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National Study of Abuse of Older People

Summary of findings

AUT
TE WĀNANGA ARONUI O TĀMAKI MAKAU RAU

TE KĀHUI RANGAHAU MANA TAURITE
NEW ZEALAND POLICY RESEARCH INSTITUTE

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The views expressed in this report are those of the authors and do not necessarily reflect those of the MSD or any other government agency.

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Disclaimer

The following disclaimer applies to findings based on analysis of data from the Integrated Data Infrastructure (IDI).

These results are not official statistics. They have been created for research purposes from the Integrated Data Infrastructure (IDI), which is carefully managed by Stats NZ. For more information about the IDI please visit https://www.stats.govt.nz/integrated-data/

Access to the data used in this study was provided by Stats NZ under conditions designed to give effect to the security and confidentiality provisions of the Data and Statistics Act 2022. The results presented in this study are the work of the authors, not Stats NZ or individual data suppliers.

The results are based in part on tax data supplied by Inland Revenue to Stats NZ under the Tax Administration Act 1994 for statistical purposes. Any discussion of data limitations or weaknesses is in the context of using the IDI for statistical purposes, and is not related to the data's ability to support Inland Revenue's core operational requirements.



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EXECUTIVE SUMMARY

Key messages at a glance

- One in six older people in Aotearoa New Zealand (NZ) experiences abuse each year – around 256,000 people.
- Māori, Pacific peoples, those with disabilities and/or who are socially isolated, Takatāpui and Rainbow communities, and those in high-deprivation areas are most affected.
- Abuse brings serious health, social, and financial impacts, costing at least NZ$1.78 billion annually, most of which falls on victims and their families.
- Current administrative data capture only the most severe cases, and abuse in aged residential care (ARC) remains largely invisible.
- Stronger legal protections, clear and accessible referral pathways, better data, and cross-sector prevention are needed to reduce the abuse of older people (AOP).

The National Study provides the first full picture of AOP in NZ

The *National Study of Abuse of Older People* combined a prevalence survey, administrative data analysis, qualitative interviews, financial sector research, and economic modelling. This report synthesises the findings from all components of the study, providing the most comprehensive evidence to date on the scale, nature, impacts, and costs of AOP in NZ.

One in six older people experience abuse each year

The Prevalence Survey found that 16.7% of people aged 55+ (around 256,000 people) experienced harm from someone they knew in the past year. Psychological harm was most common (12.4%), followed by financial (4.0%), cultural & spiritual (3.2%), physical (2.8%), neglect (1.2%), and sexual harm (0.9%). Much of this harm occurred within family relationships. Only a little over half of victim-survivors sought help, with many reporting unmet needs for emotional and practical support.

The prevalence of abuse varies across groups

Māori, Pacific peoples, disabled people, Takatāpui and Rainbow communities, and those living in high-deprivation areas were more likely to experience abuse. Social isolation was a key risk factor, as were complex living arrangements, including caring for children and/or grandchildren with high need. Older women were more likely to report a child or other family member as the main person responsible for harm. Older people often experienced multiple, overlapping forms of harm, with patterns varying across population groups. The research also identified gaps in support services, particularly culturally-appropriate support.

Administrative data only capture the most severe cases

Analysis of the Stats NZ Integrated Data Infrastructure (IDI) showed that administrative records capture only a small share of harm in the population – mainly physical assaults resulting in contact with police, hospitals, or the Accident Compensation Corporation (ACC). This limitation means that administrative data substantially underestimate the overall prevalence of AOP, with particularly poor coverage of some forms of harm, such as financial abuse. Even so, IDI data confirmed inequities, with younger older people (55–64 years versus 65+), Māori, and people in high-deprivation areas disproportionately affected. The administrative data also highlighted health impacts: higher use of mental health prescriptions after sexual and physical assault, and short-term increases in hospitalisations and ACC payments after physical assault.

Aged residential care is a major evidence gap

Around 30,000 people live in ARC in NZ, but little is known about the scale or nature of AOP in these settings. Current data sources do not capture ARC adequately. Addressing this gap should be an urgent priority.

Abuse has lifelong impact and intergenerational roots

Older people who participated in the qualitative interviews spoke about being silenced, invisible, and/or isolated, marginalising them within their families, whānau, and support networks. Their experiences showed that harm rarely began in later life, reflecting earlier trauma, discrimination, or family violence that evolved as people aged. Family members also used older people's relationships with their grandchildren to manipulate or control them, including by threatening to restrict contact. The impacts of harm included disconnection from family and whānau, diminished cultural & spiritual roles, disrupted employment, financial stress, and loss of housing and assets. Structural and systemic failures in legal protections and service systems contributed to harm.

Gaps in legal safeguards enable financial abuse

Banking and legal professionals revealed serious gaps in protections. Misuse of Enduring Powers of Attorney (EPOAs) was a common concern, with weak accountability and oversight. Referral pathways are ad hoc, leaving many victim-survivors without support. Professionals emphasised the need for clearer legal safeguards, comprehensive cross-sector collaboration, and accessible referral pathways to detect and respond to financial harm. Consistent data collection is required to fill the remaining knowledge gaps.

The economic cost of AOP is NZ$1.78 billion each year

Economic analysis estimates that AOP costs the NZ economy at least NZ$1.78 billion annually. Most of this (NZ$1.17 billion) falls directly on victims and families through financial losses, increased need for residential care, and lost earnings. The Government bears around NZ$615 million in costs, mostly to the health system. Wider society also absorbs compliance and opportunity costs. Non-economic harms, such as reduced wellbeing and loss of cultural connection, add further unmeasured costs that are not included in the $1.78 billion estimate. There is a clear economic case for preventing AOP.

Preventing AOP is a social responsibility

Greater public awareness of the types and tactics of AOP is crucial to challenge ageist stereotypes that hide abuse and silence older people. The findings highlight four overarching messages:

- AOP is a problem in NZ – it affects one in six older people, with major health, social, and economic consequences.
- AOP is not experienced uniformly – inequalities are stark, in terms of both abuse prevalence and access to support services.
- AOP in aged residential care is largely invisible – this is a critical evidence gap needing urgent attention.
- AOP needs public awareness and systemic solutions – institutions and legal tools can help prevent harm, but weaknesses in these systems can also contribute to it.

Recommendations centre on prevention, equity, and stronger systems

- Prioritise communities at greatest risk with urgent, tailored support, and investment.
- Strengthen safeguards in law and professional practice, including urgent reform of the Protection of Personal and Property Rights (PPPR) Act and stronger oversight of Enduring Powers of Attorney (EPOAs).
- Develop clear, accessible referral pathways and cross-sector training so financial, health, justice, and community services can identify and respond to harm.
- Fill knowledge gaps by investing in data and research, especially on aged residential care, and among younger cohorts aged 55–64, and continuing work underway (e.g. research with Takatāpui and Rainbow older people).
- Recognise older people's wellbeing as a societal responsibility and key pillar of NZ's preparedness for an ageing population. Prevention is a sound economic investment, reducing downstream costs to the health, welfare, and justice systems.

1. INTRODUCTION

This report is part of the *National Study of Abuse of Older People in Aotearoa New Zealand* commissioned by the Ministry of Social Development (MSD) as part of its Prevention of Abuse of Older People (AOP) work programme. The National Study was undertaken in 2024 and 2025, with the wider project including five main components:

1. Prevalence Survey – A nationally representative survey capturing older people's self-reported experiences of abuse.
2. Integrated Data Infrastructure (IDI) analysis – Examination of AOP through linked administrative datasets, including police, Accident Compensation Corporation (ACC), hospital admissions, InterRAI, and the NZ Crime & Victims Survey (NZCVS).
3. Qualitative Interviews – In-depth interviews with older victim-survivors of abuse to explore the contexts in which AOP occurs, and the barriers and enablers to seeking help across four groups: Māori, Pacific, NZ European, and disabled people.
4. Contextual analysis of financial abuse – Mixed methods study exploring how financial abuse is identified, addressed, and prevented within financial institutions, supplemented with insights from the legal sector.
5. Analysis of economic and social costs – Estimates the economic impact of AOP on individuals, whānau, communities, and government systems, and outlines broader social consequences such as reduced wellbeing and lost productivity.

This study includes 10 key reports:

1. Overall synthesis report, summarising the key findings from all parts of the project (this report).
2. Disability synthesis report, summarising key findings about AOP among disabled older people.
3. Survey findings report, presenting results from the *Prevalence survey on the abuse of older people in Aotearoa New Zealand*.
4. Survey methodology report.
5. Survey thresholds report, a supplementary report to the main *Prevalence Survey Report* that presents research into the application of AOP thresholds to the survey data.

6. Main *Evidence from the Integrated Data Infrastructure (IDI)* report, detailing analysis of AOP among those living in the community using administrative and NZCVS data from the IDI.
7. Supplementary IDI report on AOP among those in ARC.
8. *Qualitative Interviews Report*, presenting findings from qualitative interviews with victim-survivors undertaken across four groups: Māori, Pacific, NZ European and disabled older people.
9. Financial institutions report, presenting system-level insights on financial AOP from qualitative interviews with finance industry and legal professionals and supplemented with other information gathered from financial institutions.
10. Economic and social costs report, presenting research into the economic and social costs of AOP in NZ.

1.1 Structure of the report

This report summarises the main 'result' reports in the series listed above in the following order: main *Prevalence Survey Report* (Section 2); main *IDI Report* (Section 3); *Qualitative Interviews Report* (Section 4); *Perspectives on Financial AOP Report* (Section 5); and *Cost of AOP Report* (Section 6). We conclude by drawing together the key messages from across the *National Study* (Section 7).

More technical and supplementary reports are not summarised, but elements are drawn on where relevant. These reports are: *Survey Methodology Report*, supplementary *Thresholds Report*, and the supplementary *Aged Care IDI Report*.

1.2 Study aims and definition of AOP

The main aims of the study were to:

- Establish a baseline prevalence of AOP in NZ, for multiple forms of abuse and population groups.
- Explore the uses and limitations of administrative data for measuring and monitoring AOP.
- Identify impacts of AOP on a range of health and economic outcomes.
- Contextualise quantitative results with the lived experiences of older people.
- Examine how the financial and legal sectors respond to AOP and identify systemic measures, along with relevant recommendations, which could better protect those experiencing AOP.
- Estimate the cost of AOP to the NZ economy.

