



INTERNATIONAL
INSTITUTE
OF LONGEVITY



longevity think tank

Longevity clinics at an inflection point: from expansion to accountability



Executive Summary

Longevity medicine is transitioning from a conceptual framework to a rapidly expanding clinical domain. This report analyses findings from the Global Survey on Health, Wellness and Longevity conducted October 2025–January 2026 as a collaboration between the International Institute of Longevity and Longevity Think Tank. The primary focus of this report is a sub-sample of 22 longevity clinics across four regions, complemented by insights from a broader ecosystem of 50 organisations, including technology providers, wellness operators, and research institutions.

Across this synthesis, three structural tensions emerge: the pace of clinical adoption relative to evidence generation, the mismatch between data availability and validated measurement, and a broader shift from aspirational models of care to demands for clinical accountability.

Longevity clinics are rapidly integrating molecular diagnostics, imaging, behavioural interventions, and longitudinal monitoring into a model of care focused on early detection and modification of age-related disease risk. However, this clinical expansion is occurring faster than the evidence and the measurement & operational frameworks required to support it.

The future legitimacy of longevity medicine will depend not only on continued innovation, but on the development of shared measurement systems, coordinated data infrastructure, and agreed standards of responsible clinical practice.

Importantly, these findings also reflect a shift in how clinics must define success—not only in terms of growth and service offering, but in the ability to deliver consistent, measurable outcomes and a high-quality patient experience. Addressing lack of standardization and workforce shortages will be crucial.

A summary of overall findings and strategic implications from the longevity clinic sub-sample is in Figure 1 below.



Figure 1 | Key findings and strategic implications for longevity clinics.

Survey data from 22 longevity clinics highlight a sector characterised by rapid expansion, increasing reliance on biomarker-driven assessment, and strong demand for preventive, longitudinal care models. At the same time, variability in measurement, lack of standardisation, and workforce constraints limit the ability to deliver consistent, high-quality client outcomes at scale. These dynamics reflect a broader transition in the field—from innovation to accountability—where clinics must increasingly demonstrate measurable impact, integrate data into actionable care pathways, and balance clinical credibility with a differentiated patient experience. Regional trends further reveal significant white-space opportunities, particularly in the UAE/GCC, where high growth expectations contrast with limited current clinic presence.

Introduction

Longevity medicine has emerged as a bridge between advances in geroscience and their practical implementation in clinical care. By integrating diagnostics, lifestyle interventions, and longitudinal monitoring, it seeks to address a longstanding limitation of preventive medicine: the absence of scalable, individualised, and continuously managed models of care.

Over the past decade, this model has moved from theoretical proposition to operational reality. Within the clinic sub-sample, 86% report current use of biological age assessments, with universal adoption anticipated in the near term. At the same time, all clinics surveyed report plans to expand their services or geographic footprint, and the majority are investing in advanced technologies, including artificial intelligence and wearable-based monitoring.

Despite this convergence, clinics are not homogeneous. Considerable variation exists in clinical focus, spanning preventive health, functional medicine, and longevity optimisation models. Nevertheless, a clear core model is emerging, centred on medical consultation, diagnostics, and biomarker-driven assessment.

These trends are reinforced by the broader ecosystem, where rising demand for personalised health and increasing reliance on technology platforms are reshaping care delivery. Clinics are therefore operating within a wider network of partners, including technology providers, wellness and hospitality operators, and research institutions.

This rapid expansion signals a field entering a phase of scale. However, it also exposes a set of structural challenges. Longevity medicine is evolving faster than the scientific and clinical frameworks required to support it. The central question is therefore no longer whether the field can develop innovative approaches to

healthspan extension, but whether it can deliver these approaches in a manner that is measurable, reproducible, and clinically accountable.

This divergence between clinical expansion and evidentiary development is illustrated in Figure 2.

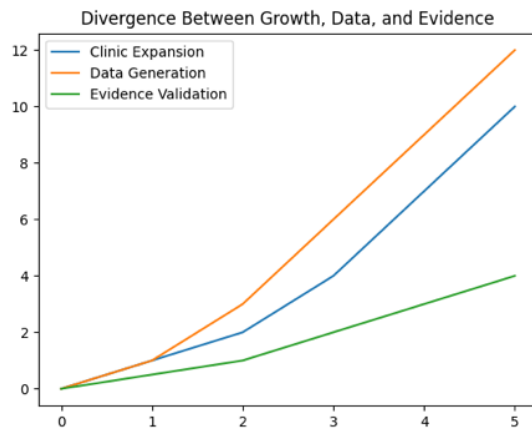


Figure 2 | Divergence between clinical expansion and evidentiary development in longevity medicine.
The rapid growth of longevity clinics and associated data generation is occurring ahead of the development of validated measurement frameworks and clinical evidence, creating a structural gap that defines the current phase of the field.

