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AUT

NATIONAL STUDY OF ABUSE OF OLDER PEOPLE:

Social and economic costs in Aotearoa New Zealand

Prepared for Ministry of Social Development | Te Manatū Whakahiato Ora by the New Zealand Policy Research Institute, AUT



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Glossary

Acronym	Definition
ACC	Accident Compensation Corporation
AOP	Abuse of older people
ARC	Aged residential care
CBAx	The Treasury's cost benefit analysis tool
DALY	Disability-adjusted life year
DWL	Deadweight loss
EARS	Elder Abuse Response Service
IDI	Stats NZ's Integrated Data Infrastructure
MCS	Mental Component Summary
MSD	Ministry of Social Development | Te Manatū Whakahiato Ora
NZCVS	NZ Crime & Victims Survey
NZHWRS	New Zealand Health, Work, and Retirement Study
PAN	Population attributable number
PAR	Population attributable risk
QALY	Quality-adjusted life year
RR	Relative risk
RSR	Rapid scoping review
VOSLY	Value of a statistical life year

EXECUTIVE SUMMARY

Key messages

- **Abuse of older people (AOP) imposes major economic and social costs**, totalling at least NZ$1.78 billion annually.
- **Victims and families carry most of the burden**, highlighting inequity and the urgency of prevention.
- **Prevention is likely to be cost-effective**, as current spending is a fraction of the harm being caused.
- **Non-economic harms matter** and must be acknowledged alongside financial costs.
- This report provides a **baseline for policy action and further research**, placing AOP on the agenda as a pressing social and economic issue.

Why this report matters

This report forms part of the *National Study on the Abuse of Older People* (AOP), commissioned by the Ministry of Social Development (MSD). It provides the first comprehensive estimate of the economic and social costs of AOP for Aotearoa New Zealand (NZ) and is the first such estimate globally. By quantifying the scale of harm, the report highlights not only the financial impact on individuals, whānau, government, and society, but also the less tangible yet no less important consequences for wellbeing, relationships, and social cohesion.

The scale of the problem: A NZ$1.78 billion annual cost

Our estimate is that AOP among people aged 55 and older costs this country NZ$1.78 billion each year.

- Individuals and families bear the largest burden – approximately NZ$1.17 billion, or 66% of total costs.
- Government expenditure attributable to AOP is estimated at NZ$615 million annually (or 34%).

- These figures reflect only measurable economic impacts. The true cost is higher, as many non-economic harms cannot easily be expressed in monetary terms, and some economic impacts cannot be measured due to data gaps.

Older people and their whānau carry the heaviest share of the burden

- **Financial losses** due to abuse are the single largest cost, estimated at **NZ$709 million annually**.
- **Lost earnings** due to reduced workforce participation amount to around **NZ$107 million** each year.
- **Private contributions to residential care** linked to AOP add approximately **NZ$350 million** each year.

Beyond these financial figures, victims and families also experience reduced wellbeing, disrupted relationships, financial insecurity, and loss of independence – costs that are profound but difficult to quantify.

Government bears substantial costs[1] across multiple systems

- **Health system costs**, including aged residential care (ARC), are the largest component, estimated at **NZ$546 million**.
- **Justice system costs** are estimated at **NZ$16 million**.
- **Welfare and benefits** paid to older people experiencing AOP contribute around **NZ$7 million**.
- **Reduced tax revenue** linked to victims' lost earnings amounts to **NZ$32 million**.
- **Specialist elder abuse services and prevention programmes**, such as the Elder Abuse Response Service (EARS), currently cost around **NZ$14 million** annually.

[1] Government expenditure figures use 2024/2025 data and/or average 2023/2024 and 2024/2025 financial years.

The consequences of AOP ripple beyond individual victims and government agencies

Society bears additional, largely unmeasured costs, including:

- **Opportunity costs** for iwi, charities, and support organisations that redirect resources to respond to AOP.
- **Lost productivity and contributions** of older adults, including paid work, volunteering, and governance roles.

These costs are significant yet largely invisible in financial accounts.

Not all costs are economic

While economic costs provide a headline figure, the deepest harms are often non-economic. Victims face deterioration in mental and physical health, cultural & spiritual harm, and a loss of dignity and autonomy. These impacts are not fully captured by monetary estimates, even when using tools such as quality-adjusted life years (QALYs) or wellbeing measures. Recognising these harms is essential to understanding the true scale of AOP's impact.

Spending on prevention is dwarfed by the cost of AOP

Current government investment of around NZ$14 million annually stands in stark contrast to the NZ$1.78 billion annual economic burden. Even modest increases in effective prevention and early intervention have the potential to yield substantial savings for the Government, while sparing individuals and whānau the greatest share of harm.

Strengths and limitations of this study

- This is the first detailed estimate of AOP costs worldwide, providing an essential evidence base for policy.
- Our approach is deliberately conservative, meaning the figures are more likely to understate than overstate the true costs.

- Data gaps remain, particularly in justice system impacts, productivity losses, and long-term non-economic outcomes.
- Some assumptions about prevalence, causality, and lifetime impacts were necessary; these are transparent but should be refined in future work.

Conclusion

AOP is not only a profound human rights issue but also a major economic challenge. The costs identified in this report show that inaction carries a high price, borne most heavily by victims themselves. Addressing AOP through prevention and early intervention is both a moral imperative and a sound investment for NZ's future.

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. It presents research into the economic and social costs of AOP in Aotearoa New Zealand (NZ). The report provides an estimate of the economic impact of AOP on individuals, whānau, communities, and government systems, and outlines broader social consequences such as reduced wellbeing and lost productivity. As part of the *National Study*, it provides a crucial understanding of the scale and significance of AOP's impacts on society.

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, 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.
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. *Aged Residential Care – Evidence from the Integrated Data Infrastructure (IDI)* report.
8. *Findings from qualitative interviews with NZ European, Māori, Pacific, and disabled older people who have experienced abuse* report, presenting findings from qualitative interviews of 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 **(this report)**.

This report proceeds as follows: next, we summarise the aims of the current study and provide definitions for AOP, and economic and social costs in this context. Section 2 then outlines the methods used to conduct the rapid scoping review (RSR), and Section 3 reports relevant findings from the RSR, including a preliminary framework for estimating the cost of AOP (see Section 3.3). Section 4 describes our approach to estimation, including how we modified the preliminary framework, and summarises the data we use. Section 5 estimates the economic costs and discusses social costs, respectively. Lastly, Section 6 discusses limitations, implications for policy, and directions of future work.

1.1 Study aims and definition of AOP

The main aim of this research is to estimate, where possible, the economic and social costs of AOP in NZ. We use a range of data sources to obtain costs estimates for AOP and its consequences, and rely on the population-level data[2] collected in the main *Prevalence Survey Report*, the Ministry of Justice's NZCVS and data held in Stats NZ's IDI, to scale these costs for the NZ population of people aged 55 and above.

Definition of AOP

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 *National Study* uses the

[2] The *National Prevalence Study of Abuse of Older People* was approved by the AUT Ethics Committee (AUTEC Ref. 24/30).

following working definition of AOP, which is consistent with the most recent study of AOP prevalence survey done 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).

The 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 surveys, the 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.

1.2 What costs do we consider?

The consequences of experiencing AOP, including physical injury, deterioration in mental health, and reduced quality of life, are wide-ranging and impact both the individual, their family/whānau, and society. These consequences impose various costs, including increased spending (e.g. the costs of providing healthcare to treat victims of physical abuse) and opportunity costs (e.g. reduced workforce participation resulting from some types of AOP). In Table 1 we lay out some of these costs. Later on, in Table 2 (Section 3.3) and Table 3 (Section 4) we present these costs within a framework informed by our RSR.

Table 1: Types of costs that result from AOP

Categories of cost	Examples
Financial losses to individuals	Direct theft, fraud, or misappropriation of money or assets. Losses from misuse of powers of attorney or coercion into financial decisions. Unpaid contributions to agreed household or care costs.
Individual and societal costs of poorer mental health and wellbeing	Treatment costs for depression, anxiety, trauma, and other mental health impacts. Loss of quality of life and life satisfaction. Increased use of social services and community support. Reduced social participation and connectedness.
Individual and societal costs of physical health outcomes	Acute healthcare costs (hospitalisations, ACC claims, GP visits) following harm. Long-term rehabilitation, home care, or disability support costs. Loss of independence, with possible earlier entry into aged residential care (ARC).
Societal costs of financial support provision	Increased government expenditure on benefits or hardship assistance. Greater reliance on public housing or subsidised accommodation. Flow-on effects on whānau providing unpaid care or financial help.
Societal costs of AOP's existence	Costs of prevention, detection, compliance, and monitoring in some business sectors. Missing contributions of older people in community organisations and the workforce.

We take a conservative approach so likely underestimate the costs we do include. Moreover, there are several costs we don't consider due to lack of data/measurement currently, such as to businesses (e.g. financial institutions) of preventing AOP, or because they're not amenable to measurement in financial terms, such as reduction in wellbeing or quality of life.

1.3 Complexities and considerations

Estimating the cost of abuse involves navigating a range of methodological assumptions and conceptual complexities. A key early decision for analysts is how to conceptualise the affected population and define the prevalence (or incidence) of abuse within it. There is an equity dimension to this decision; some costs, especially social costs, will differ between groups even for similar types of abuse. For example, our qualitative interviews (Wilson et al., 2026) highlight the cultural tradition of not speaking negatively of others within some Pacific communities, imposing a unique social cost of abuse on this group. More generally, different groups both experience abuse differently and have different options available to them when they experience it, resulting in different patterns of social and economic costs (KPMG, 2009).

Foremost, prevalence assumptions can greatly affect cost estimates. Prevalence, in turn, is inherently connected to underlying definitions of abuse. In Australia, KPMG expanded the scope of its definition of abuse of women between its 2009 and 2016 reports; this widened scope resulted in a 62% increase in the estimated cost of abuse from AU$13.6 billion to AU$22 billion (KPMG, 2016). Our exploration of thresholds of AOP may have implications in this regard (Scott et al., 2026).

A second area of complexity is the nature of abuse, especially for AOP. In our qualitative interviews, some participants reported that AOP was a continuation of abuse that had existed earlier in their lives (Wilson et al., 2026). This raises questions about how to apportion costs – what share of long-term impacts should be attributed specifically to AOP? Even when abuse strictly meets definitions of AOP, serious thought must be given to how the duration or severity of abuse might affect costs. For example, we might expect victims' mental health to be affected by having experienced abuse at all with the first instance having the greatest impact (Chen et al., 2026b), but we would also expect their personal finances to be increasingly affected with each instance of financial abuse.

From a public services perspective, the relationship between abuse and cost is also not always linear (nor always linked to prevalence). Some services – such as police response – incur similar costs per case regardless of frequency or severity. Others, particularly specialist support or therapeutic services, may involve higher cumulative or upfront costs as duration or complexity increases. Finally, different forms of

abuse often co-occur (e.g. physical abuse and emotional abuse), creating challenges in isolating the effects of each type and avoiding double-counting in cost estimates (Deloitte Access Economics, 2018).