Although there is some variation in the exact definition used across international research, the working conceptual definition of AOP is similar across the existing surveys examined. The study uses the following working definition of AOP, which is consistent with the most recent survey of AOP prevalence carried out in Australia:

> *A single or repeated act or failure to act, including threats, that results in harm or distress to an older person. These occur where there is an expectation of trust and/or where there is a power imbalance between the party responsible and the older person. (Qu et al., 2021)*

This study aims to capture different forms of physical, sexual, financial, psychological, cultural & spiritual harm, and neglect. The Australian survey (Qu et al., 2021) was the first to include harm relating to language and culture. Our study extends this previous work by asking a more detailed set of questions on cultural (including language) harm, as well as spiritual harm. We also asked these questions of all participants, whereas the Australian survey only asked these questions of culturally and linguistically diverse (CALD) participants.

Like most international prevalence surveys, our survey only asked about harm that was committed by someone known to the respondent (e.g. family members, friends, neighbours, acquaintances or professionals such as medical professionals, care workers, or finance professionals). In practice, this may not always align with the working definition of "an expectation of trust and/or where there is a power imbalance" between the party responsible and the older person.

For example, a neighbour or casual acquaintance might be known to the older person, but may not hold a position of trust or power. Conversely, a stranger acting in an official capacity (e.g. a government agent) might hold significant power or trust, yet be excluded from the survey's scope because they are not personally known to the respondent. This highlights a potential grey area in how abuse is defined versus how it is measured in prevalence studies.

The definition of AOP used in this study does not require intent to harm. Harm is considered harm regardless of whether it was caused deliberately or unintentionally through action or inaction. This reflects the reality that abuse can occur in a range of situations, including those where the behaviour is not recognised as harmful by the person responsible, or where it has become normalised over time. By focusing on the impact on the older person, rather than intent, the study aims to capture the full range of experiences that may cause harm or distress, particularly where there is an expectation of trust or a power imbalance.

A note on terminology: We use the terms abuse of older people (AOP) and harm interchangeably. Abuse refers to the actions or failures to act that cause harm or

distress to an older person. Harm describes the consequences or outcomes of those actions. Together, these terms capture both the behaviours and their impact on older people.

2. PREVALENCE SURVEY[1]

This section summarises the key results of the *Prevalence survey on the abuse of older people in Aotearoa New Zealand* report (main *Prevalence Survey Report*; Meehan et al., 2026), listed in Section 1 as the first component of the *National Study*.

2.1 Method and questionnaire design

The *National prevalence study of abuse of older people survey*[2] was carried out in the second half of 2024 under the neutral title Health and Wellbeing of Older New Zealanders Survey to create a safe and respectful context for participants.

The survey used computer-assisted telephone interviews (CATIs) with 5,613 people aged 55 and over who were living in the community. A blended sample was drawn from the NZCVS panel and the Electoral Roll. Māori, Pacific, and Asian respondents were oversampled to allow robust subgroup analysis, and survey weights were applied to ensure national representativeness.

The questionnaire covered six forms of harm: neglect, financial, psychological, physical, sexual, and cultural & spiritual. Respondents were asked about specific behaviours from people they knew, such as family, friends, neighbours, or professionals. To assist participants during the survey, predefined response categories were available by text (SMS) or email.

Based on weighted data, the sample reflected NZ's community-dwelling population aged 55+. About 41% were aged 55–64, 33% aged 65–74, and 26% aged 75+. Just over half were women, and 74% identified as European, 10% as Māori, 9% as Asian, and 4% as Pacific.

2.2 Abuse measures

Harm subtypes

The survey measured six forms of harm through behaviour-specific questions about things done by someone the respondent knew in the last 12 months:

- Neglect (10 questions). Respondents were first asked if they needed help with daily activities such as meals, transport, or personal care. If they did, they were then asked who provided the help and whether they always received the help

1 Meehan, L., Scott, A., Iusitini, L., Wilson, D., Chen, W.-L., Pacheco, G., & Naughton, C. (2026). ***National Study of Abuse of Older People: Prevalence survey on the abuse of older people in Aotearoa New Zealand***. New Zealand Policy Research Institute, Auckland, NZ.
2 The study was approved by the AUT Ethics Committee, AUTEC Reference number 24/30.

they needed. For example, *"In the last 12 months, did you need help doing routine housework, and if so, did you always receive it?"*

- Financial abuse (8 questions). Covered misuse of money, property, or financial authority. For example, *"In the last 12 months, has someone taken your money or possessions without your permission?"*
- Psychological abuse (10 questions). Explored insults, belittling, exclusion, manipulation or threats. For example, *"Has anyone repeatedly ignored you or excluded you?"*
- Physical abuse (9 questions). Asked about violent or coercive acts. For example, *"Has someone grabbed, pushed or shoved you?"*
- Sexual abuse (5 questions). Focused on unwanted sexual behaviours. For example, *"Has someone touched you in a sexual way against your will?"*
- Cultural & spiritual abuse (11 questions). Covered disrespect or exclusion linked to culture, language, age roles, or spiritual beliefs. For example, *"Has someone prevented you from speaking your preferred language?"*

Any single incident of financial, physical, or sexual harm was considered AOP. For neglect, psychological, and cultural & spiritual harm, thresholds[3] were applied to focus on more sustained patterns of abuse versus infrequent instances that the participant did not consider serious (referred to as the Cumulative Harm Index (CHI) – Very Serious threshold). See the supplementary *Thresholds Report* (Scott et al., 2026a) for a detailed discussion of thresholds used.

2.3 Survey prevalence estimates

Around one in six (16.7%) older people reported experiencing AOP in the past 12 months, which equates to over one-quarter of a million people. Psychological harm was the most common (12.4% or 189,600 people), followed by financial (4.0% or 61,200), cultural & spiritual (3.2% or 49,300), physical (2.8% or 42,600), neglect (1.2% or 17,600), and sexual harm (0.9% or 12,900) (Figure 1).

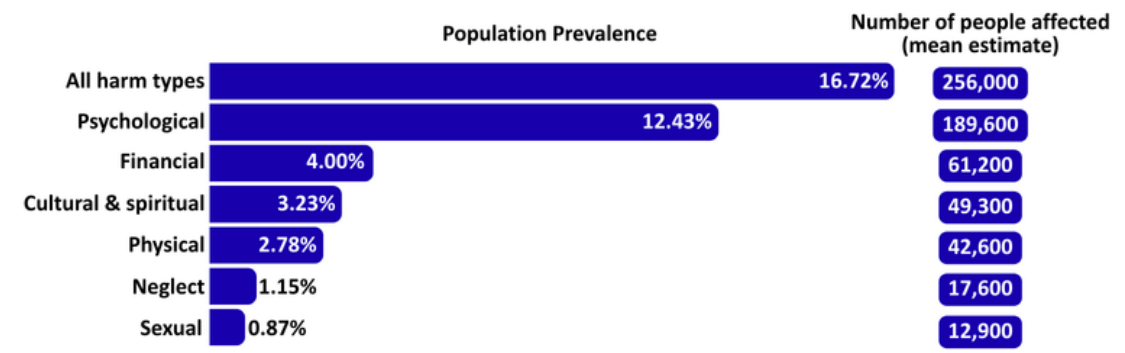
Most respondents who experienced any type of harm experienced one AOP subtype in the previous 12 months (68.0%), corresponding to a little over one in 10 for all survey respondents (11.4%). Just over one-fifth (21.4%; 3.6% of all respondents) experienced two, 8.0% experienced three, and 2.5% experienced four or more.

Co-occurrence patterns reveal that older people often experience harm as multiple, overlapping abuses, emphasising the value of screening and risk assessment tools capable of identifying additional, less visible AOP subtypes. Detection may also

3 A threshold is a rule used to help decide which experiences are counted when estimating how common abuse is. It may consider how often the behaviour happened or how serious it was for the person affected. Thresholds are used to distinguish between harmful behaviours that were infrequent and/or not considered serious by the respondent and those that reflect a more sustained pattern of abuse.

vary by context (e.g. physical harm might be identified in healthcare settings, while financial harm may depend on disclosure or recognition by professionals in finance or law).

Figure 1: Survey prevalence of harm, overall and by harm subtypes



Notes: Estimated numbers of people affected (weighted counts) are rounded to the nearest 100. Due to missing responses, the base populations vary slightly by harm subtype: neglect: 5,580 unweighted/1,525,000 weighted; financial: 5,611 unweighted/1,530,100 weighted; psychological: 5,581 unweighted/1,524,500 weighted; sexual: 5,467 unweighted/1,494,600 weighted; cultural & spiritual: 5,601 unweighted/1,528,300 weighted. Prevalence rates for harm subtypes add to more than the overall prevalence, as some people experience more than one type of harm.

For those who experienced harm, the most common person responsible was a partner or ex-partner (21.9%), followed by a child (20.6%), friend (14.4%), or sibling (10.3%). Work-related contacts (16.0%) and other family members (e.g. in-laws, grandchildren; 16.0%) were also frequently mentioned as the primary person responsible.[4] Figure 2 shows people responsible for harm mentioned across all AOP subtypes.

Just over one-half (56.2%) of older people who experienced harm said they sought help or advice. People were most likely to seek help for physical harm (60.3%). A much lower share – less than one-third – sought help after sexual harm (28.2%), while a little over one-third sought help for cultural & spiritual harm (36.3%). These results are shown in Figure 3.

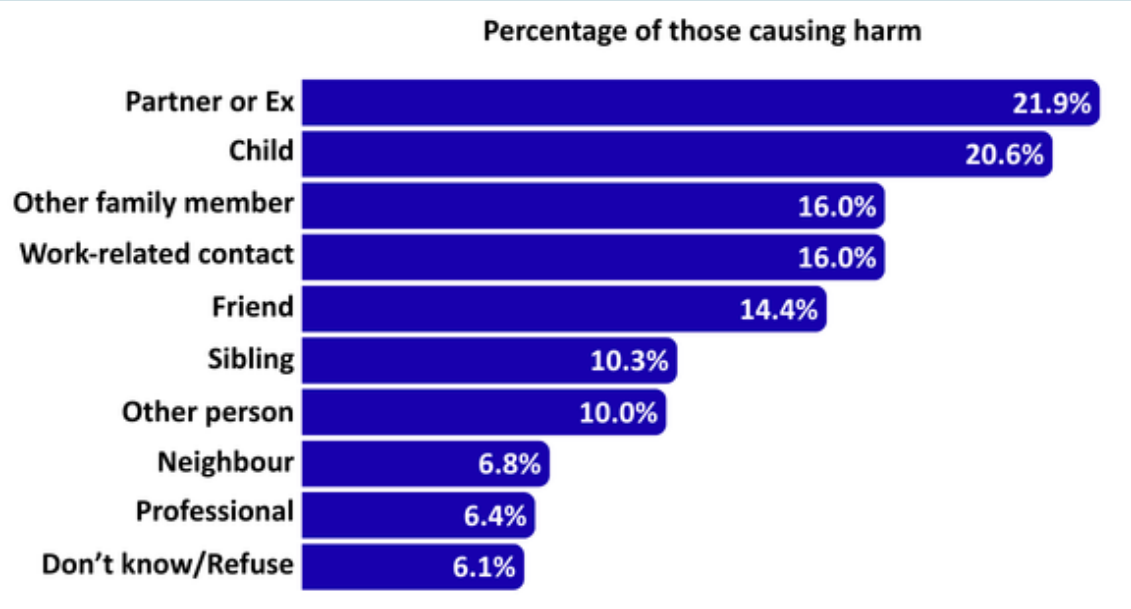
The most common reason for not seeking help was a desire to handle it themselves (52.2%), followed by not needing help (33.2%), or feeling it was a private matter (21.3%).

