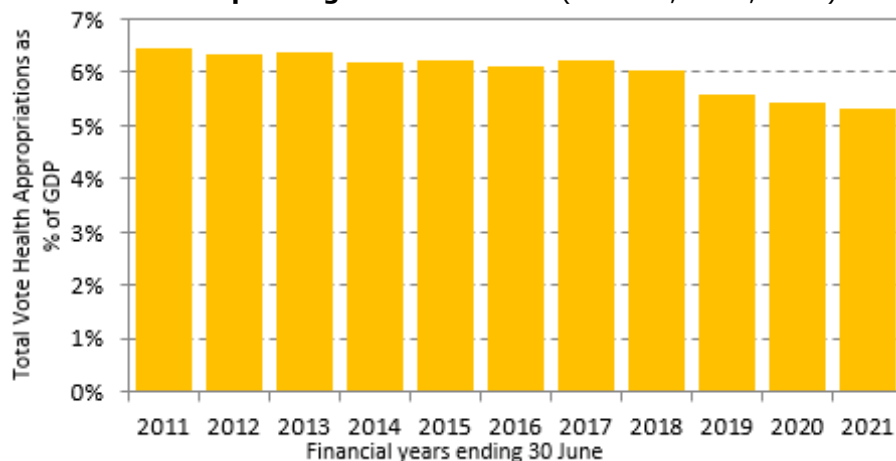
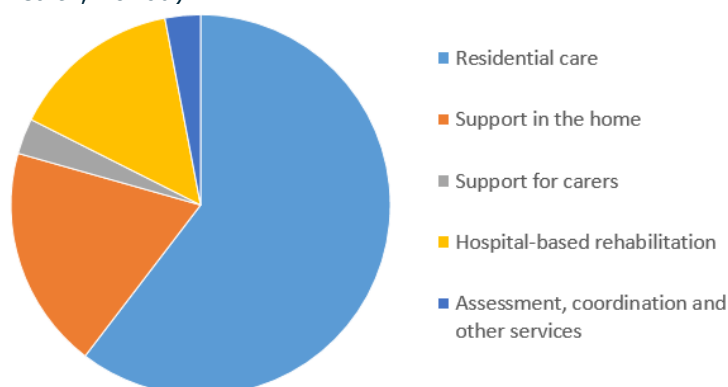


Figure 4 shows residential care is the largest cost in the DHBs’ budget for older people: in 2015 of \$983 million DHBs spent on support services, 60% went to aged residential care (Ministry of Health, 2016d), with the bulk of that funding to private, for profit providers:

Of the nearly 700 aged care residential homes in New Zealand 61% are privately owned, 20% owned by non-profit organisations, 19% are publicly listed and 1%

have other types of ownership. (New Zealand Labour Party & Green Party of Aotearoa New Zealand with Grey Power, 2017, p. 6)⁸

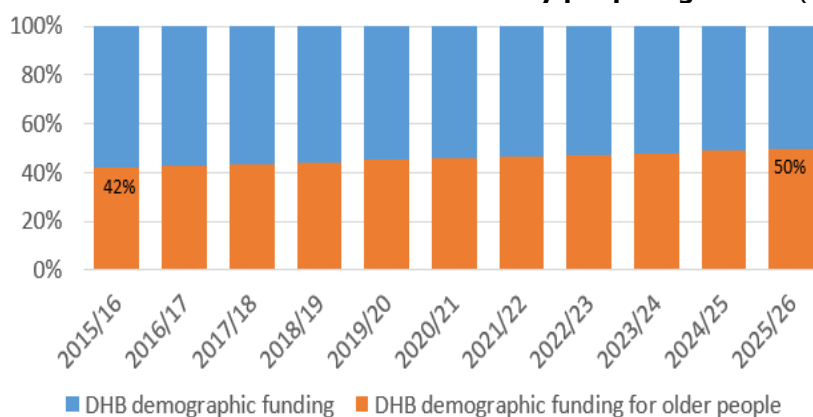
Figure 4. Proportional spending on types of support service for older people (Ministry of Health, 2016d)



In 2014 - 2015 MSD spent around 20% of its total social services expenditure on contracted services delivered by a mix of government, not-for-profit and for-profit providers. The Productivity Commission (2015, pp. 5 - 8) reported:

the existing system is not well suited to deal with the multiple and inter-dependent problems experienced by the most disadvantaged individuals and families. In addition, the need for accountability and political risk management favours the use of prescriptive contracts, short contract periods and onerous reporting requirements, factors that work against innovation and discourage productive and trusting relationships between government agencies and non-government providers and careworkers.

