



SYMPOSIUM ISSUE SPRING 2026



“Protecting our future in Primary Health - stronger together”

Mehemea ka moemoea ahau anake.

Mehemea ka moemoea tatou, ka taea e tatou

*If I dream, I dream alone. If we dream as a collective, we can achieve
our dream*

Na, Te Puea Herangi

LOGIC is the official journal of the New Zealand College of Primary Health Care Nurses, NZNO.

Editor: Jess Beauchamp
logiceditorcphcn@gmail.com

Publisher: Michael Brenndorfer
nzcphcnpublisher@gmail.com

Editorial Committee:
 Michael Brenndorfer, Marianne Grant, Belinda van Essen, Anastasia Kostjukovsky, Vanessa May.

Circulation: To all members of the New Zealand College of Primary Health Care Nurses, NZNO and other interested subscribers, libraries and institutions.

Content: LOGIC is prepared by the Editorial Committee from submitted and invited articles and other material. While every effort is made to ensure the accuracy of the information, the Publisher takes no responsibility for errors, omissions or any consequences of relying on this material or the accuracy of information. The inclusion or exclusion of a product or advertisement does not mean the Publisher of LOGIC advocate or reject their use in any way.

Correspondence: The Editorial Committee welcomes all correspondence about articles or intended for publication. Please contact the Editor at
logiceditorcphcn@gmail.com
 Please ensure the writers name appears on the title page of any article or letter intended for publication.

Copyright:
 This publication is copyright in its entirety. Material may not be printed without written permission from the College.
ISSN: 2463-5642

Front Photo credit: The Christchurch Botanical Gardens. Anastasia Kostjukovsky.

Contents:

College Chair report	
Tracey Morgan.....	3
LOGIC editor report	
Jess Beauchamp.....	5
Symposium programme.....	7
Sometimes you just need a safe place to think	
Ali van Barneveld.....	8
Taking healthcare to women	
Ruth Davy.....	10
Free cervical screening	
Vanessa May.....	13
LARC training.....	16
Nursing in the Dept of Corrections	
Leanne Samuel.....	17
MCaFHNA conference 2027.....	21
The price of your life: An American immigrants view on the privatisation of New Zealand's National Healthcare	
Chanteé Hale.....	22
Primary Health Care, how we got here	
Michael Brenndorfer.....	27
Primary care at the ballot box: why health policy matters to nurses	
Vanessa May.....	30

College of Primary Health Care Nurses Chair Report

October 2026

“Kaua e mate wheke mate ururoa”.

Strive for your goals by being strong and resilient like a hammerhead shark, do not give up no matter how hard the struggle is.

The whakatauki above sums up the continual struggle that Primary Health, no matter where we are working, have endured since last coming together. Chronic Staff Shortages, under resourced and Pay Equity/Parity is the main driver of why Aotearoa is in ‘crisis’. The funding model is broken and only the Government can fix this problem to ensure Aotearoa has a quality public health system. This Committee will continue to advocate and be a lead voice for Primary Health to ensure our voices are heard because as Dr Margaret Chen states: “if you are not on the menu then you are not at the table”. I want to take this opportunity to thank the Executive Committee, Professional Practice Committee, LOGIC Committee, Cathy Leigh (Professional Nurse Advisor), Sally Chapman, Kelly Nelson and Elisabeth Auchinvole for your time and commitment you have all provided to ensure the College of Primary Health continues to provide the leadership for all our members.

Since coming together two years ago Primary Health has continued to make itself available in every space “Maranga Mai!” every nurse everywhere and here are a few that the Committee has done:

- **GPLF Forum:** continues to have a Nursing Voice on this General Practitioner Leadership Forum ensuring every opportunity to engage; meets three times a year face to face and also on Teams. Key highlights have been looking at Extended Services; Workforce Planning; Accountability. Working on a Collective Strategy 2026-2036 highlighting long term sustainability. This Committee met with Minister Simeon Brown highlighting the issues raised above.
- **Colleges and Sections:** Primary Health has looked at how we as Colleges can come together collectively to meet and strengthen our voices within NZNO. After the successful Leadership meeting in February, we met with Women’s Health; Mental Health; as a starting point on how we can work together smarter. These have proved successful and still much more work needed in the future
- **Sub Committees:** Primary Health has meet with Foot Care Nurses and are in discussions with a couple other groups on how they can fit with Primary Health sharing articles; discussions; any issues. This is proving to be a positive pathway moving forward. Again “Maranga Mai!” as the vehicle of every nurse everywhere
- **National Delegate Committee Primary Health:** This is still in its infancy but has gathered great momentum of other areas within Primary Health coming together. This group met twice this year and looking on how this group will function and develop and provided action for the already stretched workforce

- **PHC MECA:** Success once again. An offer was sent to all members which was accepted. Because you all matter, we can say we are in another step closer. While it is a success it does not mean we are there yet. The ultimate goal has to be what the members want “to be paid the same as those working for Health New Zealand.” We have to celebrate the small wins but do not take our eyes off the overall prize which this Campaign will continue to work towards.
- **Pay Parity:** The government must support pay parity so all nurses with the same skills, qualifications and experiences are paid the same. Pay Parity with Health New Zealand will help stop nurses leaving Primary Health Care and returning to the hospital or leaving to go overseas. Pay parity for nursing staff in Primary Health will allow better access for New Zealanders in their own community and lower the demand on crowded Emergency Departments. Our communities deserve accessible care and our nurses deserve fair pay.
- **Pay Equity:** The Coalition Government urgently changed the Equal Pay Act without public consultation scrapping 33 pay equity claims. Ten of those claims from NZNO were included; Primary Health Care, Hospice, Plunket and Care and Support funded sectors. Some of these counterparts accepted lower wage increases in their collective agreements on the understanding they would receive pay equity payments.
- **Ovarian Cancer:** A Health Submission report in February 2026 which Primary Health were inclusive in part of this report and continue having that external relationship through regular updates with this amazing group.
- **Public Health Advisory Committee:** Over the past two years the College have been actively engaged with the preparation of the Primary Care Report. The College have also been successful as being selected as one of the final reviewers in the publication of this final report.

As the Chair of the College, I want to thank you all once more on the tumultuous year that this continues to prove. However, we have weathered any waves put before us and shown the power of the voices of Nurses in Primary Health in every sector; we are a voice to reckon with.

We are the frontline workers and we must continue to fight the fight together:

“Maranga Mai! Every nurse everywhere” ake ake ake!

No reira

Tracey Morgan College of Primary Health Care Nurses Chair

LOGIC Editor Report October 2026

Jess Beauchamp

Nō Ingarangi me Kōtirangi ōku tupuna. I tae mai ōku tupuna ki Aotearoa ki Takapō. I tipu ake au Tāmaki Makaurau. Nō te Whanganui-a-Tara au. He Tangata Tiriti ahau. Ko Jess toku ingoa.

Kia ora koutou katoa,

A warm welcome to the spring edition of LOGIC, the completion of which happily aligns with our College Symposium in Ōtautahi Christchurch. The LOGIC committee has been working hard and we have an outstanding selection of articles. This editions authors share a magnificent depth of practice knowledge and experience and it is an absolute privilege to share that with you. Courageous and innovative leadership shines out of their stories, often over decades and makes inspiring reading.

Also we are mindful the General Election is looming in November, so the last three articles are necessarily politically focused and provide reflection and comparison about the current “state of things” and the trajectory towards privatisation. We all need to be alert and thinking about who and how to vote in November and the last article has some tips so your choice is an informed one.

Taking a moment to farewell and sincerely thank Sarah Darroch who has been a LOGIC committee member for the last couple of years. Sarah we wish you well and would love to hear how you and your study are progressing. Keep in touch!

And welcome to Vanessa May who has recently joined the committee, at full speed, and with two articles in this edition, what a debut!

I’m Vanessa, Associate Director of Nursing at Well Women & Family Trust in Aotearoa New Zealand. I’m a registered nurse with a background in women’s health, cervical screening, contraception and primary health care.