Clinical expansion ahead of evidence

The defining feature of the current phase of longevity medicine is the divergence between the pace of clinical adoption and the development of its evidence base.

Clinics are implementing integrative models combining diagnostics, behavioural interventions, and continuous monitoring, enabling earlier detection of disease risk and more precise intervention. These approaches are beginning to reveal clinically relevant insights not captured by conventional screening.

However, key components of this model remain insufficiently validated. Biomarker use is widespread but non-standardised, with variability in frequency, interpretation, and integration into clinical workflows. While biological age assessments are increasingly utilised, there is limited consensus regarding their clinical meaning or responsiveness to intervention.

The distribution of biomarker use across clinics reflects both widespread adoption and variability in clinical integration (Figure 3).

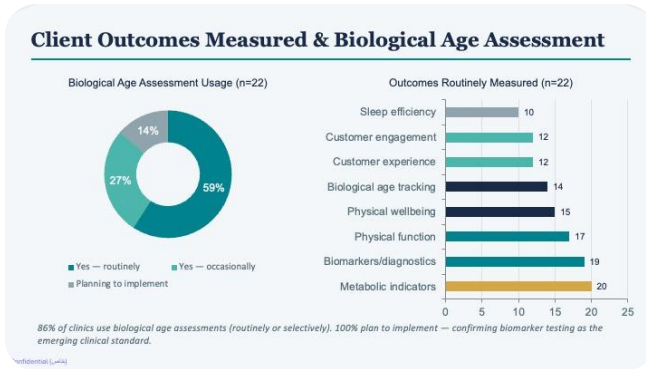


Figure 3 | Distribution of biomarker use across longevity clinics.

Biomarker-driven approaches are widely adopted but not uniformly integrated or standardised in terms of outcomes assessment. While a majority of clinics report routine use, a significant proportion use biomarkers intermittently or are still in the process of implementation, reflecting variability in clinical workflows and interpretation.

Composite assessments integrating multiple data streams are becoming more common, yet their relationship to long-term health outcomes remains unclear.

This creates a structural paradox: clinical practice is advancing in anticipation of evidence that has yet to be fully established. While this accelerates innovation, it introduces risks related to variability in care, overinterpretation of data, and premature adoption of interventions.

The measurement bottleneck

If the expansion of longevity medicine is characterised by data abundance, it is equally defined by limitations in measurement.

Clinics are generating large volumes of longitudinal data, including molecular, imaging, and behavioural metrics. However, the ability to translate these data into clinically meaningful endpoints remains constrained. This bottleneck is illustrated in Figure 4.

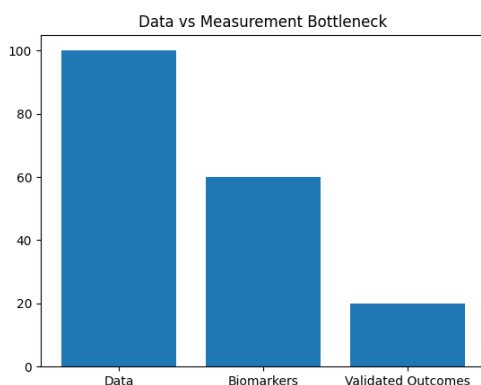


Figure 4 | The measurement bottleneck in longevity medicine.

Although clinics generate large volumes of multi-modal data, the absence of standardised, clinically validated endpoints limits the translation of these inputs into actionable, reproducible and comparable outcomes.

Biological age metrics illustrate this challenge. While widely adopted, they can produce divergent results depending on methodology, and their modification does not yet reliably correlate with improved clinical outcomes.

Clinical decision-making increasingly relies on complex, multi-modal datasets that are difficult to interpret and standardise. This creates risks of overdiagnosis, misclassification, and inconsistent care pathways, while complicating communication with patients.