Causality

The phrase “costs of AOP” has an implicitly causal interpretation; all the costs included in the estimate are *because of* AOP, and if we could eliminate it then these costs would also be eliminated. In reality, attributing the costs that we identify to AOP requires some strong assumptions.

The gold standard for causal research is the randomised control trial. This is because randomisation should mean that the groups being compared are similar in every way except for the phenomenon being studied, and so any differences in outcome can reasonably be attributed to that phenomenon. For obvious reasons, we cannot randomly assign people to experience AOP or not. This is common across topics of interest to social scientists, and so researchers have designed approaches that are “as-if random" (Dunning, 2008). Often called quasi-experimental approaches, these research designs exploit events and phenomena that divide people into groups through a mechanism that is unrelated to the outcome of interest. Common mechanisms in the social sciences include arbitrary dates, or variation in the amount of rainfall.

While such approaches are convincing in terms of causality, not every research problem has a convenient quasi-experimental solution. In these situations, researchers are limited to addressing differences between groups that can be observed in the data. This can be accomplished by either including control variables in regression models, or by matching study groups on those variables. In our context, this would mean either adding control variables to a model where an outcome like hospitalisation was regressed on being an AOP victim, or creating a group of non-AOP victims who are similar to AOP victims. A limitation of these approaches is that only characteristics which are observed in the data can be accounted for in this way, and there are multiple potential differences between AOP victims and non-victims that could be related to relevant outcomes. For example, a lack of social support could make someone both more vulnerable to abuse and less able to manage minor health issues outside of hospital, and this would create a spurious association between AOP and hospital use in the data.

This has important implications for cost estimation; there is a risk of attributing outcomes to AOP that may have occurred regardless, thereby overstating its impact. This is an issue with all cost of abuse studies which rely on extant research. The existing work that informs our approach (see Section 3.2) generally avoids addressing whether the relationship between abuse and its outcomes is truly causal. That is, they do not assess whether abuse directly causes the outcomes being measured (such as health issues, economic impacts, or social consequences). For example, Kahui and Snively (2014) explicitly state

that they do not consider causality in their analysis. We follow this approach, taking care to be conservative and minimise the risk of overestimating AOP costs.

Simplifying assumptions

To estimate the cost of AOP, we have assumed that all cost components are independent of each other. This assumption is necessary because our inputs come from disparate data sources; removing this assumption would require complex systems data, which to our knowledge does not exist. However, it is unlikely that costs are truly independent. Incurring some economic costs will almost certainly affect non-economic costs. For example, using elder abuse support services will incur a cost to that service but may have corresponding benefit for wellbeing. Similarly, using the justice system may result in a further relationship breakdown between the older person and the person causing harm. Even economic costs are not independent of each other. Use of the justice system will result in costs accruing to government but could reduce costs to victims if it results in the abuse stopping.

2 RAPID SCOPING REVIEW METHODS

A scoping review seeks to map and summarise existing evidence on a topic (Pollock et al., 2024). For this work, time and resource constraints prevented undertaking a full scoping review, which typically requires a large multidisciplinary team and can take 12 months or more. Instead, we undertook a rapid scoping review (RSR), which applies feasible limits to searches rather than striving to be comprehensive. In the remainder of this section, we describe the methods we used for the RSR, including the limits we applied to make the undertaking feasible in the time period.

2.1 Search strategy and source selection

All searches were conducted in Google Scholar to ensure inclusion of both academic literature and a wide range of grey literature.[3]

To facilitate a rapid review of existing evidence, searches were conducted iteratively with a narrow scope initially and a progressively wider scope until no novel relevant sources were returned. The first two searches sought articles citing a known source, while all subsequent searches were based on keywords only (keywords denoted by " " in list below). The searches used, in order, were:

1. Sources citing Spencer (1999), "Zealand"
2. Sources citing Spencer (1999)
3. a) "cost of abuse", "older", "Zealand"
   b) "cost of abuse", "elder", "Zealand"
4. a) "cost of abuse", "older"
   b) "cost of abuse", "elder"
5. "cost of abuse", "Zealand"
6. "cost of abuse".

For all searches, the titles of the first 100 hits were examined and results in languages other than English were excluded, with promising titles retained for further consideration. We read the abstracts and/or executive summaries of retained sources, and all those that suggested the full text included an estimate

[3] Grey literature refers to all works not published through commercial publishers. In the context of research, it generally means reports published by governments, charities, think-tanks, international organisations, and similar, in contrast to academic journal articles or books.

of the cost of abuse – of any group – and some explanation of how that cost was calculated were retained and read in full.

Following a full text read, studies which calculated the cost of abuse for at least two separate costs (e.g. health system and justice system) or for at least two stakeholders (e.g. individuals and national government) were considered highly relevant and used for two "snowball"-style searches. "Forward snowball" searches involved identifying sources citing these most relevant studies using Google Scholar, and following the procedure described above (scanning titles of the first 100 hits excluding those not in English; reading abstracts/executive summaries based on title scan; reading full text based on abstract/executive summary; categorised by relevance) to identify additional sources. Second, our "backward snowball" approach identified citations of key concepts in text, rather than scanning full reference lists. When novel sources were identified, snowballing was repeated as above.

2.2 Extraction, synthesis and utilisation of information

Information in the following categories was extracted into a spreadsheet:

- Geography (e.g. Aotearoa New Zealand; Canada; etc)
- Population/abuse type (e.g. children; abuse in care; etc)
- Who bears costs
- Type of costs included
- Costs explicitly excluded
- Approaches to calculating costs
- Data sources and cost measures

Not all sources contained information in all categories. In some cases, reading a source prompted re-reading of another source and re-extraction or re-consideration of information. There was considerable overlap between sources in terms of frameworks and categorisations for cost estimates, which is not surprising given the snowballing techniques employed led to the inclusion of several studies that were informed by others that were also included.

The purpose of the RSR was to inform our own efforts to estimate the economic – and social – costs of AOP in NZ, and this purpose shaped how information was synthesised, ultimately producing a framework that incorporates all relevant costs. We constructed the framework by first identifying all stakeholders

who sources identified as potentially bearing costs associated with abuse. We filtered this list to exclude stakeholders who do not apply to the NZ setting or to AOP. Where similar or overlapping stakeholders appeared, we consolidated them into broader categories to reduce duplication and enhance usability. We then extracted all cost types cited in our sources and mapped each one to the appropriate stakeholder group. Cost types that were not relevant to NZ or to older people were again removed.

3 RAPID SCOPING REVIEW LEARNINGS

3.1 Cost of AOP estimates

The RSR did not identify any work from NZ that sought to estimate the economic cost of AOP. In fact, we found no work from any country that sought to comprehensively calculate the economic cost of AOP to each stakeholder and for all types of AOP.

The most comprehensive estimate we found was from the UK by the charity Hourglass, who work in the AOP space providing a helpline for victims and their families, as well as working on research and policy. To calculate the cost of AOP in England and Wales, Hourglass first estimated prevalence based on calls to their helpline and assumptions about how many cases each call represented. Then, they took a per case figure from a broader cost of abuse study on domestic violence in the UK by the Home Office, adjusted this for inflation, and combined this cost with their own prevalence estimate to arrive at a total cost of AOP. Their per case estimate, further adjusted for inflation and converted into NZ$, is approximately NZ$104,200.

Although theoretically covering all types of abuse and all costs to the economy, the Hourglass estimate is not useful for us. First, we could simply take the Home Office estimate directly to apply to NZ prevalence data. Secondly, and more importantly, estimates based on costs of abuse for the full population are of limited use in calculating the costs of AOP. This is because: 1) patterns of abuse are different in older adulthood, with an increasing proportion of men experiencing abuse in older adulthood compared to few earlier in life; 2) potential differences in division between (e.g. the state and the individual) of costs of abuse at different life stages; and 3) age sensitivity of economic analyses (Spencer, 1999).

Some international studies provided more narrowly scoped estimates (e.g. looking only at the costs of one type of abuse or the costs to one specific stakeholder). Some of these estimates and/or approaches are described below, and where possible recalculated for the NZ context for comparison. It should be noted, however, that our AOP work generally considers the relevant population to be those aged 55 years and older, while most of the estimates we present below consider the population aged 65 years and older (see Meehan et al., 2026 and Scott et al., 2026 for a discussion on the age threshold within the NZ context). In this section we try to use the same age categories as the underlying sources when recalculating for the local context. However, this will mean both underestimating costs because those affected between ages 55 and the sources' age thresholds are not included, and making the strong assumption that the age structure of the source population is similar to that of the NZ population.

Even within the narrower scope of existing estimates, there is considerable variation. Looking only at financial abuse, estimates of the cost to victims and the Medicare and Medicaid systems in the US in the early 2010s range from US$3 billion to US$36 billion annually (Stanger, 2015) – a significant difference. Adjusting for differences in the size of the US and NZ populations,[4] the equivalent range for NZ would be US$5.5 million (NZ$11.6 million adjusted for inflation) to US$65.7 million (NZ$139 million adjusted for inflation).

For comparison, an Australian report estimated that in 2020, financial abuse (of people of all ages) cost victims AU$9,100 each and the wider economy AU$8,300 per victim (Commonwealth Bank of Australia & Deloitte Access Economics, 2022). Converted to current NZ$ and applied to our population, this is a total cost to victims of NZ$710 million and to the wider economy of NZ$650 million. This estimate of cost to victims exceeds even the higher US estimate by several multiples. It also assumes that costs are similar for people aged 55 years and for the population as a whole.

Some authors have looked specifically at the health costs of AOP. Zhang et al. (2024) looked at costs to Medicare Part A (hospital and other acute care) and Part B (outpatient and routine care) in the US, and found that in the 120 days following identification of abuse AOP victims accrued US$5,691 (NZ$13,000 adjusted for inflation) more in acute costs than matched controls. However, there was no statistically significant difference in costs for routine/ongoing care or for periods after 120 days. Similarly, differences in visits to emergency departments (EDs) and hospitalisations between known victims of AOP and matched controls increased in the period up to 120 days after identification of abuse (Rosen et al., 2023). In another study, vulnerable older victims of financial abuse had on average US$1,142 (NZ$2,500 adjusted for inflation) higher per patient per month costs to Medicaid and Medicare (Jonk et al., 2020).

None of the above studies suggest an approach suitable for estimating the cost of AOP in NZ. In the absence of local data, the financial abuse estimates may be useful for calculating the financial loss components. Differences between the US and NZ health systems mean the estimates of increased health costs by Zhang et al. and Jonk et al. are unlikely to be good proxies. In the US, Medicare covers almost all people aged 65+ and some younger disabled people, but it excludes most of the 55–64 age group unless they meet strict eligibility criteria. By contrast, NZ's publicly funded health system provides care for the whole population, so cost patterns, funding responsibilities, and patient out-of-pocket expenses differ significantly. These structural differences mean US health cost estimates cannot be directly applied to the NZ context.