My role spans clinical leadership, nursing workforce development and education, with a strong focus on building nursing capability and leadership in women’s health. I’m involved in cervical screening education and training, and support LARC training programmes to strengthen access to contraception and grow the skilled nursing workforce.

I’m passionate about supporting nurses to build confidence and capability, translating evidence into practical care, and improving access, equity and outcomes for wāhine and whānau.



E mihi kau ana ki ngā kaituhi! A massive thanks to all our authors! And the Committee for their work in getting this edition together.

For those who are attending the Symposium, enjoy! Take care of yourselves everyone. We plan to be back in December with the Christmas edition.

Do remember that the College Facebook page (NZ College of Primary Health Care Nurses – NZNO) has regular posts, often current topics and professional development, and is a useful way to keep up to date with College happenings between LOGICs.

In solidarity,

Jess Beauchamp

LOGIC Editor



NZNO College of Primary Health Care Nurses Symposium 2026

9 - 10 October | Rydges Latimer Christchurch

Protecting our future in Primary Health - Stronger Together



Programme

Friday 9 October

1830-2030	Welcome Function & Exhibition Open
-----------	------------------------------------

Saturday 10 October

0745-0830	Registration & Exhibition Open
0830-0845	Symposium Opening
0845-0900	Welcome & Housekeeping Tracey Morgan, College Chair
0900-0930	Guest Speaker Kerri Nuku, Kaiwhakahaere, Tōpūtanga Tapuhi Kaitiaki o Aotearoa NZ Nurses Organisation
0930-1000	Nursing in Primary Health Care - The Missing Piece Paul Goulter, CEO, Tōpūtanga Tapuhi Kaitiaki o Aotearoa NZ Nurses Organisation
1000-1030	Morning Tea & Exhibition
1030 - 1130	Breakout Sessions
	Support When You Need It – Navigating Palliative Care Raewyn Jenkins, Palliative Care Clinical Nurse Educator, Nurse Maude
	Medicinal Cannabis in Primary Care, A Practical Guide for Nurses in Aotearoa Claris Jones-White, Medical Science Liaison, NUBU
	Advancing Women's Health: The Role of the Nurse Practitioner Jill Lamb, Nurse Practitioner, Christchurch Women's Hospital
1130-1230	Tau Oranga Health Care: Establishing an NP-Led Primary Health Care Practice Jacinda Childs, Nurse Practitioner & Co-Founder, Tau Oranga Health Care Jayme Mawhiti Kitiona, Nurse Practitioner & Co-Founder, Tau Oranga Health Care
1230-1330	Lunch and Exhibition
1330 - 1400	Beyond the Hype: Nurses Role in AI and Digital Health Carey Campbell, Clinical Director, Amalga
1400-1430	Well Women and Family: Eliminating Cervical Cancer, Influencing Primary Nursing, Navigating Barrier to Education Belinda van Essen, Nurse Educator, Well Women and Family Vanessa May, Associate Director of Nursing, Well Women and Family
1430-1500	E Tipu e Rea: Growing a Kaupapa Māori Future in Primary Health Dhyanne Hohepa, MN, NP Raukawa ki Wharepūhanga, Tainui, Te Arawa, Tūwharetoa, Ngāpuhi Director, Hohepa Health Services Co-Director, Te Korowai o Ngā Ringa Āwhina Ltd
1500 - 1530	Afternoon Tea & Exhibition
1530-1640	On the Couch & Prizes
1640-1645	Closing

Sometimes you just need a safe place to think Ali van Barneveld

Wāhine Connect is a charitable mentoring network established in 2017 to connect and support wāhine working across Aotearoa's health sector. Over almost a decade, more than 860 wāhine have participated as mentees, supported by a community of more than 750 volunteer mentors from across health professions, disciplines, and stages of career.

As the organisation winds down, it is capturing and sharing its learnings to support future mentoring initiatives for wāhine.