Table 7. Share of health services used by people aged 65+ (Ministry of Health, 2016a)



As is shown in Table 7, the Ministry of Health (2016a) projects the costs of health and care services for those aged 65+ will exceed 50% of Vote Health by 2026. In 2013, those aged 65+, around 14% of the total population, accounted for 33% of total government health expenditure. By 2016, health expenditure on those aged 65+ increased to 42% of total government health expenditure while that group comprised only 14.9% (698,400) of the

⁸ The 2017 Inquiry into Aged Care also noted that while the 2010 Report estimated 32% of the sector was not-for-profit, in 2017 it was estimated at 20%. This has coincided with an increase in aged care facilities within the booming retirement villages and the closure and consolidation of smaller independently-owned facilities, many of which lack both the size and scale to operate as efficiently as the larger rest homes, and the investment capital. The smaller facilities are predominantly community-based rest homes, faith-based facilities and NGO providers. (New Zealand Labour Party & Green Party of Aotearoa New Zealand with Grey Power, 2017, p. 6)

population (Statistics New Zealand, 2016). The inequity is that over 85% of the population, including all children and adolescents, shared only 58% of total health expenditure.

The disproportionate allocation of health funding in New Zealand perpetuates the inequity where old are privileged over young, and Pakeha are privileged over Māori. The majority of Māori children live in the north and east of the North Island, the most deprived regions (Sin & Stillman, 2005). The report, *Te Ohonga Ake* (2017) provides an overview of the health status of Māori children and young people in New Zealand to assist with addressing child and youth health needs in a systematic way.

The findings in this report reinforce the need to continue to focus on meeting the needs of Māori children and young people and the continued need to address the considerable inequities shown across the indicators in this report. It is valuable to reflect on areas where gains are being made, and identify strategies that can support improving the health and wellbeing of Māori tamariki and rangatahi. Challenges that are very pressing include poverty related conditions, mental health and suicide. (Simpson, J et al., 2017, p. 2)

Poverty is linked to higher rates of respiratory and infectious disease (responsible for a considerable proportion of children's visits to primary care each year) through its associations with poor housing, poor nutrition, smoking, air pollution, and difficulties with accessing healthcare (Simpson, J, et al., 2017, p. 33). For example, household characteristics of Counties Manukau children aged less than two years admitted to hospital with lower respiratory infections in 2007 indicated that 25% lived with seven or more other people, 33% lived with four or more children, and 27% were in households that used no form of heating (Simpson, J, et al., 2017, p. 45).

Extra state-funded support is urgently necessary in the lower decile (poorer) schools as another aspect of 'care and support'. The availability of school-based health services, funded through the Ministry of Health via DHBs, is a critical factor in supporting both health and equity. Access at school to confidential, affordable health professionals can prevent the escalation of problems, but this decile-targeted programme means that even the part-time services of school nurses, doctors, physiotherapists, social workers and psychologists all depend on a school's location and the funding streams available to it (Howie, 2017).

Those who are socioeconomically deprived experience more hardships than their peers and lack adequate access to resources, such as food, education and health care. New Zealand's findings are consistent with the high international prevalence of adolescent Non-Suicidal Self Injury (NSSI)⁹: almost 50% of secondary school students report having engaged in NSSI at least once (Robinson, et al., 2017, p. 126-7). Robinson et al. (2017, p. 134) found that 37.8% of their young adolescent New Zealand sample reported experiencing some degree of subjective socioeconomic deprivation, and this experience was associated with greater depression, anxiety, and engagement in self-injury. These findings reiterate the need for greater mental health and wellbeing support for these adolescents and their families.

Among young people, socioeconomic disadvantage, Māori ethnicity, and child welfare care are also associated with higher suicide rates, and as already noted, New Zealand has the OECD's highest youth suicide rate. From 2000 to 2012 suicide rates for Māori 0–24 year olds were consistently and increasingly higher than those for non-Māori non-Pacific 0–24 year olds (Simpson, J., Adams, Oben, Wicken, & Duncanson, 2016, p. 97).

The Ministry of Health (2016e) reports that in 2013, the suicide rate increased with each level of neighbourhood deprivation, and the rate of suicide in the most deprived areas was twice the rate in the least deprived areas; and suicide accounted for nearly 35% of all

⁹ NSSI includes deliberate behaviours such as cutting and scratching the skin without suicidal intent, typically as strategies to manage overwhelming emotions or to punish the self (Robinson et al., 2017, p. 126-7).

youth deaths (33.3% of all male youth deaths and 37.1% of all female youth deaths) (Ministry of Health, 2016e). The data does not indicate the motives for suicide, however, it is impossible to ignore the association at all ages between high rates of suicide and deprivation. Public and social policies can alleviate deprivation.

Ageing unequally starts early and builds up from early childhood to old age. Early-life health and socio-economic conditions lay the foundations for people's life-courses and are important predictors of future well-being. Material, physical, and educational factors as well as living arrangements and the composition of families are important factors for child well-being. Disadvantages in these dimensions reinforce each other. Preventing child income poverty and material deprivation is a priority. (Government of the Republic of Slovenia & OECD, 2018, p. 2)

Intergenerational equity involves social and economic issues around policy and provision of formal and informal care. Care is a universal need, although it applies most particularly for the very young and the very old. The increased demand for aged care workers runs parallel with the dramatically increased demand for childcare workers as childcare is increasingly marketised rather than performed at home unpaid. Over recent years the health care and social assistance industry, which covers hospitals and medical care, residential care services, child care and other social services, has become the largest industry by employed numbers in New Zealand, employing 1 in every 10 workers (See Dale, M C, 2016; Statistics New Zealand, 2014). However, while 12.4% of 75+ New Zealanders live in a retirement village, 87.6% live in the community (Gordon, 2017, p. 45), as citizens.