Of those who sought help, 38.6% turned to whānau or family, and 32.0% to friends. Use of services varied by AOP subtype. Formal services like police or legal advice were more commonly used for physical (48.5%) and financial harm (40.9%). A little

4 For employed respondents, the most common relationship between the main person responsible for harm and the older person is a work-related contact (27.0% of those experiencing harm), almost four times higher than for those who are not employed (7.0%), and just 2.6% for retired respondents. Likely reflecting higher employment rates for younger respondents, the main person responsible was more likely to be a work-related contact for those aged 55–64 years (21.2% versus 11.8% for those aged 65–74 years).

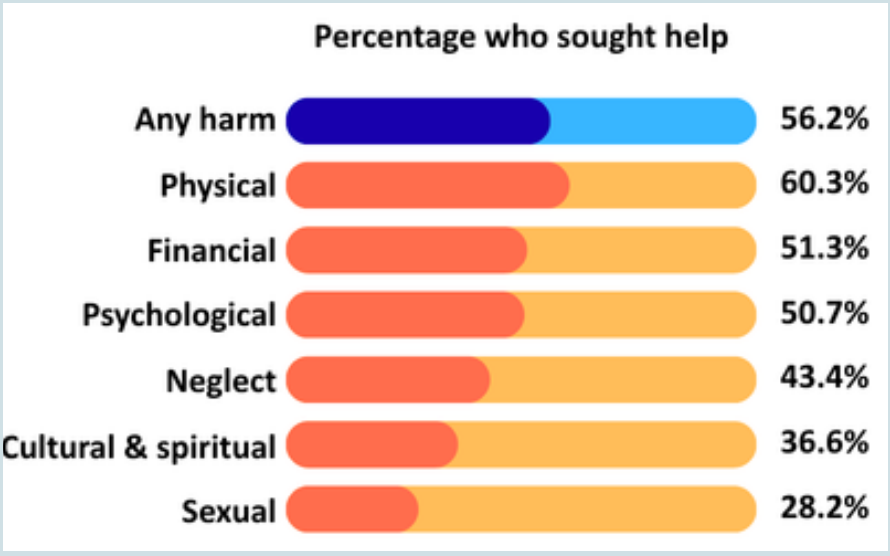
over one-quarter (27.5%) of older people who experienced AOP reported they would have liked additional support or advice – particularly emotional support, counselling, and general advice.

Figure 2: Relationship between those experiencing harm and those causing harm, overall



Notes: Percentage of those experiencing harm according to CHI-Very Serious threshold. Figures are based on the main person responsible; categories sum to more than 100% as respondents could identify one main person responsible per harm subtype experienced. Thus, those who experienced multiple AOP subtypes could identify the multiple main people responsible.

Figure 3: Share of those experiencing harm who sought help, by harm subtype



Note: Percentage of those experiencing each subtype of abuse, using CHI–Very Serious threshold where relevant.

Harm was more common among people aged 55–64 (23.3%) than those aged 75+ (7.9%). Māori reported higher rates of harm than European (15.8%) or Asian (10.6%) respondents, at about one in four (25.8%).[5] For Pacific respondents, prevalence was about one in five (20.7%). AOP rates were also higher among neurodiverse respondents (35.6%[6]) and those with high functional limitations (27.7%) or mental health conditions (40.9% [7]).

People living in larger (19.1% for households with three or more people) or multi-generational (18.3%) households, or who didn't own their home (28.0%), were also more likely to report experiencing harm. Having more people to rely on for help and ease of getting practical help from this support network was important. For example, those who find it difficult to get practical help had much higher AOP rates than those who find it easy (48.6% versus 13.0%).

Older people who had experienced harm in the past (before the previous 12 months) by someone they knew were more likely to experience AOP in the last 12 months (32.4% versus 12.2%). This finding supports further exploration of life course patterns of harm.

2.4 Discussion

An international comparison suggests NZ's prevalence rate of one in six older people is approximately equivalent to global prevalence (Yon et al., 2019). Closer to home, the prevalence rates are higher than Australia across most harm types. Differences in survey design across international work limits comparisons, but the *Prevalence Survey* expanded on previous research in at least two key ways:

1. The broader age range in the NZ survey (55+ versus 60+ or 65+ in other studies).
2. The expansion of behavioural indicators of AOP, including a novel behavioural scale measuring cultural & spiritual harm.[8]

Also, the wider *National Study* – of which this survey is part – contextualises the survey findings using qualitative and mixed-method approaches (see Sections 4 and 5). This effort to include the lived experiences, perceptions, and insights of victim-survivors allows us to give voice to marginalised groups, placing the survey findings into context. Further, the focus on financial abuse in the finance and legal sectors expands understanding of a prevalent, but under-reported, AOP subtype.

5 Prioritised ethnicity, ordered as Māori, Pacific peoples, Asian, MELAA & Other, and European.
6 Rate for those diagnosed with a neurodivergent condition. The rate is 37.8% for those with suspected but undiagnosed neurodivergent condition.
7 Rate for those diagnosed with mental health condition. The rate is 38.2% for those with a suspected but undiagnosed mental health condition.
8 The Australian prevalence study also asked about cultural & spiritual abuse, but asked a limited number of items to only those respondents identifying as CALD.

The comprehensive approach (outlined in Section 1) strengthens the *National Study* relative to related international research.

The prevalence survey did have limitations. Survey design shapes what is visible and included in the headline prevalence rate: harm by strangers and in institutions is excluded, and thresholds determine which experiences are counted. While the CATI method allowed geographic coverage across NZ, it excludes older people without phone access or those not listed in the 'blended' sampling frame. As noted across the *National Study* report series, broader limitations include difficulties in defining and measuring concepts like intent, power imbalance, and cultural understandings of AOP, as well as small sample sizes for some subgroups.

2.5 Recommendations

The survey provides important insights into the prevalence and nature of AOP experienced by older people in NZ. Our report highlights clear areas for urgent policy attention and investment.

Prioritise and support high-need groups

One in six people aged 55+ living in the community experience abuse each year, impacting all demographic groups regardless of wealth or health status. However, some older people are more at risk than others. These high-need groups require urgent, targeted support, and investment.

Older people who are disabled[9] and/or socially isolated face significantly heightened risks of abuse and should be prioritised in government support, funding allocation, and service development. Further, older people who care for family members with complex needs – such as mental health challenges – require special assistance to navigate demanding care dynamics. This includes developing tailored services, outreach models, and safeguarding mechanisms that reflect the needs of these communities. Survey findings in this report, as well as other recent work in NZ, reinforce the urgent need for targeted, community-informed interventions. Streamlining help-seeking processes and ensuring services are fit-for-purpose, accessible, and culturally appropriate is essential. Implementing recommendations from the *National Study* will also help ensure that older people experiencing harm have someone to turn to when they need support.

9 As part of the ***National Study*** report series, there is a supplementary ***Disability Synthesis Report*** (Meehan et al., 2026) drawing together findings on abuse for disabled older New Zealanders.

Address gaps in knowledge of AOP

The survey identifies several groups whose experiences remain under-researched, including younger older adults (aged 55–64), employed/working older people, and Takatāpui and Rainbow communities.[10] These groups may face distinct forms of abuse and barriers to support. Further work is needed to understand their experiences through both expanded data collection and/or dedicated qualitative research.

A major and obvious gap is the lack of data on AOP among residents in ARC. This group was intentionally excluded from the survey due to the different nature of institutional settings, but there is currently little reliable data in NZ about the prevalence, types, or drivers of harm in ARC. Importantly, this group is even less visible in administrative data than older people living in the community (Chen et al., 2026a). Given the heightened vulnerability of some people in care, and known international and national concerns about institutional abuse, this represents a critical evidence gap that warrants urgent attention.

Additional topics worthy of future research include more detailed analysis of who causes harm for older people and other environments relevant to them, beyond ARC. Risks and interventions are likely to differ dependent on who is responsible for harm (e.g. professional care) and where that harm occurs (e.g. retirement villages), compared to the general population.

Strengthen data and reporting infrastructure

Prevalence surveys such as this one tend to be one-off snapshots in time, limiting their ongoing value to inform policies centred on older people's wellbeing. To ensure effective, evidence-based policy and interventions, improvements in data infrastructure – including addressing the limitations of available administrative datasets (see Chen et al., 2026a, 2026b) – are necessary to enable prevention and response efforts to be monitored and resourced.

2.6 Summary

Understanding the prevalence and nature of AOP is essential for informing policy and intervention efforts. The findings underscore the need for targeted support services, public awareness initiatives, and continued monitoring to ensure the safety and wellbeing of older people in NZ. The *Prevalence Survey Report*, as part of the *National Study*, contributes detailed insights to a more robust evidence base for addressing abuse in later life.

10 For the latter, we note work underway parallel to the ***National Study*** by Sandra Dickson (Hohou Te Rongo Kahukura) and colleagues.

3. INTEGRATED DATA INFRASTRUCTURE (IDI)[11]

This section summarises the key results of the *Evidence from the Integrated Data Infrastructure (IDI)* report (main *IDI Report*; Chen et al., 2026b), listed in Section 1 as the second component of the *National Study*.

The survey described in Section 2 provides reliable national prevalence estimates, as reported by older people living in the community. Administrative data, like that held in the IDI by Stats NZ, help show how harm comes to the attention of services such as police, hospitals, and the ACC. The IDI provides rare whole-population information on the most severe cases of harm – those that come to the attention of public services – and allows us to examine differences across demographic groups and impacts on health, income, and wellbeing.