[4] The NZ population aged 65+ in 2010 was 563,500 (Stats NZ | Tatauranga Aotearoa, 2022b) and the US population aged 65+ in the same year was 308,745,538 (Werner, 2011).

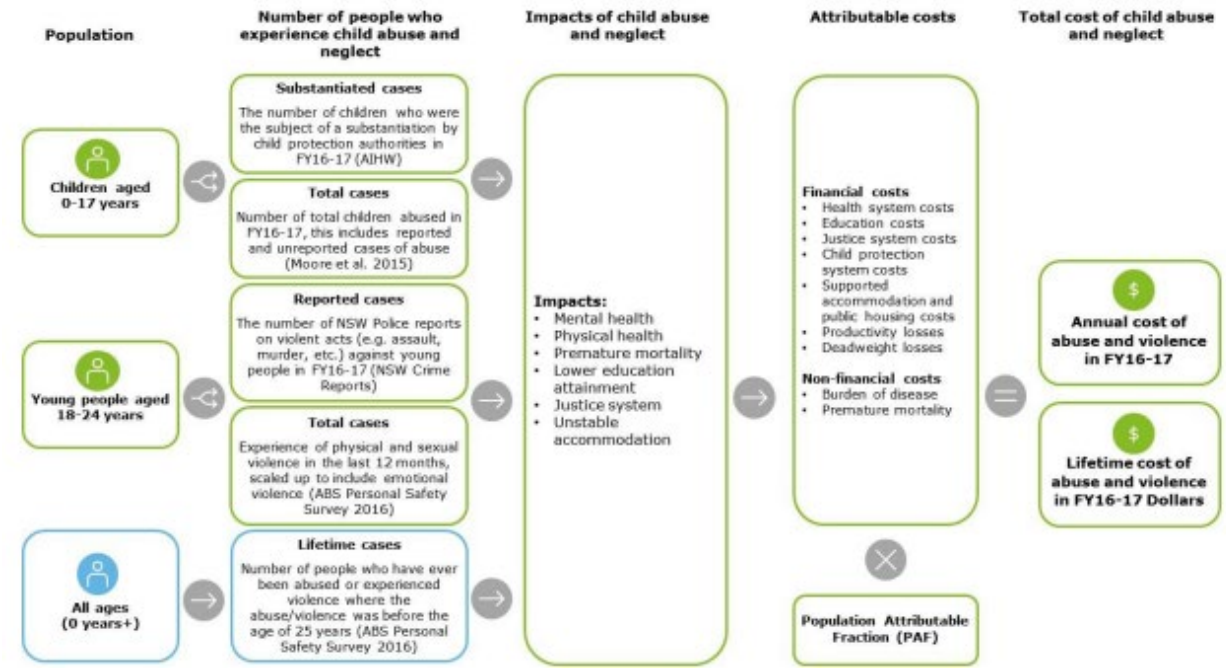
3.2 Key sources from other types of abuse

A handful of reports presenting cost estimates from different contexts proved particularly relevant in elucidating key concepts. These reports are notable because they attempt to provide a comprehensive estimate of the costs of abuse to a range of stakeholders. While they focus on other forms of abuse rather than AOP specifically, they are relevant in illustrating methodological approaches and categories of costs.

Deloitte Access Economics *The economic cost of violence against children and young people* (Australia)

Deloitte Access Economics (2018) estimated the cost of violence against children and young people (defined as ages birth to 24 years) in New South Wales (NSW) and Australia, both for the 2016/17 financial year and for lifetime costs. As shown in Figure 1 , there were three components of the authors' calculations: the number of children and young people who experienced abuse, the impacts of this abuse, and the attributable costs of these impacts.

Figure 1: Deloitte Access Economics' approach to calculating the economic costs of violence against children and young people (image credit: Deloitte Access Economics, 2018)



The authors describe multiple approaches to identifying the number of children who experienced abuse, using total cases within the relevant financial year for most calculations and lifetime cases for calculations

related to physical and mental health impacts. The authors undertook a literature review to identify relevant impacts.

The report calculated the cost to the NSW state government, the (Australian) Federal government, and individuals and society. Costs from both new and repeat cases of abuse were included. The report estimated that the costs totalled AU$11.2 billion in 2016/17, with approximately AU$2.3 billion borne by NSW state government departments, AU$600 million by the Federal government, and AU$8.2 billion by individuals and the broader community.

KPMG *The cost of violence against women and their children* (Australia)

KPMG (2009; see also KPMG, 2016), commissioned by the Australian Government, produced a series of reports on the cost of violence against women and their children. The first report was published in 2009, and subsequent reports largely updated initial findings with new data.

The authors report set out costs across seven categories:

- Pain, suffering, and premature mortality
- Health system
- Production-related costs
- Consumption-related costs
- Second-generation costs
- "Administrative" costs, which include the justice system, victim and survivor support, and violence prevention
- Transfer costs.

This report also used eight categories for allocating costs across society: victims/survivors; children; friends and families; employers; multiple levels of government; and the rest of society. It also separately calculated the cost of violence against women from specific vulnerable groups, namely, immigrant and refugee women; women with disabilities; Aboriginal and Torres Strait Islander women; and children who witness violence.

The final report (KPMG, 2016) estimated that the cost of violence against women and children in Australia was AU$22 billion in 2015/16. Victims and survivors bear about half of the total costs, with Federal, state, and local governments bearing about a fifth of the costs, and the wider community, family, perpetrators, employers, and so forth, bearing about 30%.

Kahui and Snively *Measuring the economic costs of child abuse and intimate partner violence to New Zealand*

Kahui and Snively (2014) take the approach of the KPMG Australian study and apply it to NZ in 2014, adjusting some categories of costs for NZ data availability. The authors consider costs in six categories (i.e. the same categories as the KPMG report but excluding second-generation costs):

- Pain, suffering, and premature mortality
- Health system
- Production-related costs
- Consumption-related costs
- "Administrative" costs, which include the justice system, victim and survivor support, and violence prevention
- Transfer costs.

They further allocate costs between children, adult victims/survivors, perpetrators, and employers. The authors further consider costs to vulnerable groups, which they list as women, Māori, Pacific people, young people, people with disabilities, and members of the Takatāpui and Rainbow communities.

Figure 2: Cost breakdown from Kahui and Snively (image credit: Kahui and Snively, 2014)

Cost category	Cost drivers	Approach
Pain, suffering and premature mortality 3.6 billion (51%)	Estimated total DALYs by health conditions, prevalence rates among victims compared to non-victims, estimated value of a DALY	Top-down
Health costs $377.3 million (5%)	Prevalence rates among victims compared to non-victims, health costs estimated by cost of illness studies	Bottom-up
Productivity-related costs $954.1 million (14%)	Average hourly wages, estimated time spent in justice system (e.g. court appearances), estimated time spent adversely affected by effects of violence	Bottom-up
Consumption-related costs $705.5 million (10%)	Average weekly household expenditure and estimated number of households by household composition	Bottom-up
Administrative and other costs $836.7 million (12%)	Total expenditure in justice and welfare system	Top-down and bottom-up
Transfer costs $582.3 million (8%)	Total expenditure in social welfare system	Top-down

The authors provided conservative, moderate, and high-end scenarios with differing prevalence rates. Although most sub-costs were presented for all three scenarios, the headline findings (NZ$7 billion/year in 2014) and discussions were based on the highest prevalence rate, with the authors suggesting this was still likely to be an underestimate.

MartinJenkins *Economic cost of abuse in care*

The authors seek to estimate the lifetime financial and non-financial costs of abuse in care that occurred in NZ between 1950 and 2019. Financial costs cover the whole economy and include spending on public and social services (health, child welfare, justice and policy, social welfare, education), along with deadweight losses and productivity costs. Non-financial costs capture pain and suffering experienced by victims and loss of life, measured using disability-adjusted life years (DALYs), and converted to monetary units with standardised values used in government. Prevalence estimates are taken from primary research commissioned within the wider Abuse in Care Inquiry, of which the economic costs work also forms a part. Costs estimates are lifetime costs.

The authors draw on the wider Inquiry findings to describe a number of impacts of abuse on individuals. Like Kahui and Snively (2014), this report finds the vast majority of the costs of abuse in care is the non-financial element, pain and suffering. For each victim of abuse in care, in 2019 the cost to the economy was estimated at NZ$243,000 (in Q1 2025 prices), while the non-financial cost to the individual was estimated at NZ$890,000 (in Q1 2025 prices).

3.3 Framework for estimating the cost of AOP

Informed by the key sources described above, we developed a preliminary framework for the types of costs that could be captured in our estimate. The framework categorises costs according to who experiences the costs and whether the costs are monetary or not.

Table 2: Preliminary cost framework resulting from the rapid scoping review

Cost to whom?	Economic costs	Non-economic costs
Government	Specialist services Justice system Health system Transfer costs Reduced tax revenue	
Victims and their families	Lost income Physical and mental ill-health Consumption costs	Pain and suffering Premature mortality
Perpetrators	Lost income	
Society as a whole	Deadweight costs Productivity costs	

The framework splits out some wider categories used by the source studies. For example, KPMG (2009) and Kahui and Snively (2014) have a single category for administrative costs, while we have split these into justice system costs and specialist services. Similarly, source studies had a single category for production costs, while we have split these into reduced tax revenue for government, lost earnings for victims and people perpetrating abuse, and productivity costs for businesses.

3.4 Other learnings

The RSR also pointed to some decisions to be made while undertaking a cost of abuse study. One is choosing between prevalence and incidence as a measure of frequency. Prevalence describes the number of existing cases within a given time window, while incidence describes the number of new cases in that window. Prevalence-based estimates would be expected to be higher than incidence-based estimates because they will include more cases. Which estimate is more appropriate will depend on the purpose of estimation. Prevalence-based estimates may be more useful for planning purposes, as they account for costs that are "baked in". On the other hand, incidence-based approaches may be more useful for policy-making or cost-benefit analysis, as they provide estimates of costs that could hypothetically be avoided through effective prevention (McCarthy et al., 2016).

A second choice is the timeframe in which costs should be included. In their study of the cost of violence against women and children in Australia, authors from KPMG (2009) suggest that in addition to the distinction between new and existing cases, prevalence-based and incidence-based costs also differ on the timeframe of costs they include. The former only include the costs in the prevalence period (e.g. the relevant calendar year) and the latter include lifetime costs. We see the discussion of time period as distinct from that of the choice between an incidence-based or prevalence-based approach, because prevalent and even past abuse will continue to accrue costs across the lifetime. Corso and Fertig (2010) simplify the time element by dividing costs associated with child maltreatment into short-term and long-term costs.