Measurement—not discovery—therefore emerges as the central bottleneck. Without reliable, reproducible, and clinically meaningful metrics, it is not possible to evaluate interventions, compare outcomes across clinics, or establish a robust evidence base.

From aspiration to accountability

The maturation of longevity medicine is accompanied by a shift from aspirational narratives to demands for accountability.

Clinics are under increasing scrutiny from regulators, the medical community, and an increasingly informed consumer base. Within the clinic sample, lack of standardisation and shortages of trained practitioners are identified as the primary constraints on growth. These constraints are quantified in Figure 5.

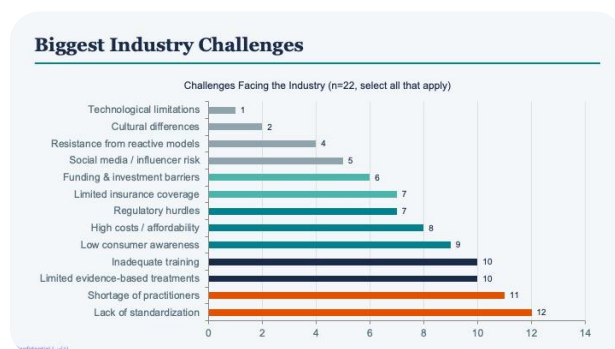


Figure 5 | Structural constraints limiting the scalability of longevity clinics.

Surveyed clinics identify lack of standardisation and workforce shortages as the primary barriers to delivering consistent, high-quality care at scale, highlighting system-level limitations rather than isolated operational challenges.

These are structural challenges that directly limit the ability to deliver consistent, high-quality care at scale.

At the same time, the use of unvalidated interventions and poorly characterised compounds raises ethical and safety concerns, highlighting the need for clearer boundaries around acceptable practice.

Accountability in this context operates across multiple dimensions. Clinically, it requires continuity of care and systematic outcome tracking. Scientifically, it demands validation of biomarkers and rigorous evaluation of interventions, including through real-world data. Ethically, it involves defining acceptable risk and ensuring transparent communication with patients.

The transition from aspiration to accountability is therefore not a constraint, but a necessary condition for the field's legitimacy.

Scaling without coordination

Longevity clinics are entering a phase of rapid expansion. All clinics surveyed report plans for growth, with a majority intending to open new locations and invest in technology. Engagement patterns suggest a shift toward structured, repeat interactions—most commonly quarterly—indicating movement toward longitudinal care models rather than episodic interventions. The divergence between expansion and system readiness is shown in Figure 6.

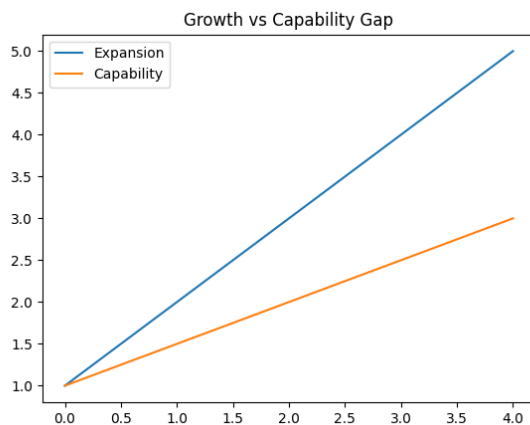


Figure 6 | Divergence between expansion and operational capability.

While all surveyed clinics report plans for expansion, the development of shared standards, training pathways and measurement frameworks is lagging, creating risks to consistency, comparability and clinical quality.

Clinics are increasingly functioning as integrated care platforms, combining diagnostics, monitoring, intervention, and behavioural management into continuous health programmes.

However, this expansion is occurring in the absence of shared clinical and operational frameworks. Differences in diagnostic approaches, biomarker selection, and intervention strategies limit comparability and hinder the development of best practice.

This lack of coordination extends beyond individual clinics. It constrains data aggregation, slows evidence generation, and limits engagement with regulators and payers.

Geographic patterns further shape this expansion. Both clinic-specific and broader ecosystem data identify the UAE/GCC as a leading region for future growth, despite relatively limited current clinic density. These markets exhibit higher levels of technology adoption and premium client engagement but also reveal gaps in areas such as mental and behavioural health integration, highlighting region-specific development pathways. Regional variation in growth dynamics is illustrated in Figure 7.