3.1 Data sources

All data are sourced from Stats NZ's IDI, and analysis is restricted to those aged 55 years and older living in private dwellings between 2015 and 2022.

We identified cases of AOP using the following data:

- Police victimisation records – offences where the offender was identified and known to the victim.
- ACC claims – injuries coded as assaults, maltreatment, or sensitive claims, mainly occurring in the home.
- Hospital admissions – admissions coded for maltreatment or assault by a known person.
- interRAI Home Care Assessments – clinical indicators of risk of abuse (not definitive cases).
- NZCVS – self-reported victimisation data (2018–2022).

Administrative datasets only capture incidents visible to public services (e.g. police reports, hospital admissions, or ACC claims). This excludes most psychological, financial, and cultural & spiritual forms of abuse, and any cases that do not result in contact with services. By contrast, the NZCVS captures a wider range of victimisation experiences, although it still omits some forms such as financial abuse.

3.2 IDI prevalence estimates

We measure prevalence by person-years: the proportion of people aged 55+ who experienced AOP in a given year. Single incidents and ongoing abuse may be

11 Chen, W.-L., Benson, R., Meehan, L., Scott, A., & Wilson, D. (2026). ***National Study of Abuse of Older people: Evidence from the Integrated Data Infrastructure (IDI)***. New Zealand Policy Research Institute, Auckland, NZ.

recorded in multiple datasets. To avoid this complexity, we count whether someone experienced at least one incident in that year. This approach provides annual prevalence but does not capture intensity.

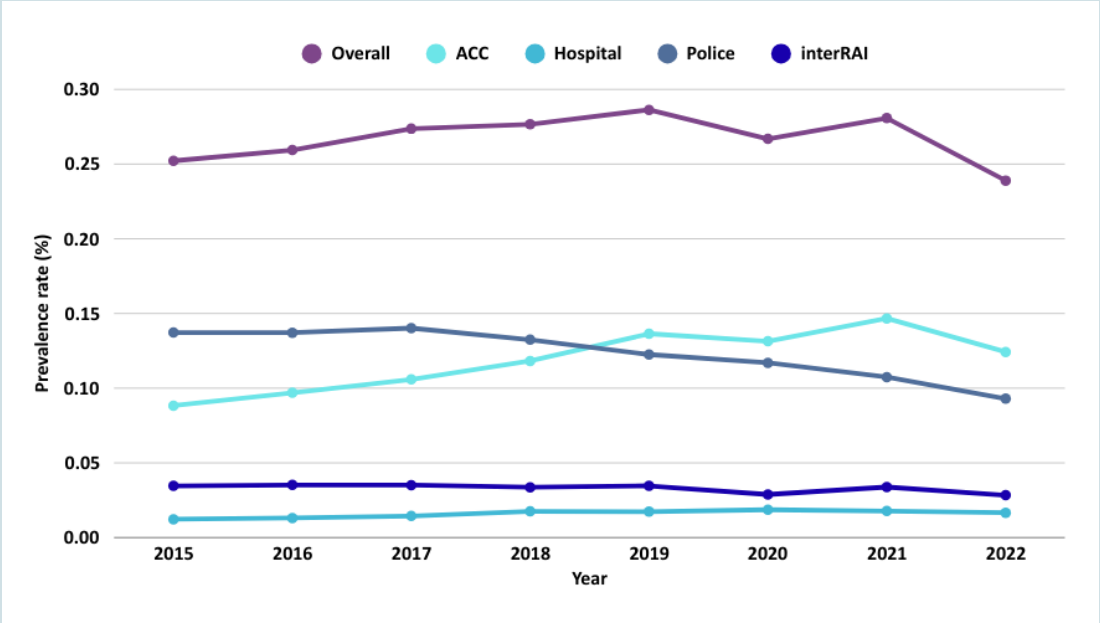
Administrative data

The overall AOP prevalence using IDI data is about 0.27%, and this rate is relatively steady over time. Figure 4 shows AOP prevalence from 2015 to 2022 by administrative data source, as well as overall.

Police data make the largest contribution to the overall AOP rate. Police data provide a prevalence rate of about 0.14%, with this rate decreasing over time to less than 0.10% by 2022. In contrast, AOP prevalence as measured by ACC data has increased over time, from 0.09% in 2015 to a peak of 0.15% in 2021. Hospital and interRAI data both have prevalence rates of less than 0.05%, with not much change over time.

These changes over time can reflect changes in policies/practices or actual changes in the underlying prevalence, or both. A general limitation of administrative data is that the reason for changes remains unclear without further research using different approaches (such as survey).

Figure 4: Overall AOP prevalence in administrative data by data source, 2015-2022



Note: Observation counts vary by data source and year, with the total counts 27,675 person-years (AOP identified) and 10,369,149 person-years (total community-dwelling population aged 55+ years).

Prevalence patterns differed across groups (Figure 5 displays averages over the 2015–2022 period). As in the prevalence survey data (Section 2), rates were highest for younger older adults (55–59 years, 0.42%), Māori (0.72%), and those living in high-deprivation areas (0.56%). Rates were lowest for those aged over 70 years (0.17% for both 70–74 and 75+ groups), older Asian people (0.13%), and in low-deprivation areas (0.12%).

Rainbow older New Zealanders also experienced higher AOP rates than the non-Rainbow community (0.47% versus 0.23%)[12], as did those with no qualifications, non-homeowners, and those born in NZ. For the latter, the difference may reflect varying levels of interaction with public services for older adults born outside NZ, rather than actual lower AOP rates.

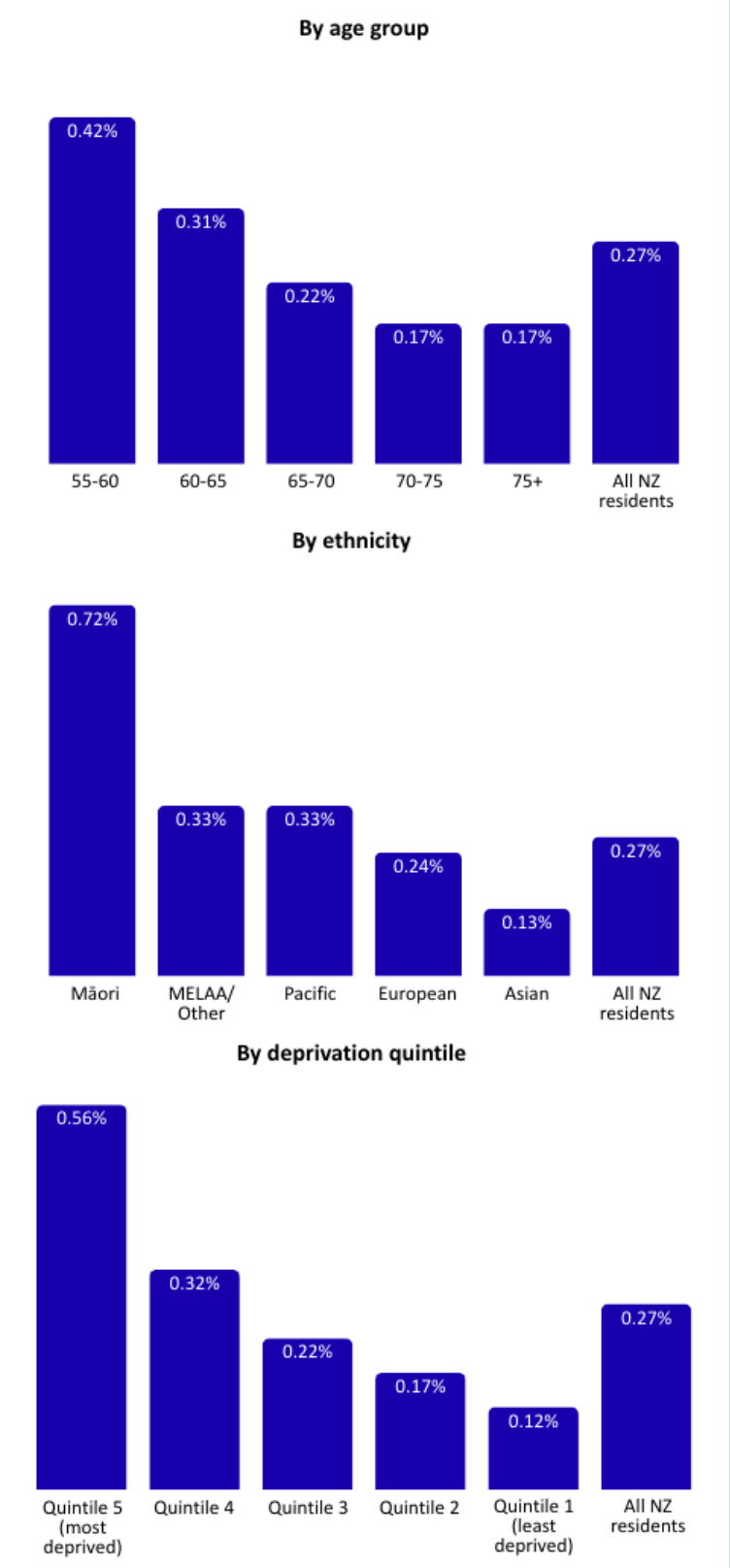
There is little difference by gender, although the prevalence rate for men begins to decline from 2018 while for women the decrease is from 2020. There are similarly small differences by urban/rural area over the time period, with similar rates across groups by 2022. For disability status, refer to the supplementary *National Study of Abuse of Older People: Disability synthesis report* (Meehan et al., 2026).

Prevalence in the NZ Crime & Victims Survey (NZCVS)

Prevalence of AOP in the NZCVS was about 4% in 2018, decreasing to 2.2% in 2022 (Figure 6). Harassment, threats, and theft are the largest categories, with a prevalence of about 0.9% during the period. Prevalence of assault (about 0.7%), burglary (about 0.5%), sexual assaults (about 0.4%), and cybercrime (about 0.2%) are lower, while cases of robbery are rare enough to be suppressed by Stats NZ to maintain confidentiality.