Calculating lifetime costs requires assumptions beyond those required for calculating single year costs. These include how costs might change over the lifetime, and the length of the lifetime, and the discount rate used to convert future costs to present values. In the case of AOP, it may be more challenging to arrive at an appropriate set of assumptions because of the unique features of the older population (Spencer, 1999). For example, the older population has shorter and more variable remaining lifespans, higher likelihood of health decline, and different patterns of service use compared to younger groups.

These factors increase uncertainty in the estimates, as small changes in assumptions can have a large effect on the calculated lifetime cost.

4 HOW WE CALCULATE THE COSTS OF AOP IN AOTEAROA NEW ZEALAND

In this section, we describe the methods we used to calculate the costs of AOP in NZ.

Modifying the framework for AOP

AOP is distinct from the abuse studied by the key sources. We therefore modified the initial framework to make it relevant. We added:

- Financial loss from financial abuse, as an economic cost to victims and their families.
- Moves to residential care, as both economic and non-economic costs to victims and their families. We also include the cost of residential care as an economic cost to government, but this is contained within the category health system rather than shown separately.
- Opportunity costs to iwi, charities, and other support organisations, as an economic cost to society as a whole.
- Trust and social cohesion, as a non-economic cost to both government and society as a whole.
- Lost relationships, as a non-economic cost to victims and their families.
- Undermined whanaungatanga, as a non-economic cost to society as a whole.
- Missing contributions of victims of AOP in roles like paid employment, governance, and volunteering, as a non-economic cost to society as a whole.
- We replace “pain and suffering” and “premature mortality” with “wellbeing”.

We also excluded some costs identified in the key sources. In particular, we removed deadweight loss (DWL). In this context, DWL refers to the loss in overall economic efficiency that can occur when taxes are raised to fund public spending. For example, if higher income tax rates lead some people to work fewer hours. However, AOP-related government expenditure is small relative to total government spending. If AOP-related costs were removed, the funds would almost certainly be redirected to other areas of public spending rather than used to reduce taxes (Buchanan & Wagner, 1977; OECD, 2022; Slemrod, 1990). Moreover, DWL is difficult to measure accurately, and the estimates can be highly sensitive to assumptions about tax rates and behavioural responses (Chetty, 2009).

We also removed consumption costs. In the source material, consumption costs were framed as the increased per person living costs of being single compared to being in a couple. In the context of violence against women this category is relevant, as those who leave violent relationships will face this cost. In the context of AOP, the abuser is not necessarily a member of the victim's household. In fact, Meehan et al. (2026) finds that in most cases of AOP (78%), the victim is not living with the person causing harm. Where this individual is living with the victim, the harm may take the form of not contributing to household costs, which we capture under financial loss. For these reasons, we have not included a separate category for consumption costs in this analysis.

Although our population is older people, we maintain categories for reduced tax revenue and lost earnings. Our definition of "older people" is those aged 55 years and above, and those aged 55–64 years are generally considered to be working age. Moreover, although 65 years is the age of eligibility for receipt of NZ Super and KiwiSaver withdrawals, it is not uncommon for people to continue working beyond this age (Stats NZ | Tatauranga Aotearoa, 2025). For example, Meehan et al. (2026) finds that 41% of those aged 65–74 are employed.

Finally, we remove entirely from consideration costs to the person causing harm (i.e. perpetrators). This is partly a pragmatic decision due to an expected lack of data. It is also a theoretical and values-based decision. To include costs to those causing harm in an accounting of the cost of AOP, we would also need to include the amount these individuals gain from financial AOP. As well as cancelling out the loss to victims in the accounting, it would be antithetical to the purpose of the wider project to present the benefits to those perpetrating abuse as worthy of consideration. Similar logic underpins our decision not to include wider economic gains (e.g. businesses which provide training to bank staff on identifying AOP).

Our framework for costs associated with AOP is presented in Table 3.

Table 3: Our framework for the costs of AOP

Cost to whom?	Economic costs	Non-economic costs
Government	Specialist services Health system Justice system Welfare and benefits Reduced tax revenue	Reduced trust and cohesion

Cost to whom?	Economic costs	Non-economic costs
Victims and their families	Lost earnings Financial losses Move to residential care	Reduced wellbeing Lost relationships Financial insecurity Move to residential care
Society as a whole	Opportunity costs for support organisations Productivity costs	Reduced trust and cohesion Missing contributions of older adults Undermined whanaungatanga

How we treat non-economic costs

Non-economic costs reflect intangible concepts that do not lend themselves to expression in monetary terms. This has not prevented economists from undertaking the task. A commonly used approach is to use a standard value for a year of human life and adjust this for quality of life (quality-adjusted life years or QALY) or years lived with disability or illness (disability-adjusted life years or DALY). Diverse outcomes can be expressed in terms of their effect on QALYs or DALYs, allowing for expression of these outcomes in financial terms. In NZ, the Treasury values a QALY at NZ$44,783 (The Treasury | Te Tai Ōhanga, 2024). Another approach to measure non-financial outcomes in financial terms is to collect data on how much of a financial gain (or loss) would produce the same difference in subjective wellbeing (Smith & Davies, 2020). The literature contains critiques of specific methods and how they are applied (e.g. Robinson, 2024; Lathe et al., 2024), as well as of the practice itself (Gould et al., 2024).

Separately from the merits of presenting non-economic costs in monetary terms, relevant data is needed to express a given non-economic outcome in monetary terms. Given the subjectivity of the outcomes of interest, the context in which these data were collected is particularly important. We therefore only present cost estimates for these non-economic harms where data linking the relevant outcome to QALYs or subjective financial wellbeing exists for NZ. This does not imply that those costs we do not express in financial terms have no financial cost, nor does it imply a difference in the importance of the financial or non-financial harms between outcomes we express in these terms and those we do not.

4.1 Available data

Abuse frequency

The best estimate of AOP prevalence available comes from a nationally representative survey commissioned as part of the wider *National Study*, which collected data from people aged 55+ living in the community in NZ between July and December 2024. These data are recent and weighted to be representative of the target population across various demographic characteristics. However, like all surveys, there is a risk of sampling bias if the prevalence of AOP in respondents differs from that of the population in a way that is not accounted for in weighting. As with most international AOP prevalence surveys, the survey's target population is restricted to those living in the community and therefore does not include the approximately 30,000 people aged 55+ living in ARC in NZ, but it does include those living independently in retirement villages. This exclusion recognises the distinct nature of abuse in institutional settings and the need for separate investigative approaches (Yon et al., 2019).

The survey provides the best available prevalence estimates for each kind of AOP (neglect, financial, emotional or psychological, physical, sexual, and cultural & spiritual), as well as an overall indicator covering abuse in any of these categories. We further estimate a high and low prevalence rate in each category and for the overall measure. Our main *Prevalence Survey Report* (Meehan et al., 2026), *Survey Methodology Report* (Tee et al., 2025), and *Thresholds Report* (Scott et al., 2026) provide further detail on the methods and analytic choices that produced the prevalence estimates. Table 4 shows the frequency estimates (either in cases or in prevalence) that were used in calculations.

Table 4: Frequency estimates used in calculations

Cost category	Frequency used in low estimate	Frequency used in middle (headline) estimate	Frequency used in high estimate
Financial losses	Cases of financial abuse, 95% CI lower bound (50,900)	Cases of financial abuse, point estimate (61,200)	Cases of financial abuse, 95% CI upper bound (71,500)
Lost earnings	Cases of physical abuse, 95% CI lower bound (33,800)	Cases of physical abuse, 95% CI lower bound (33,800)	Cases of physical abuse, 95% CI upper bound (51,400)
Private costs of residential care	Overall AOP prevalence, 95% CI lower bound (0.154)	Overall AOP prevalence, point estimate (0.170)	Overall AOP prevalence, 95% CI upper bound (0.181)
Specialist services	N/A; top down calculation	N/A; top down calculation	N/A; top down calculation

Cost category	Frequency used in low estimate	Frequency used in middle (headline) estimate	Frequency used in high estimate
Emergency department (ED) visits (health system)	Physical and/or sexual abuse prevalence, 95% CI lower bound (0.027)	Physical and/or sexual abuse and/or neglect prevalence, point estimate (0.0427)	Overall AOP prevalence, 95% CI upper bound (0.181)
Inpatient stays (health system)	Physical and/or sexual abuse prevalence, 95% CI lower bound (0.027)	Physical and/or sexual abuse and/or neglect prevalence, point estimate (0.0427)	Overall AOP prevalence, 95% CI upper bound (0.181)
Public costs of residential care (health system)	Overall AOP prevalence, 95% CI lower bound (0.154)	Overall AOP prevalence, point estimate (0.170)	Overall AOP prevalence, 95% CI upper bound (0.181)
Justice system	Cases of AOP overall, 95% CI lower bound (235,000)	Cases of AOP overall, point estimate (256,000)	Cases of AOP overall, 95% CI upper bound (276,400)
Welfare and benefits	Cases of AOP overall, point estimate (256,000)	Cases of physical abuse, 95% CI lower bound (33,800)	Cases of physical abuse, 95% CI upper bound (51,400)
Reduced tax income	Cases of physical abuse, 95% CI lower bound (33,800)	Cases of physical abuse, 95% CI lower bound (33,800)	Cases of physical abuse, 95% CI upper bound (51,400)

We are not aware of any data that systematically measures the incidence of AOP in NZ. It may be possible to calculate a proxy of incidence from the Elder Abuse Response Service's (EARS) administrative data. Such a proxy would likely be an underestimate of the true incidence, as not all cases of AOP will be reported to EARS. Also, as discussed in Meehan et al. (2026), service provider data can give a skewed view of AOP frequency (e.g. rates of help seeking vary by type of abuse).

Outcomes

We summarise the data sources on outcomes which contributed to our headline estimate in Table 5 and in the text below.

FINANCIAL LOSSES

We identified multiple estimates of financial loss. One estimate is taken from a report on financial abuse within intimate partner relationships for Australians of all ages (Commonwealth Bank of Australia & Deloitte Access Economics, 2022). Two reports estimate per case financial loss based on amounts

reported during calls to AOP hotlines in Australia (Jackson, 2009) and the UK (Hourglass, 2024a). In the US, a blog for Consumer Reports provided two, quite different, estimates of the total loss to financial abuse in the US. However, this source did not report per case, making it more challenging to apply for our purposes.

LOST EARNINGS

A study by Meehan and Schober (2024) contributes to several components of our cost estimate, including lost earnings. The authors used data from the NZCVS, linked to the IDI, to estimate the relationship between being a victim of crime and, among other things, earnings, benefit receipt, and hospitalisation, and includes estimates for the population aged 50 and over. Also, estimates are provided for the whole sample identified as victims in the NZCVS, as well as for those who are victims of interpersonal violence. We consider estimates from the whole sample to map to our overall AOP estimate from the main *Prevalence Survey Report*, while interpersonal violence is analogous to our physical AOP category in this report (Meehan et al., 2026).