The issue of care provision is complicated by numerous factors: the ageing population is not evenly dispersed across the country; and the supply of trained and/or available caregivers is unlikely to meet the growing demand. Since provision of care is driven largely by the profit-motive of private providers, care needs are under-provided for both old and young in low income communities. Importantly, care-workers themselves are an ageing population: as of 2013, 81.7% of the workers in the health care and social assistance industry were women, of whom approximately 75% were aged over 40 years (Ravenswood, Douglas, & Teo, 2015).

Unpaid or 'informal' carers contribute to providing for the needs of both the ageing population and the young. The need for informal caregivers increases with both population ageing and the public and private preference for ageing in place rather than institutional care; with the inability or incapacity of parents to care for their children; and with the government's preference for parents' paid work over providing care for their children.

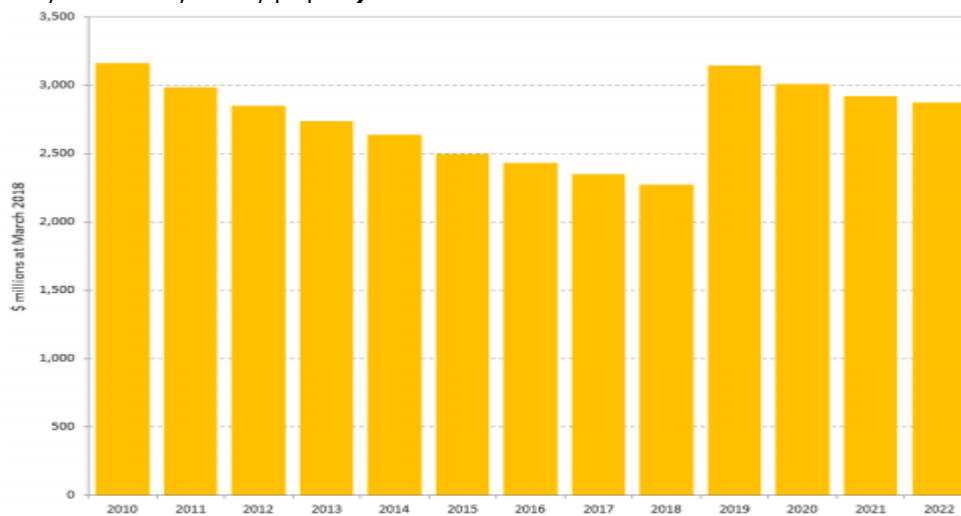
For example, in the 2013 census, 9,543 grandparents reported they were raising grandchildren. They were 45% Pakeha, 42% Māori and 13% Pasifika, ages ranged from less than 35 to more than 85, and the families tended to be clustered in deprivation deciles 9 and 10 (most deprived) (Gordon, 2016, p. 22). While many of these grandparents are raising vulnerable and at-risk children who would otherwise be in foster care, not all grandparents qualify for the Unsupported Child Benefit (UCB), the main government support for children not living with their parents and not in CYF foster care.

Whether or not they are receiving financial assistance from the state, to ensure the care of the children, these grandparents often have to make changes to their work participation, including reducing or changing employment hours, fitting within the school day, working nights, moving to part-time work, working from home and similar strategies (Gordon, 2016, p. 27). Gordon (2016, p. 33) and Gott, Allen, Moeke-Maxwell, Gardiner, & Robinson (2015) also report financial insecurity and worries about their ability to cope with the high financial costs, including direct costs such as transport, food and medication; and indirect costs related to employment, cultural needs and their own health.

In addition to these immediate financial and emotional costs, the 2013 Census data showed that households of unpaid caregivers typically earned 10% less than households without caregiving responsibilities (Statistics New Zealand, 2013). This lost income to

caregivers impacts negatively on their own health and eventual retirement options. Not only is carework increasingly physically demanding as the criteria for residential care are tightened, aged-care work is low paid or unpaid, gendered, and considered 'low skill'.¹⁰

Table 8. Real spending on Working for Families, in March 2018 \$ (Johnson, Cotterill, Dale, St John, & O'Brien, 2018, p. p. 2)



For children and families, Working for Families (WFF) tax credits have been the main platform for family assistance since 2004, another aspect of care and support. Despite an increasing population, real public spending on WFF reduced until 2018 through failure to index annually, cuts to the total family income threshold for abatement of tax credits, and increases to the abatement rate on earned income over the threshold (see Table 8). . In response to the evidence of family hardship, in December 2017 the newly elected Labour/NZ First Government announced a Families Package that “will provide targeted assistance to improve incomes for low- and middle-income families with children” (Robertson, 2017).

As part of the new Government’s focus on reducing child poverty, the Families Package includes: increasing the Family Tax Credit; raising the Working for Families abatement threshold; introducing a Best Start tax credit to help families with costs in a child’s early years; reinstating the Independent Earner Tax Credit; and increasing accommodation assistance.