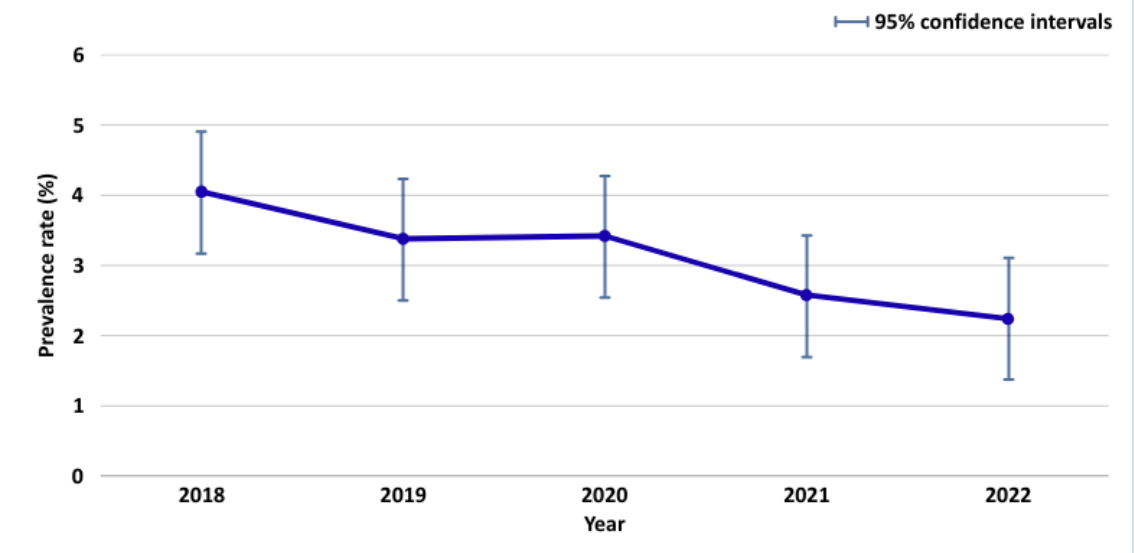
12 Observation counts for the Rainbow cohort are 615 person-years (AOP identified) and 131,001 person-years (total community-dwelling population aged 55+); no subgroup analyses possible due to small counts.

Figure 5: Overall AOP prevalence in administrative data by demographic groups, average over 2015-2022



Note: Observation counts vary by data source and year, with the total counts 27,675 person-years (AOP identified) and 10,369,149 person-years (total community-dwelling population aged 55+ years).

Figure 6: NZ Crime & Victims Survey AOP prevalence rate over time



Note: Observation counts vary by year for the NZCVS data in the IDI. Unweighted/weighted counts of total community-dwelling population aged 55+ years by year are: 1,527/667,000 (2018), 3,813/1,658,000 (2019), 2,277/1,052,000 (2020), 2,895/1,358,000 (2021), and 1,695/1,029,000 (2022).

3.3 Measuring AOP impacts

To measure the health and economic impacts of AOP, we first identified individual incidents and when they occurred. The interRAI data (provides risk of abuse) and the NZCVS (asks about experiences over the past 12 months but not exact dates) are not suitable for this purpose. Instead, we drew on police, hospital, and ACC records between 2015 and 2019.

Incidents were grouped into three categories: sexual assault (20.3%), physical assault (68.6%), and robbery or theft (10.9%). Incidents fitting more than one category were prioritised, with sexual assault first, then physical assault, then robbery/theft.[13] To avoid double-counting, events recorded within 30 days of each other were treated as a single incident. Of those older people with any incident, nine in 10 (90.6%) had one recorded. This does not mean harm was one-off, only that multiple instances were unlikely to be observed in these administrative datasets.

13 Prioritisation reflects that sexual assault has profound physical and psychological impacts, with victims less likely to disclose abuse and recovery often more complex than for physical assault.

To control for unobservable differences between older people who experience AOP and those who do not, we create a 'Later AOP' comparison group. These individuals experienced an AOP incident exactly three years (12 quarters) after someone in the same birth year-incident type category. We exclude instances where a person matches with themselves (e.g. between the AOP and Later AOP groups).[14]

We compared the AOP and 'Later AOP' groups across health (ongoing victimisation, hospitalisations[15] – including avoidable ones – and mental health medication prescriptions), contact with police as victims, and economic outcomes (income, employment, benefit and ACC payments). Together these measures assess both health and economic impacts captured in administrative data. For each incident type, regression models estimated differences in outcomes, such as hospitalisation or income loss, adjusting for time and individual characteristics.[16]

Health and wellbeing

As shown in Figure 7, victims of sexual and physical assault were more likely to be dispensed mental health prescriptions in the two quarters after an incident. The increase was short term, with effects disappearing after about six months. No increase was seen for robbery or theft.

There was no clear evidence in the data that AOP led to continued victimisation over time. The only noticeable increase occurred during the quarter in which the incident took place, which is expected to be when the event is recorded in police data.

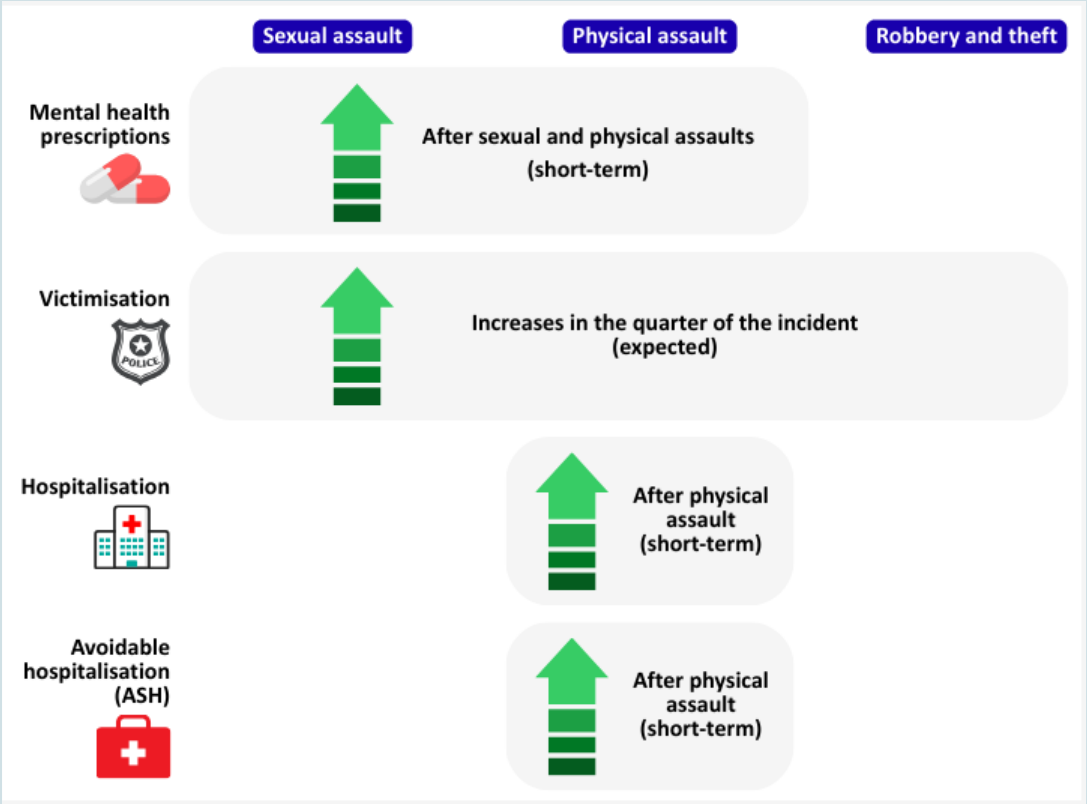
Physical assault victims were more likely to be hospitalised in the quarter of the incident (about 11 percentage points higher) and to a lesser extent in the following quarter. They also had a short-lived increase in avoidable hospitalisations ('ambulatory sensitive care hospitalisation' or ASH). Sexual assault was not linked to higher inpatient admissions, likely because these cases are more often managed in outpatient or emergency settings. Robbery and theft showed no increase in hospital use.

14 The 'Later AOP' matching assumes individuals who eventually experience AOP are similar to those already affected, aside from timing. The group is created by first categorising the AOP cohort by birth year (e.g. 1931–1935, 1936–1940, up to 1956–1961) and then grouping individuals within each birth year by incident type. Although not shown here, the IDI report also used other comparison groups, such as matched controls and people harmed by strangers, to test the robustness of the results.

15 Hospitalisation is defined as having any inpatient records in private or public hospitals.

16 Note this approach relies on assuming similar pre-incident trends for both groups.

Figure 7: Health and wellbeing outcomes after AOP incidents



Note: Sample sizes vary by incident type. For the AOP/Later AOP groups, counts are 1,851/1,719 (sexual assault), 6,732/5,118 (physical assault), and 1,287/780 (robbery and theft).

Economic

As shown in Figure 8, employment outcomes did not exhibit strong or lasting effects from AOP. The only possible impact was for sexual assault victims, who were up to two percentage points less likely to be employed after the incident in the quarter that it occurred.