This study is particularly useful because there is a dearth of relevant studies set in the NZ context. However, the NZCVS does not fully capture AOP – more detail on the strengths and limitations of the NZCVS in capturing AOP can be found in the main *IDI Report* (Chen et al., 2026b). This means that, to produce our cost estimate, we have assumed that the relationships between victimisation measured in the NZCVS and our outcomes of interest are broadly similar to the relationships between AOP and our outcomes of interest. This is not an unreasonable assumption, but it is unverifiable.

Our main *IDI Report* is also used to sense check some of our estimates. A strength of this work is that it is limited to the older population and uses both matching and a difference-in-difference design to produce estimates, making causal interpretations more plausible. However, as discussed in that report, there are important limitations in our ability to identify AOP in the IDI data, which is why we use this source for comparison and not primary estimation.

PRIVATE COSTS OF AGED RESIDENTIAL CARE

Two studies, both set in the US, suggest that AOP is associated with an increased risk of moving to ARC (Dong & Simon, 2013b; Lachs et al., 2002).

The supplementary *Aged Care IDI Report* (Chen et al., 2026a) also includes estimates of the effect of AOP on placement in ARC. Although we would normally prefer to use local data, as we describe in that report, the IDI data are not well suited for detecting AOP, and therefore the impact on moving to residential care is not suitable for inclusion in our cost estimate. Instead, we use our IDI findings as a sense check.

HEALTH SYSTEM COSTS

Several studies link AOP to worsened health including specific mental and physical health conditions like depression, anxiety, or chronic pain, as well as a higher number of conditions and poorer self-rated physical and mental health (Fisher & Regan, 2006; Yeung et al., 2020). However, poorer health itself is a non-economic cost, best captured in our framework under wellbeing. Poorer health will translate to costs to the health system only through increased use of health services.

We found three studies that suggested AOP victims were indeed more likely to use health services, specifically the ED (Yunus et al., 2019), inpatient facilities (Yunus et al., 2019), and ARC (Dong & Simon, 2013b; Lachs et al., 2002). All three studies were set in US cities and focused on the population aged 65 and over. Also, Meehan and Schober (2024) also present estimates of the association between victimisation and inpatient and emergency room use.

We did not find sources relating AOP to use of other parts of the health system such as ACC or primary care.

JUSTICE SYSTEM COSTS

We did not find studies reporting how often AOP cases come into contact with the justice system. In the main *IDI Report* (Chen et al., 2026b) we are able to use NZCVS data to estimate how often cases of AOP are reported to the police.

WELFARE AND BENEFITS

We found no estimates of the association between AOP and receipt of benefits. We instead use Meehan and Schober's (2024) estimates of the difference in benefit receipt between people who have experienced victimisation and those who have not.

COSTS TO SOCIETY AS A WHOLE

We found no useful estimates of the productivity or opportunity costs faced by businesses and charities as a result of AOP.

Table 5: Outcome data sources used in headline estimate

Category	Outcome	Source	Suitability	Estimate
Financial losses		Commonwealth Bank of Australia and Deloitte Access Economics (2022)	Study set in Australia and population is people of all ages in abusive intimate partner relationships; AOP by definition affects a narrower age group, and includes abuse by a wider range of people.	Study estimate AU$9110/case; converted to NZ$ and adjusted to Q1 2025 prices this is NZ$11,584
Lost earnings		Meehan and Schober (2024)	Study uses NZCVS which has relatively low sensitivity and specificity for detecting AOP.	NZ$147.70/ quarter
Private costs of residential care	Entering residential care	Dong and Simon (2013b)	Longitudinal study of people aged 65 and over from three Chicago neighbourhoods; may not be comparable to older people in NZ. Strict AOP definition required reporting to protective services.	RR=3.05
Health system	Entering residential care	Dong and Simon (2013b)	Longitudinal study of people aged 65 and over from three Chicago neighbourhoods; may not be comparable to older people in NZ. Strict AOP definition required reporting to protective services.	RR=3.05
Health system	Use of hospital as inpatient	Dong and Simon (2013c)	Longitudinal study of people aged 65 and over from three Chicago neighbourhoods; may not be comparable to older people in NZ. Strict AOP definition required reporting to protective services.	RR=2.72
Health system	Use of emergency department	Dong and Simon (2013a)	Longitudinal study of people aged 65 and over from three Chicago neighbourhoods; may not be comparable to older people in NZ. Strict AOP definition required reporting to protective services.	RR=2.33
Welfare and benefits		Meehan and Schober (2024)	Study uses NZCVS which has relatively low and specificity for detecting AOP.	$NZ50.40/quarter

Category	Outcome	Source	Suitability	Estimate
Reduced wellbeing	Mental health (change in MCS score)	Mouton et al (2010)	Study used large, multidisciplinary study of post-menopausal women in the US, who may not be comparable to older people in NZ. Abuse status and MCS were assessed at baseline; MCS was also assessed three years after enrolment.	Change in MCS score (0-100): 0.55

Cost estimates

An important source of cost data is the Treasury's CBAx tool (The Treasury | Te Tai Ōhanga, 2024). The tool is a spreadsheet designed for government agencies to use in cost-benefit analyses. The relevant section for our purposes is the "database" tab, which lists the dollar value of a large number of outcomes and events. We use CBAx values for the cost of private and public contributions to ARC, hospitalisation, emergency room visits, and justice system costs. We also use CBAx values for some non-economic cost estimates, specifically, worsened mental health. CBAx includes QALY and value of a statistical life year (VOSLY) which theoretically would allow other non-economic costs to be calculated.

We calculate the cost of reduced tax revenue using Meehan and Schober's estimates of lost earnings and Inland Revenue data on the income distribution (Inland Revenue | Te Tari Taake, 2024).

For the costs of specialist services, we rely on a report to the Minister for Seniors released in response to an Official Information Act request, which brings into the public domain useful data on AOP spending (Ministry of Social Development | Te Manatū Whakahiato Ora, 2024).[5] The report summarises spending on people aged 55 and older across 23 government departments. Some spending described in this report relates directly to AOP (e.g. EARS). Other spending described will only be partly related to AOP (e.g. health spending on people aged 55+). We include only spending related directly to AOP from this source.

4.2 Calculation

We have calculated low, medium, and high costs for each economic cost component. Where we rely on a single outcome and/or cost data source, the low, medium, and high cost estimates come from the low,

[5] Data in this report were collected at a single point in time (October 2024) and estimated using available service information from relevant agencies. These data are therefore likely to change in future years.

middle, and high prevalence estimates. Where we have multiple estimates of outcomes or cost, we describe in the text values we use to calculate low, medium, and high estimates and our rationale.

The method used to calculate each cost component varies according to the available data. For some costs, we are able to simply multiply a per case cost by our prevalence estimate. This is how we arrive at costs for financial losses, lost earnings, and welfare and benefits. Other components also multiply per case costs by prevalence but adjust that cost for other considerations. For justice system costs, we also multiply by the probability of reporting AOP to the police. For reduced tax revenue, we use Inland Revenue data to determine the appropriate tax bracket to apply to calculate this cost from lost earnings. No calculations were required for costs of specialist services, as these were taken directly from the source.

More steps are needed for health system costs and the private cost of residential care. For these costs, we first calculate the Population Attributable Risk (PAR):

$$PAR = \frac{P_e(RR - 1)}{P_e(RR - 1) + 1}$$

where P_e is the prevalence of AOP, and RR is the relative risk of the outcome for AOP victims compared to non-victims. RR is calculated by dividing the probability of the outcome of interest for AOP victims by the probability in non-victims.[6] When probabilities are the same, the RR will equal 1; values above 1 tell us the outcome is more likely for AOP victims and values below 1 tell us the outcome is less likely.

The PAR tells us, as a proportion, how many cases of the relevant outcome are "attributable" to AOP. Although "attributable" is in the name, this does not imply attribution in terms of causality (see discussion in Section 1.3). Instead, it should be interpreted as the proportion of cases of the outcome that exist because of the higher probability of the outcome in the group exposed to AOP (without taking a position on whether this higher probability is causal).

To get costs, PAR is multiplied by the total number of cases of the outcome to obtain the marginal number of cases attributable to AOP, and this is multiplied by the per case value from CBAx.

One part of the formula for PAR is the RR. This report attempts to calculate the costs of AOP per year, but studies from which we extract the RR may have had follow-up of different periods. Where possible we scale our cost estimates accordingly. For example, an estimate derived from a study with a three-year follow-up would be divided by three. Where this is not possible (e.g. if the study had non-standard

[6] The relevant probabilities can in turn be calculated simply from just case numbers in each group or can be generated as part of regressions which control for potential confounders.

follow-up periods), we assume that 50% of any increased risk would occur within the first year and thus divide our estimate by two. We consider this to be a conservative assumption based on the *National Study's* IDI work, with a substantial share of costs incurred relatively soon after victimisation (Chen et al., 2026a).

Cost estimates in our data sources are reported in a range of currencies and come from different time points. To make these comparable, we first account for inflation using the relevant CPI or equivalent to standardise to Q1 2025 or as close as possible. Where a cost estimate covers a wide time interval, we use the CPI from the middle of the period. We then convert to a NZ$ equivalent using the International Monetary Fund's Purchasing Power Parity (PPP) conversion factors (International Monetary Fund, 2025). Per case costs we calculate are rounded to the nearest NZ$100 and total annual costs are rounded to the nearest NZ$1,000,000.

5 ECONOMIC COSTS

In this section we present the costs we calculated in each category of our framework under the broad categories of costs to victims and their families, government and society, as well as non-economic costs.

5.1 Cost to victims and their families: NZ$1.17 billion

Table 6: Summary of economic costs to victims and their families

Category	Low	Headline	High
Financial losses	$12m	$709m	$828m
Lost earnings	$20m	$107m	$163m
Residential care	$124m	$354m	$546m
Total	$156m	**$1,170m**	$1,537m

Note: Estimated annual costs, expressed in NZ$ millions, Q1 2025 prices.

Financial losses: NZ$709 million

Our headline estimate of the cost of financial abuse is NZ$11,600 per case, or NZ$709 million in total each year. The per case estimate is based on the cost to Australian victims of financial abuse by a current or former intimate partner, at any stage of life (Commonwealth Bank of Australia & Deloitte Access Economics, 2022). As noted, it is likely that abuse that occurs at different stages of life manifests differently than AOP. In this case the wider range of potential people causing harm to an older person will be a factor. Also, older adults, on average, will have more wealth than the population as a whole; in 2021, individuals aged 65 and over had median net worth of NZ$373,000, compared to NZ$310,000 for those aged 55–64 years and NZ$224,000 for those aged 45–54 years (Stats NZ | Tatauranga Aotearoa, 2022a). This would increase the amount that could be lost in a given case of abuse and may also increase the likelihood of being targeted in the first place. Therefore, NZ$11,600 per case is likely to be an underestimate. A recent blog by BNZ reported that the lower values of financial abuse among cases they identified was in the thousands (BNZ Media, 2025), confirming we are unlikely to be overestimating our per case cost.