The Families Package will help reduce child poverty. In 2020/21, the Package is projected to reduce the number of children living in households earning below 50% of the equivalised (moving line) median household income by around 88,000, or a reduction of around 48% relative to the status quo. (Robertson, 2017)

In early 2018 Treasury announced there was an error in their projections. On 31 March 2018 new calculations were released that showed the projected impact of both National and Labour’s packages were overstated. Treasury re-estimations show that Labour’s package would lift around only 54,000 children above the 50% BHC line, a 27% reduction by 2021 (St John & So, 2018)

In addition to social equity being enhanced through forms of social insurance and tax credits, it is promoted through provision of and access to education. Access to and

¹⁰ This particular inequity was addressed in part by the \$2 billion TerraNova pay equity settlement (over 5 years) for care and support workers which could result in some full-time workers taking home an extra \$5,000 a year, a pay rise of 15% to 49% depending on qualifications and experience (Coleman, J., 2017). The settlement was supposed to address the historic undervaluing of this workforce and also help to support increased qualifications and reduced turnover in the sector.

involvement in education is increasingly recognised as a lifelong need (Education, 2015), and good quality ECCE is a determinant for later educational success.

For participation in early childhood care and education (ECCE), New Zealand is ranked in the top third of OECD countries with the prior ECCE attendance of children starting school reaching 96.2% for the year ended June 2015. Since 2000, the gap in ECCE participation rates across different ethnic groups has narrowed, and by 2015, 94.0% of Māori children had participated in ECCE before starting school, compared with 83.1% in 2000 (Ministry of Education, 2017a).

However, access to good quality ECCE in low-income areas remains limited. This lack of access is largely caused by the rapid increase in 'for profit' providers, for example, taking 63% of the enrolments/attendances in licensed ECCE services in 2014. Kindergartens had the next largest share (16%), followed by home-based services (10%), Playcentres (6%), and Kōhanga Reo (5%) (Simpson, J., et al., 2016, p. 23).

Decreasing enrolments for kindergartens, Playcentres and Kōhanga Reo are perhaps because overall, the growth in enrolment rates between 2000 and 2014 were highest for children aged under three years. The proportion enrolled of all one-year-olds increased from 29% to 44%, the proportion of two-year-olds increased from 48% to 65% and the proportion of three-year-olds rose from 85% to 96% over the same period (Ministry of Education, 2017a). This suggests that increased enrolments are supporting parental employment. While the government-funded 20 hours ECCE was not introduced until 2007, over the period from 2000 to 2014, the average number of weekly hours per enrolment rose 53.3%, from 13.5 to 20.7 hours (Ministry of Education, 2016).

As a consequence of increased enrolments and increased hours of attendance, the proportion of total public education expenditure allocated to ECCE has more than doubled since 2002, up from 6.4% in 2002 to 13.1% in 2013. Internationally, New Zealand ranks in the top group of OECD countries in terms of both its per-child public investment in ECCE and its proportion of total public spending allocated to ECCE (Ministry of Education, 2017b). Public investment in ECCE as a proportion of GDP increased 137% between 2002 and 2013, from 0.33% to 0.77%. Public expenditure on ECCE between 2002 and 2013, in current 2013 dollars, rose by 203% from \$542 million to \$1,641 million (Ministry of Education, 2017b).

However, the ages of the children and the hours spent in care suggest that spending on ECCE is predominantly spending on daycare, child-minding not education, supporting the politically-driven work compulsion for beneficiary families, with 'work' narrowly defined as paid employment. The drive to work as the solution to poverty, and hence to reliance on ECCE rather than parents and whānau largely ignores the importance of attachment, the enduring emotional closeness binding families in order to develop children neurologically in a stimulating, secure and loving environment and prepare them for independence.

The 2011 New Zealand Medical Association's Position Statement on Health equity included:

The ever increasing costs of healthcare are, in part at least, a result of increased treatment costs for conditions that could have been largely prevented through action on the social determinants of health. Addressing the social determinants of health is not just a way to achieve better health equity, but a critical measure to ensure the financial sustainability of the health system. (New Zealand Medical Association, 2011, p. 4)

Action on the social determinants of health to reduce health inequities would have a profound effect on the quality and longevity of life for everyone, and not just those who suffer the most from material deprivation, or those who are exposed to negative life course events. There is also a significant positive effect for the economy from such action, including decreased productivity losses through illness, decreased societal costs associated with effects of mental illness and violence, and decreased costs of law enforcement and

incarceration (New Zealand Medical Association, 2011, p. 4). The numbers of people receiving benefits would also be decreased by reducing health inequities.

Nevertheless, as the International Monetary Fund (IMF) (2017, p. xi) reports, there is a general lack of progress:

Disparities in health outcomes are not narrowing in many countries. In advanced economies, the gap in life expectancy between males with tertiary education and those with secondary education or less ranges from about four to fourteen years and has even widened in some countries... Addressing remaining inequalities will require better targeting of public spending to disadvantaged groups to improve access to quality education and health care. This would also enhance overall efficiency.