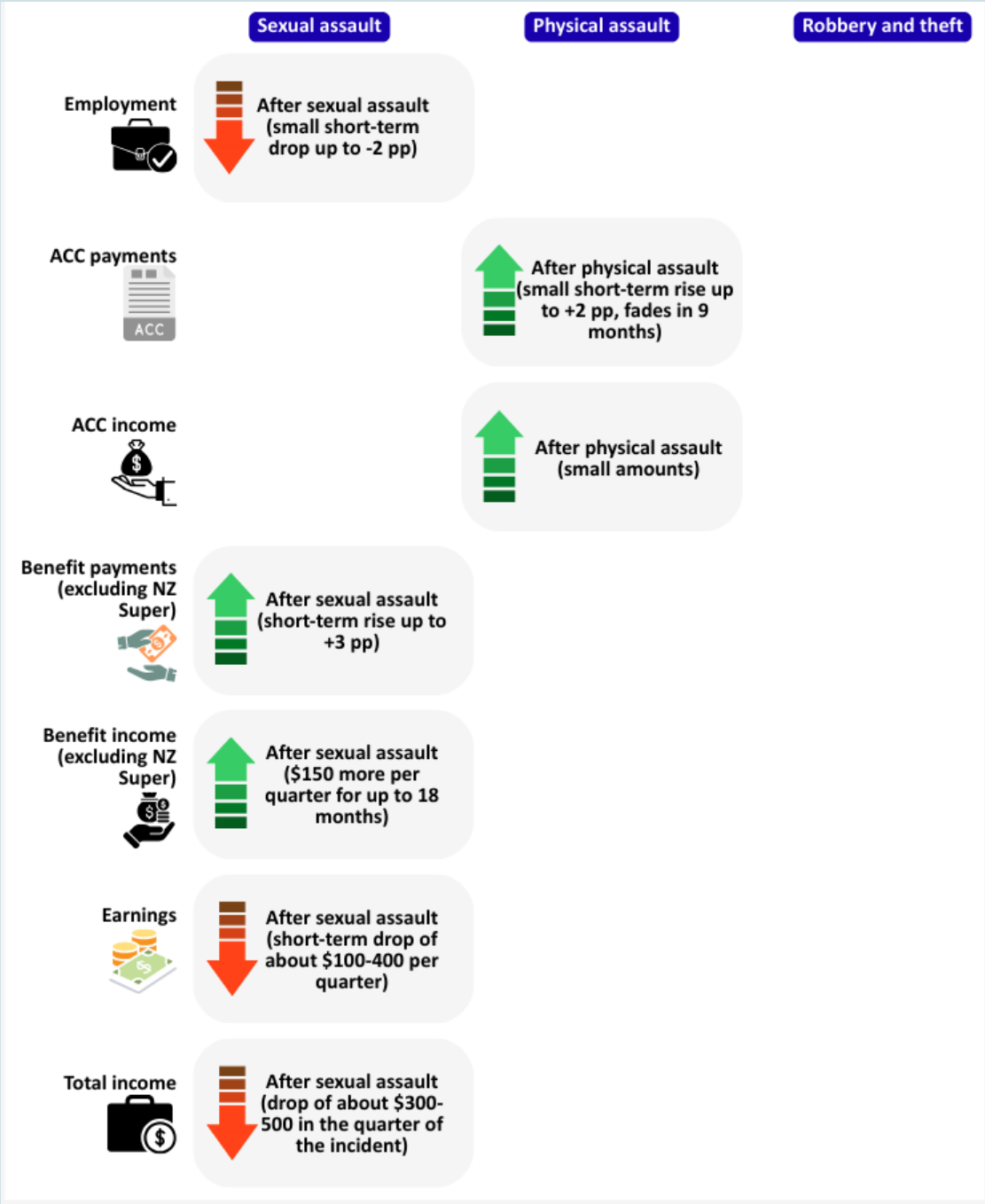
ACC data showed a short-term impact for physical assault victims, who were about two percentage points more likely to receive payments in the quarter of the incident. This effect faded within nine months, and the actual dollar amounts were small. No changes were seen for sexual assault or robbery/theft.

Benefit use (excluding NZ Super) showed mixed patterns. A conservative reading suggests no effect, but there is some evidence that sexual assault victims were slightly more likely to receive benefits for up to a year after an incident, with average benefit income about $150 per quarter higher (per victim).

Earnings and overall income were largely unchanged for physical assault or robbery/theft. Sexual assault victims, however, experienced a short-term drop in total income.

The reduction was around $300–$500 in the quarter of the incident, with smaller effects in the following quarters.

Figure 8: Economic outcomes after AOP incidents



Note: Sample sizes vary by incident type. For the AOP/Later AOP groups, counts are 1,851/1,719 (sexual assault), 6,732/5,118 (physical assault), and 1,287/780 (robbery and theft).

3.4 Discussion

We use the administrative data held in the IDI to measure prevalence of AOP in NZ and examine the impact of AOP by linking incidents to later outcomes. These include health and wellbeing impacts, such as increased hospitalisations (including avoidable hospitalisation) and the use of mental health services, and economic impacts (such as changes in employment, income, and benefit receipt). For example, victims of sexual and physical assault were more likely to receive mental health prescriptions in the six months after an incident. Physical assault victims also had higher hospitalisation (including avoidable) rates and were more likely to receive ACC income in the following nine months. Recognising these downstream costs highlights the importance of prevention, which protects older people's wellbeing while also reducing demand on the health, justice, and welfare systems.

However, the IDI data cannot provide a definitive measure of AOP prevalence in NZ. Its advantage is the continuous collection of data that allows tracking over time and it is useful for highlighting inequities. For the *National Study*, the IDI analysis complements the prevalence survey described in Section 2. Using both approaches gives a fuller picture: survey data capture experiences that often remain hidden, while administrative data capture cases where harm is visible to service systems.

Not all forms of AOP are captured in the IDI data – it is more likely to record physical forms resulting in injury or involving police. At present, little information is available on financial, psychological or cultural & spiritual abuse, or on neglect that does not meet the threshold of an offence. Some AOP types could be better captured through routine screening approaches in service settings, such as interRAI assessments, primary health care, or social service intakes. Embedding monitoring for AOP into these settings would make administrative data a more valuable source for ongoing analysis.

3.5 Summary

The administrative data provides population-level insight into AOP that is recorded by services, including hospitals and police. Our analysis finds inequities in prevalence, measures outcomes associated with AOP, and highlights critical data gaps – like the abuse of older people living in ARC.

4. QUALITATIVE INTERVIEWS[17]

This section summarises the key results of the *Findings from qualitative interviews with NZ European, Māori, Pacific, and disabled older people who have experienced abuse* report (*Qualitative Interviews Report*; Wilson et al., 2026), listed in Section 1 as the third component of the *National Study*.

4.1 Methods

The qualitative component of the *National Study* captured lived experiences of harm among older people. We interviewed 71 participants aged 55+ and living in the community across four groups: NZ European (n=18), Māori (n=15), Pacific (n=21), and disabled older people (n=17). Most were women (75%), although men were also represented. Many carried lifetime histories of trauma and abuse that shaped their vulnerability to harm in later years.

Participants were recruited through community networks and snowballing, and interviewed using culturally grounded approaches (e.g. *wānanga* for Māori, *talanoa* for Pacific peoples). Interviews took place between July 2024 and June 2025. Most were conducted one-on-one, although some Māori participants chose to take part in a group wānanga.

Interviews asked about experiences of harm or mistreatment by a trusted person or close acquaintance, its effects on health and wellbeing, and their story of keeping safe. Transcripts were thematically analysed for each cohort.

4.2 What we heard

AOP manifests in varied ways driven by systemic failures and societal stereotypes

Participants spoke about being silenced, invisible, and/or isolated, which marginalised them within their families, whānau, and support networks. Many older people discussed how the person responsible for harming them colluded with professionals, such as those working in government agencies, the health sector, and lawyers, who inadvertently believed the narrative that older people lack the capacity to care for and make decisions themselves. Participants discussed how they felt that no-one gave them a voice, even in situations where they were deemed capable of

17 Wilson, D., Iusitini, L., Tautolo, E-S., Ravenswood, K., Roguski, M., Mikahere-Hall, A., Muru-Lanning, M., Scott, A., & Meehan, L. (2026). ***National Study of Abuse of Older People: Findings from qualitative interviews with NZ European, Māori, Pacific, and disabled older people who have experienced abuse.*** New Zealand Policy Research Institute, Auckland, NZ.

making decisions and caring for themselves.

Abuse rarely began in later life for the older people we spoke to. Instead, it reflected lifetime or intergenerational patterns that evolved as individuals aged. For some, unresolved trauma, intimate partner violence (IPV), or systemic discrimination resurfaced in older age as financial abuse, coercion, or neglect.

Experiences of harm

Social isolation, neglect, emotional abuse, and financial exploitation were common across cohorts, as were broken family relationships, a diminished (and disrespected) elder status, and intentional use of grandchildren and mokopuna to manipulate, harm, or abuse their grandparents.

Alongside similarities, distinct challenges were faced by each cohort, evident in their stories of abuse.

NZ European: Those we spoke to were most likely to report emotional and financial abuse, followed by physical and verbal abuse, and coercive control. Family trusts, businesses, and inheritance disputes created avenues for abuse perpetrated by family members, including their children and grandchildren. AOP also disrupted their employment and careers, leaving them financially disenfranchised. Abuse within families tended to be gendered, with expectations that older women would care for their ageing parents. Stereotypes about age were used to exert control, and marginalisation was common.

Māori: 'Abuse' was not a term older Māori connected with. For Māori in this study, a significant part of their experience was structural, related to government policies and agencies failing to meet their needs. AOP was entangled with historical trauma, intergenerational violence and trauma, and systemic oppression linked to colonisation. Financial constraints and cultural demands could further burden older Māori, particularly when they could not fulfil their roles as kaumātua, kuia, and kauheke with their mokopuna, or adhere to ritenga (customary practices). Knowledge gaps around valid wills and claiming Māori whenua (land) left some we spoke to without housing or economic security as they aged.

Pacific peoples: Older Pacific participants experienced tension between customary cultural practices and expectations and adapting to life in NZ. Cultural norms related to upholding family status inhibited participants from having open discussions about abuse, creating barriers to addressing it. Physical abuse was less common, but neglect and exploitation were significant issues for older Pacific peoples. The demands on many families to work long hours in multiple jobs meant that older people were expected to undertake childcare and household work. This was counter

to the revered and respected status elders possess in their island nations.

Disabled people: For those we spoke to, systemic factors contributed to their experiences of abuse. Disabled participants reported that infantilisation[18] was often used as a tactic of coercive control. AOP was multi-layered and often involved people outside of their families, such as caregivers. Forms included physical neglect, caregiver harm, financial, and emotional abuse, leaving the older person financially and emotionally depleted. Those interviewed who required others' support and care were at a heightened risk of abuse.

Risk factors

Several risk factors heightened older participants' vulnerability. Financial instability and economic constraints, with manipulation or exploitation leading to financial or asset loss, were both a risk factor and consequence of AOP. A lack of social connections and support networks, like family, whānau and friends, isolated older people and enabled abuse. Threats to remove access to grandchildren and mokopuna was a significant factor in social, psychological, and cultural abuse. Family or whānau trauma and unresolved conflict were reported as contributing to abuse in later years, and adult child-to-parent violence (ACPV) was a significant risk with limited avenues for support. Natural disasters and crises exacerbate existing vulnerabilities, especially for older disabled people in the study.

Protective factors

Buffers against abuse and its impacts included supportive social networks, employment and financial security, and access to culturally appropriate services (discussed next). Participants spoke of their trusted networks, including workplaces, providing support, advice, and relief from the abuse they were experiencing.

Help-seeking

Help-seeking – both things that helped and those that hindered – were discussed by participants. Barriers to help-seeking included shame and embarrassment and systemic barriers. Older people's shame was compounded by a fear of being judged and/or not believed, often tied to psychological abuse and the person perpetrating abuse colluding with (unwitting) professionals about declining cognitive capacity. Inadequate support from services for those not fitting criteria due to age or gender,

18 Infantilisation refers to the treatment of competent adults like a child.

or culturally insensitive help, prevented help-seeking.