Alternative per case costs of NZ$200,600 and NZ$398,200 came from the UK and Australia, respectively (Hourglass, 2024a; Jackson, 2009). These numbers have the advantage that they were calculated specifically for AOP rather than the population as a whole. However, both were calculated from financial

losses reported by victims phoning support lines for AOP. This is likely to bias the estimate upwards, as those who have suffered smaller losses may be less inclined to seek help. We therefore use NZ$11,600 per case applied to our "high" prevalence rate to produce our high estimate, rather than assuming higher losses per victim.

A blog post for the US publication *Consumer Reports* provides our low estimate (Stanger, 2015). This estimate is US$3 billion in 2011. Adjusted for inflation and the size of the NZ population, this is the equivalent of NZ$12 million. It is important to note that this estimate was calculated without reference to our prevalence data and so assumes that the prevalence of financial abuse in the US is similar to the prevalence in NZ. Also worth noting is that this source has a wider definition of AOP, allowing abuse by strangers. It is not clear why the US estimate is so much lower than the Australian one. In the same US blog, the authors noted that estimates of the magnitude of financial loss vary, mentioning another figure about 10 times higher. That would bring our low estimate into the same order of magnitude as our estimate based on the Commonwealth Bank report but is still substantially lower. One possible reason is that with advances in technology it is now easier for abusers to access victims' money than it was in 2011. Another possibility is the wider scope of the Commonwealth Bank report, which captures, for example, not contributing to household expenses. This wider scope is consistent with our definition of AOP, so we are content with using this report as the basis of our headline estimate.

Lost earnings: NZ$107 million

Meehan and Schober (2024) estimate that for people aged 50+, the cost of being the victim of a crime is associated with lost earnings of NZ$147.70 per quarter (or NZ$590.80 per year), while for interpersonal violence this is NZ$793.10 per quarter (NZ$3,172.40). Our most conservative estimate comes from using the number of cases of AOP we identified in the NZCVS for the main *IDI Report* (Chen et al., 2026b), which was 31,454 among people aged 55 and over in 2022. This is intuitively appealing because the lost earnings estimates were calculated using NZCVS, and it is also conservative because it is the smallest estimate of case numbers. We note, however, that the case rate in NZCVS was 51,889 in 2018, with the cases dropping by almost 40% by 2022. It is unlikely the true rate of crime and victimisation declined so steeply; we consider the resulting cost estimate to be unfeasibly low. Also, we have not allowed for population growth since 2022, which will bias the result downwards.

We produced medium and high estimates using the higher loss associated with interpersonal violence. We consider the more precise case number definition, including only those who experienced physical violence, to be more likely to produce a cost estimate close to the true cost. To maintain a conservative approach to estimation, our "medium" cost estimate used the lower estimate of physical AOP case

numbers from the main *Prevalence Survey Report*. Our headline estimate of lost earnings due to AOP is NZ$107 million.

Private costs of residential care: NZ$354 million

We calculated the PAR – the proportion of cases that can be attributed to AOP – from our prevalence data and estimates of relative risk (RR) in the literature. RR compares how much more likely AOP victims are to enter residential care compared to non-victims. The PAR was multiplied by the total use of these services reported publicly (Moore et al., 2024) to arrive at the Population Attributable Number (PAN), which represents the estimated number of cases of service use that can be linked to AOP.

We used three estimates of the RR for residential care among AOP victims compared to non-victims. Our medium and high estimates were taken from Dong and Simon (2013b), with the medium estimate being the RR in cases of reported abuse (3.05) and the higher being for cases of confirmed abuse (4.6). We calculated the lower RR estimate (1.64) based on rates of residential care admission in AOP victims and non-victims reported by Lachs et al. (2002). Lachs et al. reported hazard ratios which controlled for a number of potential confounders, while our calculation of the RR from their study did not include any controls. However, the RR is more appropriate for the calculation of PAR, and was lower than the reported HR, therefore producing a more conservative estimate. The combination of three RRs and three prevalence rates results in nine possible cost estimates; we used the lowest of each of RR and prevalence for our low estimate, the middle of each for our middle estimate, and the highest of each for our high estimate.

CBAx puts the average per person private cost of residential care at approximately NZ$43,300. Our headline estimate of the total private cost of residential care associated with AOP is NZ$354 million.

In the main *IDI Report*, we find that there is an increased risk of between 4 and 7 percentage points of going into ARC in the two years following an AOP incident (Chen et al., 2026a). In further analysis we converted these to relative risks, which are about 1.14 to 1.16 in the same period. This is noticeably lower than Dong and Simon's RR, but because the IDI cannot capture all cases of AOP, measurement error may have biased the estimate downwards.

We note that the public funding of residential care in NZ is means tested. The average per person cost from CBAx will assume a certain mix of people eligible and ineligible for the residential care subsidy. If victims of AOP are more likely to qualify for the residential care subsidy than the general population, then the cost we calculated will be an overestimate, while if they are less likely to qualify our estimate will be an underestimate.

Also, there are not sufficient places in ARC to meet current needs (Moore et al., 2024). This means that the PAN in our cost estimate is constrained. The cost of providing residential care to all AOP victims who would benefit may be higher.

5.2 Cost to government: NZ$615 million

Table 7: Summary of economic costs to government

Category	Low	Headline	High
Specialist services	$14m	$14m	$14m
Health system	$286m	$546m	$1,431m
Justice system	$15m	$16m	$17m
Welfare and benefits	$5m	$7m	$10m
Reduced tax income	$6m	$32m	$49m
Total	$325m	**$615m**	$1,522m

Note: Estimated annual costs, expressed in NZ$ millions, Q1 2025 prices.

Specialist services and work programmes: NZ$14 million

Specialist services include: prevention activities; EARS – where providers address the immediate needs of older adults experiencing or at risk of AOP; Elder Abuse Response Helplines for older adults and EARS providers to receive advice; and a dedicated work programme within the MSD (through which the series of which this report is a part is funded). The amount spent on these services in the 2023/24 and 2024/25 financial years is shown in Table 8.

Table 8: Budget for specialist AOP services and work programmes in two most recent financial years (source: Ministry of Social Development | Te Manatū Whakahiato Ora, 2024)

	2023/24	2024/25	Average
Elder Abuse Prevention Fund	$150,000	$0	$75,000
Regional elder abuse networks	$370,000	$40,000	$205,000
EARS	$12,290,000	$12,290,000	$12,290,000
Elder Abuse Response Helplines	$170,000	$170,000	$170,000
MSD work programme	$1,400,000	$2,100,000	$1,750,000

We incorporate the average of the amount spent in the two most recent financial years into our estimate. However, government spending is influenced by many factors; funding on the services and work programmes in Table 8 is allocated by MSD and is influenced by (time-limited) Budget provisions made between 2022–2025. Although these priorities may be affected by the perceived scale of AOP in the community, the budget for these services is not directly connected to AOP prevalence. Conceptually, then, these numbers are not truly "costs" of AOP.

While Table 8 outlines recent government spending on specialist AOP services, Table 9 illustrates how these costs could change if service capacity were expanded. In the 2023/24 financial year, 4,324 and 2,773 people accessed EARS and Elder Abuse Response Helplines, respectively (Ministry of Social Development | Te Manatū Whakahiato Ora, 2024). The numbers using these services are two orders of magnitude lower than our estimate of the number of cases of AOP from the main *Prevalence Survey Report* (256,000 cases; see Meehan et al., 2026). We would not expect all victims of AOP to seek to access EARS or a Helpline, but it is plausible that more than the current 1%–2% accessing these services would benefit from these services given sufficient capacity and accessibility. Using the cost per case implied by the current budget and case numbers (NZ$2,842.28 for EARS and NZ$61.31 for the helpline), Table 9 shows how total spending would increase if more AOP victims accessed these services – ignoring possible benefits of economies of scale.

Table 9: Cost of selected services with increased service capacity

	5% of cases access service	10% of cases access service	20% of cases access service
EARS	NZ$36m	NZ$72m	NZ$145m
Elder Abuse Response Helplines	<NZ$1m	NZ$2m	NZ$3m

We have no evidence as to the optimal level of uptake of these services and therefore the plausible costs of service provision if such provision were tied to need. This illustrates that government spending on specialist service provision and other work in this space (Table 8) is not a reflection of, or equivalent to, the total costs of AOP. However, as these amounts are the current levels of actual spending, we include them in our estimate and do not offer alternative high and low values. As Table 9 shows, these are likely to be conservative compared to spending that was directly related to rates of AOP in the community.

Health system: NZ$546 million

In this section we calculate costs of AOP to the health system through publicly funded residential care, inpatient hospital costs, and ED visits. We are unable to include costs associated with use of mental health services, use of primary care services (such as GPs), and claims in the ACC system due to a lack of

suitable data. Therefore, it is likely that the true cost of AOP to the health system is higher than we report.

For residential care, inpatient hospital stays, and ED visits, we calculate the PAN in the same way described for the private cost of residential care in Section 5.1. Our headline estimate of the public cost of ARC is NZ$240 million.

As a sense check, we also undertook a top-down calculation of the cost of ARC. The total public cost of ARC was NZ$1.66 billion in the 2023/24 financial year and NZ$1.72 billion in the 2024/25 financial year (Ministry of Social Development | Te Manatū Whakahiato Ora, 2024).[7] The PAR, using our main prevalence estimate and middle RR estimate, is 26%, meaning that approximately NZ$423 million was spent on ARC for AOP victims in 2023/24 and NZ$440 million in 2024/25. This is above even our highest bottom-up estimate, suggesting our headline NZ$240 million is plausible and conservative.

As with our calculations of the private cost of residential care, the accuracy of our estimate will be affected by whether victims of AOP have the same probability of qualifying for the residential care subsidy as the population as a whole; lower rates of eligibility for subsidy may mean lower public costs and vice versa. Similarly, the issue of undersupply of places in residential care will also constrain the total public cost.

We suspect that not all types of AOP are equally likely to result in use of the health system. To be conservative, our low estimate is calculated using the low prevalence of physical and/or sexual AOP, and our middle estimate uses the prevalence of physical and/or sexual and/or neglect AOP. These types of abuse are the most likely to lead directly to physical harm, which in turn increases the likelihood of hospitalisation or ED use. In contrast, psychological, financial, or cultural & spiritual abuse may have less immediate impact on these services, and we are unable to include costs for mental health service use due to data gaps (as noted above). We had only one estimate of the RR for each of hospitalisation (2.72; Dong & Simon, 2013c) and ED use (2.33; Dong & Simon, 2013a). Using these estimates to calculate PAN and combining with CBAx resulted in estimates of NZ$246.22 million for hospitalisation and NZ$9.17 million for ED visits associated with AOP.