The evidence shows that serious inequalities in health and access to services and support persist in New Zealand between different generations, genders, ethnic and socioeconomic groups, and regions. A disproportionate amount of DHB funding is allocated to the aged, and the young are not receiving the physical and mental health services they need. The inequity is revealed in the alarming child and youth health and suicide statistics. State support for families has been inadequate, and the drive to prioritise paid work has disguised much spending on child care as spending on education.

Social inequity affects views of citizenship, and thus on both perceived and actual contributions to society. Edmiston's (2017) research on 'Poor and rich citizenship in austere welfare regimes' found that due to the material and symbolic significance of inequality, deprived respondents to his survey were less likely to feel they had social rights, and less likely to feel they were social citizens. In contrast, richer citizens were more likely to affirm their belonging and identity as 'active, productive and contributing' social citizens (Edmiston, 2017, p. 322). Intergenerational equity will not be achieved by current New Zealand policies of unequal provision of services and support between generations, genders, ethnic and socioeconomic groups, and regions.

4. What policy (and legislative) changes could improve intergenerational equity?

Recognising the global phenomenon of an ageing population, creating environments where people of all ages can actively participate and be treated with respect under the auspices of the World Health Organization's (WHO's) Age-friendly Cities and Communities (AFCC) programme is becoming a priority around the world, including New Zealand. (Davey, 2017, pp., p. 7)

Public policy is the key to an equitable and sustainable future. Many still mourn, for example, the end of the family benefit in 1991. From 1959 until 1986, it was possible, "under certain circumstances, for persons in receipt of family benefit to capitalise this benefit in order to assist in the purchase of a house, to add to or alter a house, or to repay a mortgage on a house" (McLintock, 1966 (2009)).

Once we specify the generation and protection of shared (across society and generations) and sustainable wellbeing as the main purpose of public policy, and we appreciate the multiplicity and complementarity of spheres of wellbeing, it becomes self-evident that we need to think of economic, social and environmental policies in an integrated way. (Karacaoglu, 2015, p. ii)

So, too, when addressing the issues of the ageing population.

The first policy change to promote intergenerational equity would be to improve support for families and alleviate the hardship and deprivation endured by children. The Families Package introduced by the Government in December (Robertson, 2017) was a good first step toward that, but more is needed. As St John and So (2018, p. 15) write:

the Families Package is quite insufficient for these very low income families and is coming in far too late. Poor children should not be waiting for action on the Welfare Expert Advisory Group report in 2019 for any extra relief.

The New Zealand Treasury's Living Standards Framework (LSF), a work in progress, is one possible public policy model, where "interconnected and complementary policy interventions are jointly targeted at growing, shaping, managing, appropriately distributing capital stocks across society and across generations, and protecting them against systemic risks" (Karacaoglu, 2015, p. 31).

Karacaoglu's proposed ingredients of a policy package comprising a set of complementary policy interjections include: investments in economic and social infrastructure to increase potential economic growth; enhanced sustainability of comprehensive wealth favouring 'clean' technology; incentivising more investment in training and education to influence the evolution of equity; enhance social cohesion by investing in the teaching of different languages and cultures, actively encouraging the mixing of communities, and engage in equity-improving and poverty-reducing measures; and enhance economic, environmental and social resilience to potential systemic shocks.

Although these measures offer the potential to enhance our collective wellbeing, whether that potential will be realised or not will depend on the effectiveness and efficiency of the choice of policy instruments and how they are implemented - including their effects on private individuals' incentives to do the best they can for themselves and their businesses. (Karacaoglu, 2015, p. 32)

Moreover:

measuring the economy is not like measuring the natural world. Economic relationships are always changing, and so our measurement systems need to adapt. The way we choose to hold a tape measure to reality can influence the way we choose to cut our cloth. (Makhlouf, 2017, p. 2)

However, this paper would suggest that the urgency and enormity of the demographic change requires further policy changes,¹¹ for example:

Early intervention to support unemployed youth and those not in employment, education or training (NEET) more broadly is crucial. Non-employed young people are often not in contact with public employment services (PES); without a sufficient contribution period they are often not entitled to out-of-work benefits. As a result, they are often excluded from training or job-search support programmes; this, in turn, increases their risk of becoming long-term inactive. (Government of the Republic of Slovenia & OECD, 2018, p. 6)

To promote health and well-being, in addition to providing prevention, screening services and primary care for low or no cost to prevent diseases and encourage early detection of diseases,

many OECD countries have introduced mechanisms to facilitate health care access for low-income patients through co-payment reductions or exemptions. In emerging economies a major issue in access to health is that, even when people have the right to obtain essential medicines and treatments free of charge, these, provided in principle by the public sector, may not be available due to budget constraints. Health systems also need to be adapted to better manage the growing number of people living with one or more chronic conditions, many of whom are over 65 and come from lower socio-economic groups. In particular, health care should be better integrated across various disciplines towards a patient-centred

¹¹ In June, C. Smith's (2018), "Treasury Living Standards Dashboard: Monitoring Intergenerational Wellbeing" commissioned by Treasury, was published for public consultation.

approach. There is a growing recognition that managing the care of ageing population will require interdisciplinary teams who can provide a seamless care between health and social care. (Government of the Republic of Slovenia & OECD, 2018, p. 5)

More specifically regarding pensions policy: "In New Zealand and across the world, pensions policy has tended to favour present over future generations" (Commission for Financial Literacy and Retirement Income, 2013), hence it is equally necessary to look at the access and eligibility rules for NZS. There is a subsidiary need to correct the long-lived and widely shared misapprehension that people's tax contribution is pre-funding their future old age pension entitlements (Commission for Financial Literacy and Retirement Income, 2013). This has never been the case. Tax revenue is used by the governments of the day to help finance social security, education and health spending at the time.