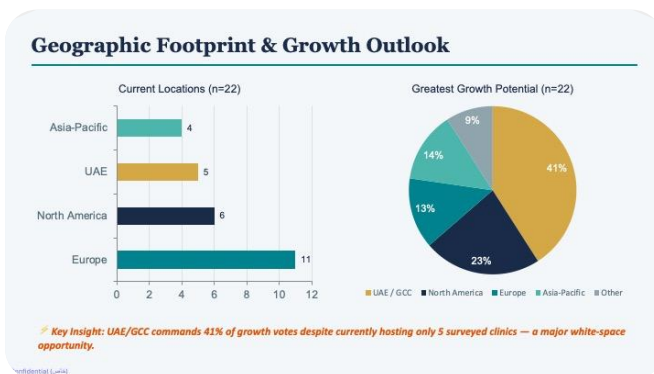


Figure 7 | Emergence of regional hubs in longevity medicine.

Survey data indicate that regions such as the UAE/GCC are expected to experience the highest growth in longevity clinic activity, despite relatively limited current clinic density, suggesting a shift toward geographically concentrated expansion and early adoption of integrated care models.

Toward a coordinated model of longevity medicine

The challenges identified above point toward the need for a more coordinated approach to the development of longevity medicine.

This requires:

- agreement on core datasets and outcome measures
- development of shared standards for diagnostics and monitoring
- mechanisms for aggregating and analysing longitudinal data across clinics
- structured training pathways to build clinical and operational capability

In this context, clinics function not only as care providers but as distributed data-generation nodes, collectively shaping the empirical foundation of the field.

Coordination does not imply uniformity. Rather, it provides a framework within which variation can be evaluated and refined, enabling collective learning.

Real-world data generated by clinics has the potential to play a central role in this process. While not a substitute for controlled trials, longitudinal datasets can provide critical insights into intervention effectiveness when analysed at scale.

The transition required—from fragmented clinical experimentation to coordinated, multi-stakeholder systems—represents the defining challenge of the next phase. The transition required for the field to mature—from fragmented clinical models to coordinated systems—is illustrated in Figure 8.

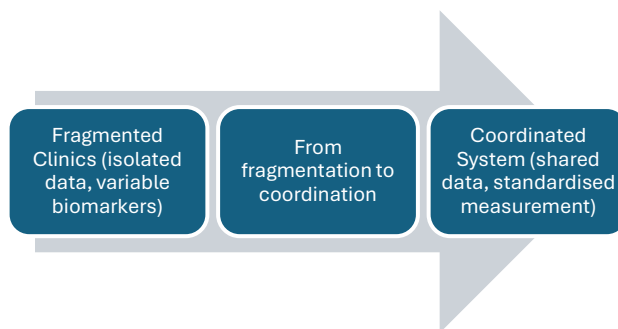


Figure 8 | Transition from fragmented innovation to coordinated clinical systems.

The maturation of longevity medicine will depend on the transition from isolated clinical models and heterogeneous datasets toward coordinated frameworks integrating shared measurement standards, longitudinal data and collective clinical learning.

Conclusion

Longevity medicine is entering a decisive phase in its development. The initial period of innovation has established the plausibility of a more integrated, preventive model of care. The current phase demands a shift from expansion to validation, from data generation to measurement, and from aspiration to accountability.

The future of the field will depend on its ability to align these elements. Clinics must not only innovate but demonstrate that their approaches lead to meaningful and reproducible improvements in health outcomes.

Importantly, the structural gaps identified do not only represent constraints. They define a critical opportunity space—particularly in the development of shared measurement systems, integration of real-world data, and scaling of technology-enabled care models.

The central question is not whether longevity medicine can extend healthspan in principle, but whether it can do so in practice—responsibly, safely, and at scale.

This is at the heart of the work of the International Institute of Longevity working with its members and partners worldwide.

Implications for Clinic Leaders

Longevity clinics are entering a phase where success will be defined not only by growth and innovation, but by the ability to deliver consistent, measurable outcomes and a high-quality patient experience. Clinic leaders should prioritise the integration of validated biomarkers into clear clinical pathways, invest in data systems that enable longitudinal tracking and actionable insights, and develop multidisciplinary teams capable of interpreting complex datasets. At the same time, differentiation will increasingly depend on designing seamless, personalised care journeys that balance scientific credibility with client engagement. As the field moves toward greater accountability, clinics that align operational scale with standardisation, outcome measurement, and responsible practice will be best positioned to lead.