Our residential care, inpatient, and ED RRs were all taken from studies in the US. It is unclear whether similar relationships between AOP and service use would be observed in the NZ context. As a sense check, we use a finding from Meehan and Schober that among people aged 50 and over being a victim of crime is associated with a 6 percentage point increase in the probability of hospitalisation. The authors

[7] We note that these are estimates, which appear reasonable as Sapere reported NZ$1.34 billion in 2022/2023 (Moore et al., 2024).

do not report a base rate for the over-50 sub-sample, which means we cannot use this finding in our estimate. For the purposes of sense checking, we can use the whole sample base rate (4.5%) to calculate an RR of 2.33,[8] which is comparable with the RRs in Dong and Simon.

In our IDI reports (Chen et al., 2026a, 2026b), we explore the risk of hospitalisation and move to residential care for AOP victims. We discuss the latter in Section 5.1 in relation to the private costs of residential care. For hospitalisation, we found that the victims of physical AOP have almost a 12 percentage point increase in the probability of hospitalisation in the three months following the incident, which is an RR of about 2.4. This RR is relatively close to Dong and Simon's. However, the IDI hospitalisation data are not well suited for identifying hospitalisations that were caused by AOP because they only capture a subset of cases (we discuss this more in Chen et al., 2026b). Combined with Meehan and Schober's results, this provides reassurance that our cost estimate is plausible despite being based on US data.

Justice system: NZ$16 million

Most cases of AOP are unlikely to involve the justice system. We cannot confirm this in our prevalence survey data, but we can use NZCVS findings from the main *IDI Report* to derive a proxy for the share of cases which are reported to police. In 2022, about 2.2% of older adults responded that they had experienced AOP, and 0.97% (or about 43% of those who experienced AOP) responded that they had experienced AOP that they had reported to the police.

We assume that when a case is reported to the police, the mean investigative time taken is one hour. This assumption is difficult to verify. In the case of a report being made, the police take a minimum of three steps (record, assess, assign) before considering what actions they can take and doing these (New Zealand Police, n.d.), Intuitively, it seems likely that the majority of police reports result in a small amount of investigative time, while a small number require much more time. One hour therefore seems a reasonable, but conservative, assumption for police time per reported case of AOP.

We use CBAx's estimate of the cost of one hour of police investigation, NZ$144, and assume 43% of our high, medium, and low case numbers report their abuse. Our headline estimate of the cost to the justice system in police time is NZ$16 million.

Police time is only one aspect of costs to the justice system. Other costs would include the courts and prisons. We consider that the number of cases where AOP would involve the courts and/or the prisons

[8] (4.5+6)/4.5=2.33.

would be quite low, but we do not have good data to quantify this. We therefore omit these from our estimate of costs to the justice system, acknowledging that this will result in an underestimation.

Welfare and benefits: NZ$7 million

We use Meehan and Schober's estimates of average benefits payments associated with AOP of NZ$4.50/quarter (NZ$18/year) for all victims and NZ$50.40/quarter (NZ$201.60/year) for victims of interpersonal violence. We use the same approach described in Section 5.1 under the heading "Lost Earnings" to identify case numbers for calculating costs. Our headline estimate of the cost of benefit payments associated with AOP is NZ$7 million.

Reduced tax income: NZ$32 million

In Section 5.1, we describe how we calculate the cost of lost earnings associated with AOP. NZ has a progressive tax structure comprising five different bands. To estimate reduced tax revenue associated with the lost earnings requires data on the distribution of incomes among people aged 55 and over. We were unable to locate such detailed data. Instead, we calculated the weighted average of the earned income among people aged 55 and above from published data on total taxable income in five-year age bands (Inland Revenue | Te Tari Taake, 2024). This was approximately NZ$53,000 in the tax year ending 2023, meaning the average person aged 55 or older would have been in the 30% tax bracket. Using the lost earnings calculated in Section 5.1, we estimate reduced tax revenue to be NZ$32 million.

5.3 Costs to society

Society as a whole also experiences economic costs from AOP, but these are more difficult to quantify than costs to victims and government, and we have not been able to find relevant data. In this section we describe some illustrative economic costs imposed on society beyond victims and government, but these do not contribute to our estimate.

The care sector is particularly exposed to costs from AOP. The governance of the sector places various requirements on businesses providing care. For example, official standards for health delivery – which cover the care sector – include protection from abuse, the provision of effective safeguards, and respect for property and autonomy (Ministry of Health | Manatū Hauora, 2021). The Ombudsman expects that in ARC facilities "all appropriate steps are taken to prevent [AOP]" and that "all concerns … about [AOP] are promptly documented and investigated, or referred to the appropriate authority for investigation"

(Office of the Ombudsman | Tari o te Kaitiaki Mana Tangata, 2024). Hiring processes for staff who work directly with "vulnerable" adults must include police vetting.

Compliance with these requirements has a cost; businesses must spend time to design relevant processes to prevent AOP by their staff and to respond to allegations. Importantly, these costs are effectively fixed in that they are unaffected by the scale of AOP either in society at large or in the relevant organisation. On the other hand, additional costs of reporting abuse or responding to allegations of abuse are more closely tied to the scale of AOP.

The financial sector also faces costs associated with AOP. Banks in NZ are bound by the New Zealand Banking Association Code of Banking Practice which requires, among other things, that they must consider customers' vulnerability and protect their accounts from unauthorised use (New Zealand Banking Association | Te Rangapū Pēke, 2021). Signatory banks are also committed to "recognise, escalate, and respond to possible financial abuse …" (New Zealand Banking Association | Te Rangupū Pēke, n.d.). Compliance is incentivised by the Banking Ombudsman, who hears complaints about banks and is empowered to require them to repay customers money lost to financial abuse in circumstances where the bank is deemed to have missed opportunities to protect the customer. These amounts can be large; a recent case before the Banking Ombudsman resulted in a payment to a customer of NZ$290,000 (Banking Ombudsman Scheme | Te Whare Rama Tōkeke, 2025).

Although these types of costs of AOP to businesses are conceptually straightforward, measuring such costs is less so. In the financial sector, for example, obligations around preventing AOP may be wrapped up within wider fraud prevention and consumer protection obligations.

Other organisations facing economic costs of AOP are charities and those with a "helping" component to their work. AOP adds to caseload, requiring funding and other resources which may be insufficient, or may be repurposed by creating opportunity costs elsewhere in the organisation. A recent review of the Elder Abuse Prevention Fund confirms that many organisations provided services based on perceived demand despite insufficient funding to meet this demand (Dovetail, 2024a).

Costs like those described in this subsection will not necessarily be absorbed by the relevant organisations. Care organisations and banks, for example, will consider their obligations around AOP as a cost of business and may seek to incorporate these when they determine rates or fees. Charities with insufficient resource to meet demand will need to make tough choices about service provision. Both of these will lead to costs borne by the general public.

5.4 Non-economic costs

Table 10: Non-economic costs of AOP that can be expressed in monetary terms

Cost	Low	Headline	High
Worsened mental health	$150.47m	$166.64m	$182.81m

Note: Estimated annual costs, expressed in NZ$ millions, Q1 2025 prices.

As described in Section 3.4, some costs are not best expressed in economic terms. We briefly describe these costs here. We were able to put a monetary value on one such cost – worsened mental health.

Reduced wellbeing

There is strong evidence that victims of AOP experience poorer wellbeing than non-victims. This includes worse physical and mental health (Fisher & Regan, 2006; Folorunsho & Okyere, 2025; Mouton et al., 2010). In a NZ sample, AOP victims were less happy, less satisfied with life, and had lower quality of life than non-victims (Yeung et al., 2020). For most components of wellbeing, we were unable to find suitable data to express the harm of AOP in financial terms. One exception to this is mental health, which we explore in more detail below.

WORSENED MENTAL HEALTH: NZ$167 MILLION

There are multiple studies showing that victims of AOP have poorer mental health than non-victims (Fisher & Regan, 2006; Knight & Hester, 2016; Mouton et al., 2010). Fisher and Regan, and Knight and Hester, for example, found that AOP victims have more than twice the odds of depression or anxiety as non-victims (odds ratio = 2.24). In Mouton et al., postmenopausal US women self-reported poorer mental health following physical and/or emotional abuse, with mental health measured by mental component summary (MCS) scores of the SF-36 (36-Item Short Form Health Survey), which is a validated and widely used tool for measuring health.

The AOP prevalence survey undertaken as part of the *National Study* also shows a negative association with mental health, both in terms of the presence of a mental health condition and scores on a widely used measure of psychological distress, even after controlling for other demographic and socioeconomic factors (Meehan et al., 2026). As discussed in that report, this is an association, rather than a causal relationship. AOP may contribute to poorer mental health, but pre-existing mental health issues may also increase vulnerability to AOP.

Although the link between AOP and depression and anxiety is intuitive, these are not the only plausible aspects of mental health that could be affected by AOP. Instead, we chose to use MCS because it is a

global measure. Mouton et al.'s estimate of the reduction in MCS scores over time was different for women who had experienced different types of abuse. The largest reduction, 1.12, was experienced by women who reported only physical abuse, but this reduction was not statistically significant. Women who experienced both physical and verbal abuse reported the smallest reduction, 0.44, and women who reported verbal abuse only had a reduction in MCS score of 0.55. We used this latter estimate, 0.55, because it is both statistically significant and the category of verbal abuse aligns broadly with our existing category of emotional/psychological abuse.

We note that Mouton's study was conducted in the US, includes only women, and considers abuse only within the context of intimate partner relationships. It is not clear whether there would be a different relationship between AOP and mental health as measured by the MCS in our context, or whether any such a difference would mean a larger or smaller reduction in MCS score.

CBAx puts the cost of a one-unit reduction in MCS at NZ$1,598. Using Mouton et al.'s estimate of a 0.55 point reduction and our estimate of the number of cases of emotional/psychological abuse of 189,600, our estimate of the mental health costs of AOP to victims is NZ$167 million.

Other non-economic costs to individuals

To the degree that a move to residential care is triggered by AOP, this may also be a non-economic cost to individuals. Research on ageing supports "ageing in place", where older people continue to live in their homes and communities with appropriate support, with suggestions that it is preferred by older people and associated with better wellbeing outcomes (Barrett et al., 2012; Pani-Harreman et al., 2021; Stones & Gullifer, 2016). Thus, moving to residential care may in some circumstances be considered a non-economic cost of AOP.

Other non-economic costs are less well researched than health-related costs of AOP. However, we suggest it is likely that some victims of financial abuse may face reduced financial security or increased material hardship, while victims of cultural & spiritual abuse may no longer benefit from membership in cultural or spiritual communities.

Non-economic costs to government and society as a whole

We did not find research on the non-economic costs of AOP to government or to society as a whole, which is not to say that such costs do not exist. Speculative examples of these costs are described below.