In Japan, advocates are proposing to solve the age pension funding and intergenerational equity problems by delaying the qualifying age to 75 years: "If people live longer, it would be natural for them to keep working longer in order to support themselves." (Saruyama, Maeda, Hasumi, & Kuroiwa, 2017, p. 4). Raising the qualifying age for NZS may appear to be the easiest and most effective incentive to support longer working lives and solve the funding problem, but it could have unintended side effects, including significant increases in aged poverty among those unable to find or continue suitable employment. In New Zealand as in other countries with ageing populations, for those who retire before reaching the qualifying age, there would need to be "a mixture of public and private sector solutions including forms of unemployment insurance, which could be targeted specifically at this group and act as a bridging mechanism between leaving work early and retirement" (Franklin & Hochlaf, 2017, p. 11).

Adoption of flexible working practises might encourage greater numbers of older adults to remain in employment. Importantly, older workers are not seeking an easy transition into retirement, with 71% preferring a challenging and rewarding role, in which they are prepared to work hard (Lonergan Research Pty Ltd, 2014, p. 12). Amongst the older workers who remain in the workforce, whether in the Crown Entity sector or private sector, financial necessity is a primary driver, and half of Crown Entity workers aged 50+ who participated in the survey did not feel confident they have enough savings to carry them through retirement (Lonergan Research Pty Ltd, 2014, p. 6). This is aligned to the perceived adequacy of retirement savings. As life expectancy increases, people will need a larger retirement savings pot in order not to outlive it (Deloitte, 2011).

Dale and St John (2016) in a paper for the Retirement Commissioner's review of retirement income policies in 2016 address a key issue of current retirement policy.¹² Residency required to qualify for NZS is only 10 years after age 20, with 5 of those years after age 50. Internationally, many countries are increasing their qualifying age to a minimum of 67 years, and most countries require contributions for 30 to 50 years in order to qualify for a full state pension. Easy access to NZS makes New Zealand a desirable retirement destination, and poses a potential fiscal black hole.

KiwiSaver and the New Zealand SuperFund will not solve the future funding problem. KiwiSaver was introduced in 2007, and while total savings climbed to \$50 billion by the end of September 2018, the average balance of the 2,800,000-odd members is under \$15,000, and KiwiSaver makes no difference to the cost of NZS because there is no means test on NZS. While some do very well, many close to retiring will get very little. The NZ SuperFund, introduced in 2003 and now at \$37 billion, will contribute only 13% of the cost of NZS in 2078, with the tax paid by the Fund contributing a further 8.5%. While in December 2017, the newly elected Government resumed contributions to the Fund,

¹² The Dale and St John paper is available at <https://www.cffc.org.nz/assets/RetirementIncomeReview2016/708-International-Picture-RPRC-NZ-Super-And-Overseas-Pensions-2016.pdf>.

planning to add \$7.7 billion between now and June 2022 (Business Desk, 2017), it is hard to see this as a priority for government spending.

Another policy change would be supporting the introduction of safe and fair long term care insurance and annuity products to enable intragenerational sharing of the costs of the ageing population (St John, 2015, 2016; St John, Dale, & Ashton, 2012). The lack of a simple, secure income insurance over and above the base annuity provided by NZS for middle income New Zealanders is another serious hole in our retirement income policies. The annuity could be linked to economic growth in some way to protect against falling behind growth in real wages, and have an add-on insurance for long-term care.

Thinking has finally moved beyond medical and health issues in the Ageing Well National Science Challenge. As reported by Chair, Dr McCarthy in the AWNSC December Newsletter (2017), nationwide consultation around Tranche 2 investment plans found that, of the proposed research focus areas, *Healthy Ageing in Individuals and Groups*, and *Age Friendly Environments* received the highest ranking from respondents. Within the specific research priorities identified across the focus areas, the following were ranked as the most important priorities:

Shaping housing, neighbourhoods and transport to maintain autonomy, wellbeing, and identity;

Design and delivery of interventions for health promotion, that support daily functioning and well-being through sustaining physical and mental capacity, and social connectedness;

Effectiveness and efficiency of health and social services for older people; enhancing access, configuration, quality and provision of services, in the face of comorbidity and complex geographic, social, family, financial and housing circumstances; and

What works for older Māori: access to, and quality of, health and social services.