Ali van Barneveld is Programme Manager for Wāhine Connect, where she has supported the delivery and development of its national mentoring programmes and community of wāhine in health

Reflections on mentoring, connection, and the contribution of nurses to Wāhine Connect

For nearly a decade, Wāhine Connect has connected wāhine working across Aotearoa's health sector with other women willing to share their time, experience, and perspective.

As we begin to wind down the organisation, we have been reflecting on what hundreds of mentoring conversations have taught us.

One lesson stands out: mentoring does not always need to provide an answer. Sometimes its greatest value is providing a safe place to think.

Mentees often came to Wāhine Connect at a point of uncertainty. Should I stay in this role? Apply for something different? How do I balance the needs of my whānau with my career? Am I ready to lead? Is what I am experiencing at work normal?

Our research found that lack of confidence was the most common reason wāhine sought mentoring, alongside juggling work or training with raising a family and balancing career needs with those of a partner.

These are not necessarily problems another person can "fix". What a mentor can offer is something different: time, perspective, experience, thoughtful questions, and a conversation outside the mentee's immediate workplace.

Looking specifically at feedback from nurses involved in Wāhine Connect, both as mentors and mentees, some consistent themes emerged: good matching, connection and having space for honest professional reflection mattered.

One nurse mentee described being unsure how to even begin the conversation. Her mentor reached out first, helping create enough safety for her to talk openly. Another valued hearing different perspectives from women across her sector, while another appreciated being able to talk about professional and family life together, rather than pretending the two existed separately.

Nurse mentors also described something important: **mentoring goes both ways**. Supporting another practitioner gave them opportunities to reflect, connect professionally, and contribute their experience, while allowing the mentee to work out her own direction.

Perhaps that is one of the simplest lessons we can carry forward.

A mentor does not need to have all the answers. She may simply be a little further along one particular road, have encountered something similar, or know the question that helps another wāhine see her situation differently.

As Wāhine Connect comes to a close, the need for these conversations has not disappeared.

For nursing, continuing this kaupapa might look like noticing the colleague who is questioning herself, making room for conversations across roles and generations, sharing experience without assuming our experience is the answer, or simply saying: *I know someone who would be a really good person for you to talk to.*

Sometimes supporting another wāhine does not require solving her problem.

Sometimes it begins with giving her a safe place to say it out loud.

Further reading: Research about Wahine Connect “Why do women in health seek mentoring -a descriptive study of a mentorship programme for women in Aotearoa New Zealand?” published in 2025 <https://pubmed.ncbi.nlm.nih.gov/40876031/>

Taking Healthcare to Women A personal reflection by Ruth Davy ONZM



Ruth Davy, RGON, Bachelor of Nursing, Master of Public Health (Hons), ONZM, is a nurse and public health leader who has dedicated more than 40 years to improving women's health and reducing health inequalities. She co-founded and led the Well Women's Nursing Service (WONS) for more than 25 years, pioneering accessible, community-based women's health services. Ruth was awarded an **ONZM in 2026 for services to nursing and women's health**. She continues to contribute to the not-for-profit sector through governance, fundraising and strategic development.

When I received the Officer of the New Zealand Order of Merit, April 2026, people asked me what I was most proud of. I found that surprisingly difficult to answer. Awards are wonderful acknowledgements, but they are only snapshots in time. What I remembered instead were the people, the conversations, the challenges, and the countless women who trusted us with their stories. I also thought about the nurses, trustees, volunteers, funders and community leaders who walked alongside me. Whatever we achieved was never the work of one person.

In 1989 I became one of New Zealand's first self-employed independent nurse smear takers. In the beginning, my clinic operated from the back of my car. I travelled wherever women needed me. Some days that meant community halls, borrowed rooms or workplaces. I knew how to provide a proficient independent nursing service for women.

The Cartwright Inquiry, 1988, changed healthcare forever with particular focus on women's health. It challenged all of us to think differently about informed consent, respectful care and women's rights. For all of us it also raised another question: if women were not accessing services, was the problem really the women, or was it the way services were being delivered? That question became the foundation of the Well Women's Nursing Service by myself, Margaret Clark, Monique Fredatovich, Sheila Alexander and others. We were later rebranded to Well Women and Family Trust.