In te Ao Māori, *whanaungatanga* is a widely held value which describes connectedness and relationships between people, and the practices that support these connections and relationships. AOP damages more than individual wellbeing; it disrupts the intergenerational relationships and collective responsibilities at

the heart of whanaungatanga. By threatening whanaungatanga, AOP can be seen as undermining the right of Māori to live as Māori. For those interested in AOP's impact on older people's relationships, including older Māori, see the *Qualitative Interviews Report* (Wilson et al., 2026).

It is not only specific cases of AOP, but AOP's existence at all, that can cause harms to wider society. One pathway is that as people become aware of AOP, perhaps through social encounters or media coverage, the perceived risk of AOP will increase. This may create costs in the form of declining trust in government and social cohesion. Social amplification of the risk of AOP could also lead to declining trust in the care sector, undermining its contribution to the lives of older adults.

Further detailed exploration of these costs is beyond the scope of the current project, and we leave this for future research.

5.5 Costs summary

For convenience, we summarise all the costs we have calculated in Table 11.

Table 11: Summary of all costs

Cost type	Cost category	Cost
Economic costs	Individuals and whānau	NZ$1.17b
	Government	NZ$615m
	Society	Not calculated
	Total economic cost	NZ$1.78b
Non-economic costs	Reduced mental health	NZ$167m
	All other non-economic costs	Not calculated

6 DISCUSSION

6.1 Key messages

- We calculate the economic cost of AOP to be NZ$1.78 billion each year. This is almost certainly an underestimate and does not include non-economic costs.
- Of these costs, only 0.7% arise from directly supporting people experiencing AOP through elder abuse services.
- An even smaller percentage is spent on prevention, with government funding typically time-limited due to the constraints of the annual budget cycle. In the most recent financial year about NZ$2.14 million could be described as prevention spending.
- Two-thirds of the economic cost of AOP is borne by individuals and their families (66%), but the Government also bears substantial costs (34%), largely through the health system.
- Developing effective prevention of AOP has the potential to have a meaningful positive impact.
- Despite limitations, ours is a plausible and conservative estimate of the cost of AOP, and the first of its kind internationally.

6.2 Comparison with previous research

To our knowledge, only one piece of work anywhere in the world purports to estimate the cost of AOP to the economy. The Hourglass (Hourglass, 2024b) estimate, adjusted for inflation and applied to our prevalence rates, is approximately NZ$27 billion, an order of magnitude higher than we calculate. This is likely explained by two key differences in approach. First, we produced bespoke calculations of the cost of AOP in a range of domains based on research on older people, while the Hourglass work simply applied a single cost of abuse estimate from a whole population study. Some costs will almost certainly be higher for working aged people than older people (e.g. lost earnings, foregone tax, and benefit payments). Secondly, our estimate does not include any non-financial costs, which other costs of abuse studies have found to dwarf economic costs (Kahui & Snively, 2014).

In NZ, there have been two prominent cost of abuse studies. Applying MartinJenkins' (2020) per case estimate of the cost of abuse in care to our prevalence of AOP data and adjusting for inflation yields

NZ$62 billion, 35 times our estimate. This is not surprising, as the MartinJenkins study estimates the lifetime costs of abuse which occurred over nearly 70 years, while our estimate is of the annual costs of abuse that occurred within the year prior to our prevalence survey. We would also expect differences in the outcomes and thus financial costs of abuse experienced at different life stages. Adjusting Kahui and Snively's 2014 estimate for inflation yields a cost of child abuse and intimate partner violence of NZ$6.9 billion per year. Despite the different scope, including a wider population coverage and inclusion of non-financial costs, this is relatively close to our estimate.

While there are no true comparator studies, comparing our estimate to the estimates of Hourglass, MartinJenkins, and Kahui and Snively suggests that our headline result of NZ$1.78 billion is plausible and conservative.

6.3 Strengths and limitations of our estimate

A key strength of our estimate is that it is based on detailed prevalence data (Meehan et al., 2026), informed by thoughtful consideration of definitions (Scott et al., 2026). Not only do we have an overall prevalence of AOP, but we also have the prevalence of specific types of AOP. This allows more precise calculation of some components of our cost estimate. For example, we can calculate financial losses for those who experienced financial abuse, or specific costs for people who experienced physical abuse.

A second strength is the transparency of our methods and assumptions. All major analytic decisions – such as how prevalence thresholds were applied, how relative risk estimates were scaled to annual costs, and how conservative assumptions were adopted when evidence was unclear – are clearly documented. This means that our estimates are replicable and can be refined or updated as new evidence becomes available. Such transparency is important for credibility, particularly in an area where there is limited precedent.

Another strength is the integration of multiple sources of information. Our estimates combine NZ-specific prevalence data with international outcome studies, NZ costings from CBAx, and administrative data where available. While none of these sources alone could provide a full picture, bringing them together strengthens the validity of the findings. This triangulation, although imperfect, is methodologically robust and allows us to construct a more comprehensive estimate than would otherwise be possible.

Finally, this appears to be the first study internationally to attempt a comprehensive estimate of the economic and social costs of AOP. This in itself is a strength, as it provides a benchmark for future work,

both in NZ and globally. By setting out a transparent and adaptable framework, our study offers a foundation that others can build on as data and methods improve.

While our prevalence data is ideally suited for our goal of calculating the cost of AOP in NZ, many of our other data sources are less so. We are reliant on overseas studies, those of whole populations rather than older adults, and studies that can only identify the most severe cases of AOP to identify outcomes of AOP that might create costs to the NZ economy. In the case of the justice system, we were forced to assume an average amount of police time per reported case of AOP with no data input. Even the CBAx data, while up to date and developed specifically for the NZ context, bases its unit costs on the whole population. An important consequence of data limitations is that we are unable to present costs for different subgroups.

Our estimate does not include costs of AOP occurring within ARC facilities. The prevalence survey only includes people living independently, and there is a lack of research on the outcomes of AOP for people living in ARC. The costs of AOP are likely to be quite different than the costs of AOP in the population living in the community. What we do include is the higher risk of entering ARC as a consequence of experiencing AOP while living independently. Still, there are estimated to be about 30,000 people living in ARC in NZ, and this population is likely to be more vulnerable than the wider population of older adults. As we note in our main *IDI Report* on the ARC population (Chen et al., 2026a), filling this data gap is crucial.

We have estimated only a small component of the non-economic costs of AOP. This is both because of a lack of data, and the reality that some costs are inherently not economic. Nonetheless, this means that the true costs of AOP to NZ are likely to be much higher than we report here; other cost of abuse studies in NZ find non-economic costs account for 51% (Kahui & Snively, 2014) to 78% (MartinJenkins, 2020) of headline estimates.

We have taken a deliberately conservative approach throughout. Where there was uncertainty, we have generally opted for lower-bound assumptions (e.g. about the number of hours of police time needed in an investigation). Also, several components of our estimate (e.g. costs to the health system) are not exhaustive, and our headline estimate does not include any non-economic costs. Although we have also produced a low estimate of total cost (NZ$481.19 million), our headline result of NZ$1.78 billion is most likely an underestimate. Such an underestimation may be considered a limitation in terms of loss of accuracy. However, as a basis for policy-making, a strength of our estimate is that the potential benefits to the economy are unlikely to be overstated. For policy purposes, this conservatism is a strength; it ensures that the estimated costs are unlikely to exaggerate the benefits of action.

We estimate that AOP costs NZ around NZ$1.78 billion annually. However, applying higher prevalence and cost assumptions yields estimates above NZ$3 billion. This underlines that our figures are deliberately conservative and that the true scale of costs is likely higher.

6.4 Looking ahead

Refining the estimate

There are three ways future research could build on this work to make the estimate both more precise and more useful. The first is by linking the main *Prevalence Survey Report* to the IDI, which we understand will happen in due course. This will allow measurement of the actual differences in public service use between AOP victims and non-victims in NZ. Importantly, this could include public services that we have not included in the current estimate, like the court system. It would also enable subgroup analysis by (e.g. ethnicity, gender, or deprivation).

The New Zealand Health, Work, and Retirement Study (NZHWRS) could also be useful (see Allen et al., 2021 for more information about the study). This longitudinal study includes people aged over 50 years old in NZ and has been running since 2006. Prior to our prevalence survey, the best estimate of AOP frequency in NZ came from these data (Office for Senior Citizens | Te Tari Kaumātua, 2015). Unlike the IDI, a longitudinal survey such as NZHWRS can capture outcomes that are unrelated to administrative data (e.g. losses associated with financial AOP).

Mixed-methods work would help with contextualising the estimate with the experiences of people in ARC. This group was intentionally excluded from the main *Prevalence Survey Report* 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). Further, some people living in ARC may not be able to consent to participate in research, making systematic quantitative data collection challenging. However, quantitative data could be collected from staff in ARC facilities, and qualitative work could include both older people and staff.

Implications for policy

We estimate AOP costs the NZ economy NZ$1.78 billion each year. Although perhaps a relatively small proportion of GDP, it is equivalent in size to sectors which have captured considerable attention for their strategic importance to the economy; the country's space industry was coincidentally also valued at

NZ$1.7 billion in 2019 (Craymer, 2024), while revenue from seafood exports was forecast to be NZ$2.2 billion in the most recent year (Ministry for Primary Industries | Manatū Ahu Matua, 2025). There is a strong economic case for preventing AOP.

Two-thirds of the costs of AOP are borne by individuals and their whānau. Although this report has focused on the economic case, this high share of costs suggests there is scope for government policy to further protect older people's wellbeing and security. Effective intervention reduces harm before it occurs, sparing older people and their whānau from financial loss, health deterioration, and social isolation. At the same time, prevention lessens downstream demand on government systems, making it both a humane and potentially cost-effective policy choice.

It is beyond the scope of this report to recommend specific prevention approaches. However, given our need to use international data to construct our estimate, there is a clear gap in evidence of what works for preventing AOP in our context (or internationally). Ongoing research efforts, such as work programmes funded by the World Health Organisation and the Office for Seniors (see e.g., Dovetail, 2024a & 2024b), are needed to build knowledge. Such evidence will be essential for realising potential economic benefits and is reliant on good local data.

6.5 Conclusion

In this report we have produced what is, to our knowledge, the first detailed estimate internationally of the economic cost of AOP. Our headline estimate of NZ$1.78 billion annually is deliberately conservative, meaning the true cost is likely higher once non-economic harms and unmeasured service impacts are considered. By quantifying the economic burden, the study makes clear that AOP is not only a profound human rights issue but also a significant economic challenge.

The estimate provides a robust baseline for policy debate and a framework that can be refined as better data become available. It demonstrates that the costs of inaction are high and fall most heavily on victims and their whānau, while also imposing substantial burdens on government systems and society as a whole. Recognising and addressing AOP is therefore both a moral imperative and a sound investment.

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