Dealing with similar concerns, after a cross-party inquiry found elderly care standards are falling, Labour have pledged to introduce an Aged Care Commissioner to protect older Kiwis from breaches in standards of care.¹³ Concerns aired at nine meetings over the past six months covered substandard housing provision, standards of residential and community-based care, access to surgery and elder abuse. Health Minister Clark has said independent oversight of the sector is needed from someone with statutory powers and the ability to investigate and make recommendations to Parliament (Broughton, 2017).

At the most practical level, minor adjustments to housing can make remarkable differences to both health and quality of life for older people, and the return on investment (ROI) is appreciable (Centre for Ageing Better, 2017). These changes may be as simple as installing handrails in bathrooms and toilets.

The ageing of the population presents an opportunity and an imperative to make changes in the housing sector to enable older adults to age in place and maintain their social, business, and service connections, according to AFCC principles. (Davey, 2017, p. 22)

Ageing in place is the preferred option for governments because of its lower cost to the state than residential care, and the preferred option for individuals for multiple reasons including independence, community, and familiarity. To realise this option, consideration needs to be given to housing types and features, transport, social, cultural, educational and recreational opportunities, and amenities that facilitate physical activity. As Davey (2017, p. 21) writes:

There is growing recognition that neighbourhoods and communities are crucial factors in people's ability to stay where they are and to age well.... Age-friendliness

¹³ This is honouring an election pledge.

requires the reduction of environmental barriers and the improvement of environmental supports, so that older people can meet their needs more easily and maintain their independence for as long as possible.

Boston and Stuart (2015) suggest other options for policy change that could contribute to intergenerational equity. Their examples include public agencies with 'guardianship-type' roles in relation to future generations; advisory bodies with responsibilities to promote sustainable development; parliamentary committees with specific duties to consider long-term issues; legislative requirements for governments to produce regular reports on their efforts to protect citizens' long-term interests; and incorporating specific requirements into domestic statutes (Boston & Stuart, 2015, p. 68).

Developing explicit constitutional recognition for future generations,.. has the potential to ensure that rights today are not unduly valued over rights tomorrow. With the inclusion of appropriate wording, a constitution can give future generations greater moral and legal status and increase the extent to which executive, legislative and judicial bodies consider the long-term consequences of their actions.... [I]n a democracy like New Zealand with an unwritten constitution it would give added legal recognition to future generations and, depending on the specific wording, could elevate their interests to the level of enforceable fundamental rights. (Boston & Stuart, 2015, p. 65)

Legislation along these lines was introduced by the Welsh Government (2015): Well-being of Future Generations (Wales) Act.¹⁴ The Act is intended to make the public bodies listed in the Act think more about the long term, work better with people and communities and each other, attempt to prevent problems and take a more collaborative approach. This new law means that, for the first time, public bodies listed in the Act must ensure that, when making their decisions, they take into account the impact they could have on people living in Wales in the future. The Act also establishes Public Services Boards (PSBs) for each local authority area in Wales, which must improve the economic, social, environmental and cultural well-being of its area by working to achieve the well-being goals (Welsh Government, 2015). The well-being goals are: A Wales that is prosperous, resilient, healthier, and more equal; a Wales of cohesive communities, vibrant culture and Welsh language; and a globally responsible Wales (Welsh Government, 2015).

The Act also establishes a statutory Future Generations Commissioner for Wales,¹⁵ whose role is to act as a guardian for the interests of future generations in Wales, and to support the public bodies listed in the Act to work towards achieving the seven well-being goals. The Welsh Government has also defined sustainable development as:

The process of improving the economic, social, environmental and cultural wellbeing of Wales by taking action, in accordance with the sustainable development principle, aimed at achieving the well-being goals. (Future Generations Commissioner for Wales, 2017)

In late June 2018 that the Minister for Seniors, Hon Tracey Martin, launched "*Discussion Document He Pukapuka Matapaki: Developing a new strategy to prepare for an ageing population*" (Office for Seniors, 2018).¹⁶ The Office for Seniors Te Tari Kaumātua, part of the Ministry for Social Development, has close links with community organisations representing the interests of older people, like Grey Power and Age Concern NZ.

In a message introducing the *Discussion Document*, the Minister said how we respond to our ageing population will have a huge impact on New Zealand's economic growth:

¹⁴ See <http://gov.wales/topics/people-and-communities/people/future-generations-act/?lang=en>.

¹⁵ See <https://futuregenerations.wales/>.

¹⁶ See <http://www.superseniors.msdc.govt.nz/about-superseniors/ageing-population/index.html>. The consultation is open from 29 June to 24 August 2018. After this date, officials will draft a new strategy and an action plan, then a second round of consultation will take place in early 2019.

Not only will Seniors be a vital part of a 21st century workplace, but in the next twenty years our country will turn to them more and more for the contribution they make as taxpayers, carers, consumers, volunteers, and employees. If, in a little under 20 years, people aged 65+ are to make up almost a quarter of our population, the implications for our economy, workforce, healthcare and government services will be significant. We need more than a "whole-of-government approach". We need everyone – government, local government, non-governmental organisations, communities, whānau, family, individuals, and businesses – to work together.