The National Cervical Screening Programme, 1989, brought a small group of us together to establish an organisation. Ready for a challenge, I jumped at the opportunity to lead the work. At the time we knew almost nothing about running a business. I didn't know how to write a contract, employ staff or even complete a GST return. Looking back, that seems almost humorous, but at the time it was daunting. It was a fast learning curve!

We wanted to take healthcare to women rather than wait for women to come to us. Over time our work expanded into marae, Pacific churches, workplaces, Women's Refuge, Work and Income offices and community organisations. From the beginning we adopted a wellness model that was women centred, caring for women as a whole. We often described it as supporting women from periods to menopause and beyond. In late 1998, we purchased New Zealand's first mobile well women's health van. The van became much more than a vehicle. It represented a different way of nursing which was accessible, affordable, and surprisingly appropriate with a lot of ingenuity!

Those years were exciting, but they were also hard work. Funding independent nurse-led services was not straightforward. Every contract had to be earned. Every innovation had to be justified. We had to demonstrate that nurses could not only provide excellent clinical care but also lead organisations, manage budgets, cover risk management, employ staff and deliver measurable outcomes. That experience taught me that leadership is as much about perseverance as vision.

People sometimes describe Well Women and Family Trust as my achievement. I don't see it that way. My role was to lead, encourage and keep moving forward, but I was surrounded by remarkable people. Together with Margaret Clark, Monique Fredatovich and Sheila Alexander we laid the foundations, and many outstanding nurses and trustees helped build the organisation into what it became. I would like the final version of this article to acknowledge many more of those people because they deserve to be remembered.

One of the turning points in my career was in 2008, receiving a Counties Manukau District Health Board scholarship to complete my Master of Public Health. Public health was always a passion, and it helped me think about systems, equity and population health. It reinforced my belief that if we genuinely wanted better outcomes for Māori, Pacific and Asian women we needed to design services around their needs, not around our convenience.

The work also became about developing other nurses. Mentoring colleagues, supporting community health promoters and encouraging nurses to step into leadership became one of the most satisfying parts of my career. Had the Nurse Practitioner role existed when I started, I probably would have followed that pathway. Instead, public health became my pathway to influencing policy, education and service design. Both are valuable expressions of nursing leadership.

There was also a sense that we had to prove ourselves to the medical profession. Some saw us as aggressive. We preferred to think of ourselves as assertive. One memory has stayed with me above many others. Shortly before he retired, a breast surgeon from Counties Manukau came to see me. He simply wanted to say thank you. He told me that referrals from our service to his Breast Clinic had saved many lives and that he

wanted us to know our work had mattered. Nurses rarely hear the end of the story. His visit reminded me that the countless early mornings, long days and funding applications had been worthwhile.

Looking back now, I realise my career was never just about cervical screening. It was about showing that nurses can lead change. We can build organisations, influence public policy, improve equity and create opportunities for other nurse leaders, educators and practitioners. I hope younger nurses understand there is no single pathway to leadership. Whether your future is clinical practice, nurse practitioner, public health, education or management, nursing gives you the chance to make a lasting difference. If this story has a message, it is simply this: be prepared to start before you know everything. You can learn how to write the GST return. You can learn how to negotiate contracts. What matters most is never losing sight of why you became a nurse in the first place.

Nursing is such a broad and formative career. It gives you the opportunity to turn your passion into lasting change.

Ruth Davy ONZM September 2026



Free cervical screening: a significant step towards eliminating cervical cancer

Vanessa May, RN



Vanessa May is Associate Director of Nursing at Well Women & Family Trust, with a background in primary health care and women's health. Her interests include cervical screening, contraception, health equity, education and improving access to care for wāhine and whānau

A welcome policy shift

Some health announcements make you stop and think, *finally*. The announcement that cervical screening will be free for all eligible women aged 25–69 from 1 March 2027 is one of them.

Around 55% of eligible women currently pay for cervical screening, with costs ranging from approximately \$35 to more than \$100. For some, this cost can mean delaying screening or avoiding it altogether. Removing this financial barrier is an important step towards improving access and reducing inequities.