Favourable conditions for help-seeking counteracted the risks identified above and barriers to finding support for older people experiencing harm. These included having trusted individuals or networks (confirming the prevalence survey results in Section 2), awareness of the diverse range of available services, and having culturally appropriate supports. The last point is crucial to ensure the help provided respects an older person's lived reality and that support is fit-for-purpose.

4.3 Discussion

Systemic and structural issues exacerbate AOP by enabling manipulation and control through legal frameworks, inadequate support systems, and services functioning on societal stereotypes of older people. For NZ Europeans, gaps in the family violence and senior response system fail to address less visible forms of abuse, such as psychological and financial abuse. This leads to isolation and poor mental health outcomes. Older Māori reported systemic and structural abuse, marginalisation, and racism within government services, cementing poverty in their lives and creating little or no trust in the support systems.

Older disabled people faced challenges in refuting false claims that they have dementia or cognitive incapacity. This enabled the people responsible for the abuse to exploit legal provisions to acquire their assets. While systemic and structural abuse for older Pacific peoples was not discussed, the invisibility of their abuse and neglect within closed family systems that do not disclose or discuss the harm and mistreatment of older people entrapped them in situations where they felt abused and neglected.

Across all groups, systemic failures often trapped older individuals in abusive relationships or situations, with limited avenues for intervention or support.

4.4 Recommendations

Figure 9 summarises the 25 recommendations made in the *Qualitative Interviews Report*, derived from the lived experiences of older people we spoke to and supplemented with findings from other components of the *National Study*.

The recommendations cover six areas: (1) Addressing structural and systemic barriers, (2) Improving responses to AOP, (3) Keeping older people safe, (4) Workforce development, (5) Raising awareness, and (6) Further research. For a detailed explanation of each point, please see the full report (Wilson et al., 2026).

Figure 9: *Qualitative Interviews Report* recommendations



4.5 Summary

The findings highlight the complexity and multifaceted nature of AOP among the four population groups included in this study. As part of the *National Study*, the qualitative interviews provide critical insights into how cultural, systemic, and interpersonal dynamics shape the experiences of AOP. These findings are crucial to inform government agencies, non-government agencies (NGOs), service providers, and communities when developing targeted interventions that address the distinct needs and challenges faced by diverse groups within NZ.

5. UNDERSTANDING FINANCIAL HARM[19]

This section summarises the key results of the *Financial and legal perspectives on financial abuse of older people in Aotearoa New Zealand* report (*Perspectives on Financial AOP Report*; Scott et al., 2026b), listed in Section 1 as the fourth component of the *National Study*.

Financial abuse is the second-most common form of harm (4% or 61,200 people) after psychological abuse (12.4% or 189,600), see Section 2. It involves someone the older person knows misusing, controlling, or exploiting their money, property, or financial arrangements. It can include taking money without permission, pressuring them to give or lend money, misusing an EPOA, or failing to pay agreed expenses. This study aimed to understand how financial AOP manifests in everyday banking and legal contexts, and how professionals within these sectors respond to it.

As the personal financial matters and advanced planning (e.g. EPOA, authority to operate [bank accounts], wills) of older people commonly involve both financial and legal professionals, they have unique insight into the systems that enable AOP and how financial abuse is identified, addressed, and prevented.

5.1 Methods

Data collection

We carried out qualitative interviews with finance (n=14) and legal (n=9) sector professionals and other stakeholders (n=13) familiar with consumer vulnerability, EPOA issues, and regulatory constraints. Interviewees represented five retail banks (~60% market share) and seven stakeholder organisations.

Banks were also invited to complete an organisation-level questionnaire that covered the scale of AOP at the bank level, referral processes, policies, training, and possible solutions. A desk review, covering all nine retail banks and nine stakeholder organisations, supplemented the qualitative data and bank-level questionnaire.

Recruitment was conducted via the NZ Banking Association, professional networks, and direct outreach, with organisational-level consent obtained prior to participation.

19 Scott, A., Nicholson, K., Meehan, L., & Wilson, D. (2026b). ***Finance and legal sector perspectives on preventing financial abuse of older people in Aotearoa New Zealand.*** New Zealand Policy Research Institute, Auckland, NZ.

Analysis

Data were analysed using an embedded case study approach, examining each organisation separately and then comparing across sites. Reflexive thematic analysis was used to identify key themes and insights.

5.2 Professional views on financial harm

Each of the groups we spoke to – retail banking professionals, finance industry, legal professionals, and other relevant stakeholders– gave insight into what financial AOP looks like and its drivers.

Professionals referred to trust as a precursor to abuse. This trust then presented an opportunity for access to funds that could be exploited. Examples included skimming accounts while shopping for an older person, overcharging for services, maintaining financial dependence by avoiding household contributions, expecting an early inheritance or gifts, and using accounts or cards without consent.

Older people were often pressured to comply with financial demands through threats of isolation, withholding contact with family/whānau or grandchildren and mokopuna, or aged care placement. Financial hardship and declining digital, financial and legal literacy, and/or cognitive capacity heightened vulnerability. These findings align with the *Qualitative Interviews Report* (Section 4). Professionals noted that perpetrators may begin with genuine intent, lack understanding of their responsibilities as attorneys, or not realise their behaviour's impact on the older person. However, intent is not required for AOP (see the definition in Section 1), only that harm or distress is experienced by the older person.

Banking professionals' perspectives

Interviews with finance professionals revealed three key themes: banking practices are inconsistent across institutions, awareness raising and training must go beyond compliance, and customer care requires standing alongside older customers. Misuse of EPOAs posed challenges for bankers who were legally bound to agreements even when decisions seemed inappropriate to them. Regulatory frameworks such as the Privacy Act 2020, the Credit Contracts and Consumer Finance Act (CCCFA) (responsible lending), competition law, and the Conduct of Financial Institutions (CoFI) regime restrict intervention and responses relevant to supporting an older customer experiencing, or at risk of, financial AOP.

Collecting systematic data on older customers' experiences of financial AOP is not straightforward, with case-by-case customer data difficult to aggregate. While some

banks focus on trend analysis and staff training, the institutions who took part in the study rely on 'spot and refer' processes supported by specialist teams.

Finance industry stakeholders

Stakeholders identified ageism as a major societal driver of abuse. This cohort also highlighted the missing cultural lens in the finance sector, noting tensions between financial systems and excluded communities. Legal mechanisms such as EPOAs and account authorities lack safeguards and oversight, with no assurance that decisions are being made in the best interests of the older person.

Two protective products were suggested: decumulation of retirement savings rather than lump sums, and equity release as an income stream. Strong referral pathways and consistent responses are essential, although the subtlety of financial AOP presents clear challenges to financial institutions – and all essential service providers – in the detection and identification of abuse. Awareness campaigns help, but caution was also advised when those examples shone a light on extreme cases of abuse.

Stakeholders recognised growing awareness and efforts within the banking sector and wider business community to prevent financial harm, but noted that progress remains uneven and constrained.

Legal perspectives

Legal professionals cited inadequate training for attorneys and unclear roles when discussing the misuse of EPOAs. There is no oversight or register of EPOAs, making it difficult to track misuse, and poor banking and legal practices can exacerbate harm. If problems do arise, the systems in place – such as legal action via the Family Court – are difficult to access and costly.

Systemic issues include an outdated Protection of Personal and Property Rights (PPPR) Act, complex interactions with other laws, and specialisation in the profession at times preventing comprehensive advice and offering inadequate safeguards for older people with declining capacity.

Practice-specific concerns include conflicts in providing independent advice, inexperienced staff handling complex wills and EPOAs, workforce shortages, and the perception that legal safeguards are prohibitively expensive. Banking practices also contribute to risk, particularly the use of joint accounts instead of EPOAs and inconsistent responses when abuse is detected.