While the *Discussion Document* outlines some of the issues, the aim is to find out what Kiwis of all ages want for the future, and to understand their priorities.

The new Strategy will inform the development of a common platform to support central and local government, nongovernmental organisations, businesses and communities to work together to respond effectively to the changing shape of society. The new Strategy will need to support and complement some key strategies that have already gone through a comprehensive public consultation process, including the Healthy Ageing Strategy 2016, Carers' Strategy 2008 and Carers' Strategy Action Plan for 2014 to 2018, and the Disability Strategy 2016.

Also in late June 2018, the Hon Tracey Martin launched a white paper from a working group co-ordinated by the Employers & Manufacturers Association and the Commission For Financial Capability on the ageing workforce: "*Act Now Age Later: Unlocking the potential of our ageing workforce*". An ageing population, a declining birth rate and a deepening skills shortage demand that New Zealand intelligently manages its ageing workforce. The impact of an ageing workforce on some sectors is already starting to bite. For example, with almost 24% of New Zealand's workforce aged 55-plus years there are only four to five teachers/nurses to replace every 10 that will retire. Similarly, a 2016 workforce survey by the Royal New Zealand College of General Practitioners found 44% of all GPs plan to retire within 10 years (up from 36% two years prior).

The most recent EMA Employers Survey showed 83% of employers have no plans to address the challenge presented by the ageing population. At the launch of the white paper, Kim Campbell, CEO, EMA said:

There are many dimensions to an ageing population, however by focusing on the workforce we are able to weave together the strands of government, employers and workers.

The white paper outlines three key recommendations for consideration:

1. A national strategy on the ageing workforce to ensure Government agencies work collaboratively on key policies;
2. Establishment of a Government-led taskforce, or similar, responsible for designing key outcomes and co-ordination of key stakeholders in an independent manner; and
3. Development of an ageing workforce tool-kit for both employers and workers to ensure their future needs are met (Employers & Manufacturers Association and Commission for Financial Capability, 2018).¹⁷

Then on 10 July 2018, the Environment and Community Committee of Auckland City resolved to join the World Health Organisation Global Network of Age-friendly Cities and

¹⁷ The report is available from EMA here: <https://www.ema.co.nz/resources/EMA%20Reports%20and%20Documents/Advocacy/Act%20Now%20Age%20Later-Aging%20Workforce%20White%20Paper%202018.pdf>.

Communities. Committee Chair Councillor Penny Hulse explained the importance of this decision:

*Auckland will be home to larger numbers and greater proportions of ethnically and culturally diverse older people over the next few decades. Our older population is growing faster than any other age-group and is predicted to increase from 11% in 2013 to 19% by 2046.*¹⁸

Age Concern and many other organisations and individuals have been advocating that New Zealand cities join this WHO network since 2011 when Age Concern held their first symposium on the subject. Membership of the network requires a commitment to a continuous improvement process for creating age-friendly environments. International membership of the global network has increased from 302 cities in 2016 to 600 cities in 2018, sharing the expectation that an age-friendly city is more inclusive and beneficial for everyone, regardless of their age. This means age-friendly cities are more intergenerationally equitable.

5. Concluding remarks

The previous New Zealand Government maintained a determined silence on the issues of an ageing population for their 9 years in office. We need to catch up, and adopt the best policies and legislation that has been developed elsewhere. We cannot afford to delay addressing the urgent issues associated with population ageing, and with the equity issues that emerge partly as a consequence of that demographic change and primarily a consequence of unfettered capitalism.

According to Oxfam, the combined wealth of New Zealand billionaires Graeme Hart and Richard Chandler exceeds that of the poorest 30% of the population: the Kiwi 1% owns 20% of the country's wealth. The OECD's latest income-inequality data shows the gap is biggest for Chile then Mexico and the US, with New Zealand in 13th place (Woulfe, 2017). Inequality appears to effect life expectancy, murder and violent crime, school dropouts, obesity, depression and mental illness (Woulfe, 2017).

Behaviour is estimated to account for only about a third of inequality's effect on health; the other two-thirds can be put down to stress (Payne, 2017). Perhaps this is associated with the fact that countries like New Zealand are no longer lands of opportunity for all: their inequality, especially at the top, is due to rent-seeking and therefore bad for growth (Stiglitz, 2012).

It is important to recognise that governing well for the future entails a concern for each and every point in time beyond the immediate present. It is not limited to protecting the interests (needs or rights) of future generations if by this is meant those who are not yet born. Governments must also serve the interests of those alive today, some of whom may live for a hundred years or more. (Boston, 2017, p. 135)

Action that could be taken now to improve intergenerational equity includes improving support for families and reducing child poverty; joining international organisations focussed on sharing information to create age-friendly communities; establishing a Parliamentary Commission for the Future; and introducing safe, fair long term care insurance and annuity products to enable intragenerational sharing of the costs of the ageing population.

¹⁸ The press release, *Auckland to join global network of age-friendly cities*, is available here: <http://ourauckland.aucklandcouncil.govt.nz/articles/media/council/2018/07/decision-digest-environment-and-community-committee-july-2018/>.

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