New Zealand's Cervical Cancer Elimination Plan 2026–2040 aims to reduce cervical cancer to fewer than four cases per 100,000 women each year by 2040. Free screening will help move us towards that goal. However, as primary care nurses know, free does not automatically mean accessible.

Screening is more than a test

For many women, accessing screening involves much more than making an appointment. Barriers may include:

- previous difficult experiences
- fear, embarrassment or uncertainty about the process
- cultural or language barriers
- transport, disability or mobility challenges
- competing whānau responsibilities

This is where nurses, primary care providers and Support to Screen (SSS) services have an important role.

Services such as Well Women & Family Trust provide nurse-led screening, HPV self-testing, outreach, community-based services, health education and support to navigate the screening pathway. Bringing services into communities helps reduce the barriers women may otherwise have to overcome on their own.

Awareness and access must go together

Making screening free will only make a difference if women know about it and can access it. Primary care, SSS providers, community organisations and health promotion teams can work together to build awareness about:

- who is eligible for screening
- how HPV screening works
- the option of self-testing
- where and how women can access services

We also need to reach women who are overdue or have never screened. Screening involves education, informed consent, reassurance, follow-up, referral to colposcopy when required, and support to navigate the health system. The pathway does not end when the sample is taken.

Free for women must also be sustainable for services

Free screening is a significant step, but it also raises an important question: how will increased demand be funded and supported?

If we want more women screened, services need enough nurses, administration support, appointments, outreach capacity and follow-up pathways to meet that demand. We also need a well-trained and supported cervical screening workforce.

As screening evolves, nurses and other providers need access to quality training, clinical education, supervision and ongoing professional development. This includes confidence in:

- HPV-based screening and self-testing
- informed consent and culturally safe care
- recognising when further assessment is required
- supporting women through follow-up and referral

Expanding the workforce is not simply about increasing numbers. We need to build capability and maintain quality while making screening accessible to more women. Funding must therefore recognise the whole screening pathway — including workforce development, education, screening, follow-up and navigation — not just the test itself.

An opportunity to do things differently

Free screening gives us an opportunity to move beyond the traditional clinic model. Community screening, mobile services, outreach, HPV self-testing and nurse-led care can bring screening closer to where women live, work and connect.

SSS providers are well placed to work alongside primary care and community organisations, particularly to improve access for wāhine Māori, Pacific women, women experiencing socioeconomic disadvantage and those who have previously struggled to access screening.

Services must also be culturally safe, welcoming and mana-enhancing. A positive screening experience can influence whether a woman returns, encourages others to attend, or avoids screening in the future.

We have the tools — now we need to use them well

New Zealand has effective HPV vaccination and HPV-based cervical screening. We know what causes almost all cervical cancers and can detect and treat precancerous changes before they become cancer. The challenge is ensuring these tools reach the women who need them most.

Free cervical screening is a significant and welcome step. But eliminating cervical cancer requires the whole pathway to work: awareness, access, workforce, training, funding, culturally safe care, screening, follow-up and treatment.

Free screening gives us the opportunity. Now we need to make sure every woman knows about it, can access it, and is supported by a skilled workforce throughout the pathway.

References

- GenPro. (2026). *General practice must be involved in design of free cervical screening*.
<https://genpro.org.nz/resources/general-practice-must-be-involved-in-design-of-free-cervical-screening>
- Health New Zealand. (2026). *National Cervical Screening Programme update*.
<https://www.healthnz.govt.nz/news-and-updates/national-cervical-screening-programme-update-april-2026>
- Te Aho o Te Kahu – Cancer Control Agency. (2026). *New Zealand Cervical Cancer Elimination Plan 2026–2040*. <https://teaho.govt.nz/index.php/CanStats/reports/new-zealand-cervical-cancer-elimination-plan-2026-2040>
- New Zealand Government. (2026). *Free cervical screening for all women*.
<https://www.beehive.govt.nz/release/free-cervical-screening-all-women>
-



NZCSRH LARC Train the Trainer Course

Building your skills and confidence to train others in Long-Acting Reversible Contraception (LARC)

The New Zealand College of Sexual and Reproductive Health (NZCSRH) is offering LARC Train the Trainer workshops for health practitioners who are already competent in LARC procedures, as per the [Long-Acting Reversible Contraception: Health Practitioner Training Principles and Standards](#), and want to develop their skills in training and assessing others.