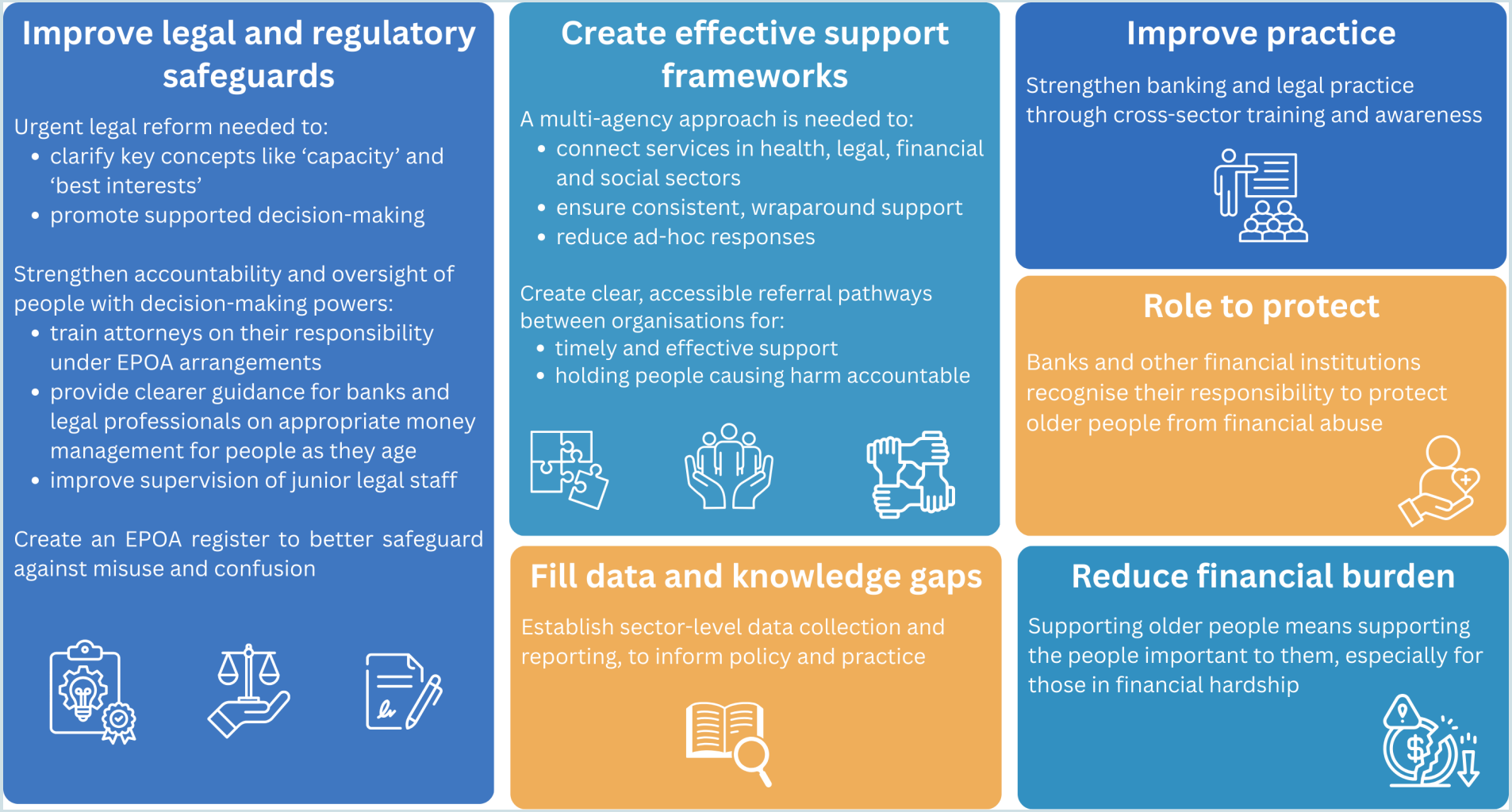
5.3 Recommendations

Financial AOP is a complex problem requiring comprehensive solutions. Efforts must extend beyond government, banks, and legal services to include telcos, utilities, and community organisations. Figure 10 summarises the recommendations made in the *Perspectives on Financial AOP Report*. For a detailed explanation of each point, please see the full report (Scott et al., 2026b).

5.4 Summary

Along with others in the *National Study*, this component contains a clear call to action for policy-makers, financial institutions, legal professionals, and all other organisations, to work to address and prevent financial AOP in NZ. By providing the perspectives of a diverse range of expert professionals from the finance and legal sectors (plus key stakeholders) in the wellbeing of older people, this research gives important context to the *Prevalence Survey Report* and wider *National Study*.

Figure 10: *Perspectives on Financial AOP Report* recommendations



6. ECONOMIC AND SOCIAL COSTS OF AOP[20]

This section summarises the key results of the *National Study of Abuse of Older People: Social and economic costs in Aotearoa New Zealand* report (*Cost of AOP Report*; Benson et al., 2026), listed in Section 1 as the fifth and final component of the *National Study*.

6.1 Methods

Scoping

We began with a rapid scoping review of international studies on the cost of abuse. While no research has comprehensively estimated the cost of AOP, studies on violence against children, women, and people in care in Australia and NZ provided useful models (Deloitte Access Economics, 2018; KPMG 2009, 2016; Kahui & Snively, 2014; MartinJenkins, 2020). Using these, we developed a framework that considers costs to government, victims and families, and society. Both economic costs (e.g. health, justice, welfare, lost earnings, and financial losses) and non-economic costs (e.g. reduced wellbeing, lost relationships, diminished trust, and cohesion) were included.

Data sources

Abuse frequency

The prevalence survey (see Section 2) provided the base prevalence rate of AOP, giving an estimate of how many older people experience AOP each year. Our main cost estimates use the central prevalence figure, with high and low estimates based on the confidence intervals.

Outcomes

We reviewed the literature to identify outcomes that contribute costs across our framework. These included financial losses, lost earnings, residential care, hospital and emergency department use, benefit receipt, and reduced wellbeing. Where possible, NZ data were used; in some cases, international studies provided the best available evidence.

20 Benson, R., Scott, A., Meehan, L., & Wilson, D. (2026). ***National Study of Abuse of Older People: Social and economic costs in Aotearoa New Zealand***. New Zealand Policy Research Institute, Auckland, NZ.

Costs

We applied unit cost estimates from the Treasury's CBAx (cost benefit analysis) tool, Inland Revenue income data, and other official sources. For health outcomes, we used relative risk estimates from international studies to estimate the proportion of outcomes attributable to AOP. Costs were calculated separately for each component, with low, medium, and high values reflecting uncertainty in the prevalence and outcome data.

Calculation

We produced low, medium, and high cost estimates for each component. Where only one data source was available, these reflect the low, central, and high prevalence estimates from the survey. Where multiple estimates were available, we selected values to reflect uncertainty and explained our rationale.

Different methods were applied depending on the outcome:

- Simple per-case costs multiplied by prevalence (e.g. financial losses, lost earnings, welfare).
- Per-case costs adjusted for probabilities (e.g. justice system, lost tax revenue).
- Direct costs where available (e.g. specialist services).
- Relative risks to estimate the share of health and residential care costs attributable to AOP.

Non-economic harms, such as reduced wellbeing and lost relationships, cannot easily be expressed in dollar terms. We only report financial values where robust tools exist for NZ, such as Quality Adjusted Life Years (QALYs) or subjective wellbeing measures. This does not mean other harms are less important – only that they are harder to monetise. Overall, this approach is conservative and likely underestimates the true costs of AOP.

6.2 Economic costs of AOP

The total annual economic cost of AOP is estimated at $1.78 billion, made up of costs to victims and families, costs to government, and wider costs to society.

Costs to victims and their families ($1.17 billion)

The annual cost to victims and families is estimated at $1.17 billion. Most of this comes from financial losses ($709 million), with further costs from the private costs of

residential care ($350 million) and lost earnings ($107 million).

We also calculated low and high estimates using different data sources and assumptions. These varied widely, reflecting uncertainty in the evidence base. However, the headline estimate provides the most plausible indication of the scale of costs to older people and their families.

Costs to government ($615 million)

We estimate that AOP costs government around $615 million each year. Most of this is through additional pressure on the health system ($546 million), followed by reduced tax revenue ($32 million), welfare and benefit payments ($7 million), justice system costs ($16 million), and specialist services ($14 million).

Costs to society

Society also bears costs from AOP, although these are harder to measure. The care sector must invest in safeguarding processes, staff vetting, and responses to allegations. The financial sector carries compliance costs linked to protecting vulnerable customers, and in some cases reimbursing large losses from financial abuse. Charities and community organisations also face extra demand on already limited resources, creating opportunity costs elsewhere.

These costs are ultimately passed on to the public through service fees, higher charges, or reduced availability of support. While not included in our total estimate, they represent a further economic and social burden from AOP.

6.3 Non-economic costs of AOP

Some harms from AOP are difficult to express in financial terms. Victims report lower wellbeing, poorer physical and mental health, reduced quality of life, and disruption of family and community relationships. Of these, only worsened mental health can currently be expressed in monetary terms, estimated at about $170 million annually.

Other non-economic harms include the loss of independence when older people are forced into residential care, financial insecurity following abuse, and exclusion from cultural or spiritual communities. At a collective level, AOP undermines values such as whanaungatanga, and can erode trust in government, services, and the care sector. These wider costs are difficult to quantify but are likely to be substantial.

6.4 Discussion

Strengths and limitations of our estimate

A key strength of this study is its use of detailed prevalence data (Meehan et al., 2026) with clear definitions (Scott et al., 2026a). This allows costs to be calculated, not just overall, but also for specific forms of AOP such as financial losses linked directly to financial harm.

Transparency is another strength; all major decisions, including thresholds, relative risks, and conservative assumptions, are documented, making estimates replicable and adaptable as new evidence emerges.

The study also integrates multiple sources – NZ prevalence data, international outcome studies, CBAx costings, and administrative data – creating a credible and comprehensive estimate. It appears to be the first international attempt to calculate AOP costs, offering a benchmark for future work.

Limitations include reliance on overseas studies, general population data, and severe cases. Justice system estimates assume average police time without local evidence, and CBAx costs apply to the whole population, not older adults. Costs for subgroups and ARC remain unknown, despite 30,000 older adults living in ARC and likely facing higher risks.

Our approach is deliberately conservative: lower-bound assumptions, incomplete health and non-economic costs, and exclusion of ARC costs mean underestimation. While this limits accuracy, it strengthens policy relevance by ensuring the benefits of action are not overstated.

Implications for policy

We estimate AOP costs the NZ economy $1.78 billion each year. While small as a share of GDP, this is comparable in size to sectors that receive significant policy attention, such as the $1.7 billion space industry or the $2.2 billion seafood export sector. There is a clear economic case for preventing AOP.

Almost 70% of these costs fall on older people and their whānau. Prevention not only protects people from financial loss, declining health, and social isolation, but also reduces downstream demand on the health, welfare, and justice systems. It is both humane and likely to be cost-effective, incentivising government to increase prevention and response efforts.

At the same time, there are major gaps in local evidence on what works to prevent AOP. Building this evidence base is critical for guiding effective policy, but relies on robust local data and evaluation.

7. CONCLUDING REMARKS

We have explored AOP in NZ using a survey, analysis of administrative data, qualitative interviews, expert consultation, and economic analysis. Although each component uncovered unique insights, some key messages stand out when considered together.

AOP is a problem in NZ

One in six people aged 55+ reported experiencing harm in the past year — about 256,000 people living in the community. For individuals, this means feeling invisible, ashamed, isolated, and powerless. It has economic and health impacts for victims and families and collectively costs them about $1.17 billion each year.

AOP is not experienced uniformly

Older people with disabilities, Māori, Takatāpui and Rainbow communities, who are socially isolated or living in high-deprivation areas are more likely to experience AOP. Social isolation, neglect, emotional abuse, and financial exploitation were common across older people's lived experiences, as were broken family relationships, a diminished (and disrespected) elder status, and intentional use of grandchildren and mokopuna to manipulate, harm, or abuse their grandparents. Alongside similarities, distinct challenges were faced by different groups, emphasising the need for tailored, culturally appropriate support.

AOP in aged residential care is invisible

As with most international AOP prevalence surveys, the target population excluded those living in ARC facilities. This exclusion recognises the distinct nature of abuse in institutional settings and the need for separate investigative approaches. However, without further research we have no data on the scale of AOP for the 30,000 people in these facilities in NZ. Although challenging, addressing this gap should be an urgent priority.

AOP is a systemic issue

Abuse is not only the result of individual behaviour. It is enabled by ageism and

institutional structures. Tools such as an EPOA, intended to protect, can be misused. Raising public awareness of the types and tactics of abuse will shine a light on individual behaviours that cause harm and remove barriers to help-seeking for older people.

Financial, legal, and other essential sectors are well placed both to protect customers and to identify systemic improvements. The Government also stands to benefit economically from investing in prevention.

Together these findings show AOP prevention is a social responsibility and a sound investment

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