Upcoming Workshops

Dunedin – Saturday 31 October

Wellington – Sunday 29 November

This full-day workshop will equip clinicians with the knowledge, skills and confidence to effectively train others in the provision of LARC, including contraceptive implants and intrauterine contraception (IUC).

Participants will develop practical teaching and assessment skills to support competency-based LARC training in clinical settings.

The workshop is open to all health practitioners across Aotearoa, who meet the [eligibility criteria](#) to become a trainer.

The workshop will cover

- Effective teaching methods for clinical skills training
- Assessment frameworks for ensuring competence and safety
- Best practice in complex LARC insertion and removal
- Supporting learners to achieve competency in clinical practice

Becoming a LARC Trainer

Attending the workshop is one part of the LARC Train the Trainer pathway. To be signed off as a LARC trainer, participants must complete the final course requirements, including:

- Training a health practitioner to competence in a LARC procedure
- Obtaining feedback on the training provided
- Completing a self-reflection on the course and training experience

Find out more: [NZCSRH website](#)

For questions about the programme or upcoming workshops, contact Fiona at administration@nzcsr.org.nz.



Nursing in the Department of Corrections Leanne Samuel

Excerpt from Chief Nurse Leanne Samuels Opening Address for the 2026 Nurses Conference for Corrections Aotearoa New Zealand



Leanne Samuel (DipN-RN, BM, MHSM, FCNA[NZ]) is a highly experienced senior health executive and nurse leader with more than three decades of leadership across health, disability, and corrections systems in Aotearoa New Zealand and internationally. She is currently Chief Nurse / Director of Primary Health care (secondment) with Ara Poutama Aotearoa – Corrections, providing national professional and clinical governance for primary health services across 17 prisons.

Leanne's career spans executive, operational, and governance roles within complex, high-risk environments including hospitals, community health, disability services, and custodial settings.

She has held senior leadership roles such as Executive Director of Nursing and Midwifery, Acting Chief Operating Officer / Deputy CEO, Director of Integrated Operations, and General Manager Pae Ora (Health), with accountability for large multidisciplinary workforces, system-wide quality and safety, emergency and incident management, and significant operational and capital budgets.

She is committed to transformational leadership, integrated systems, quality improvement, and service redesign, consistently delivering improved outcomes within politically and operationally complex environments. Leanne brings a strong equity focus with commitment to improving outcomes for Māori and Pacific communities.

Alongside her executive career, Leanne has extensive governance experience, currently serving as a Board Director for a Rural Health service, was previously elected to the Community Trust and has also held governance roles for Maori and Pacific Island trusts.

She is a Fellow of the College of Nurses Aotearoa (NZ) and has contributed nationally and internationally through conference leadership, publications, global forums, and advisory roles.

Correctional nursing is complex care while someone else holds the keys and also in very controlled and extremely complex settings. Nursing “jail craft” and knowledge of the intricacies of specific approaches to care in complex, potentially high risk settings often involves working with extremely challenging individuals. Values such as trust, respect, dignity, compassion, manaaki, whānau, wairua, kaitiaki and rangatira are all matched with creative problem solving, resilience and stress management. All whilst remaining calm in chaotic high stress situations, ensuring patient safety whilst managing our own emotional wellbeing, our potential cognitive dissonance and sometimes our own physical safety.

Sometimes a story says it all.

The keys always came before the patients. They clinked at Emma's hip as she walked the long corridor, a small metallic rhythm that announced her arrival before she spoke a word. The prison was awake now, steel doors opening, boots on concrete, the low churn of voices. Morning medication round. Morning negotiations.

Emma was a nurse, but in this place, she was also a witness, a translator, a boundary-holder, a steady pulse in a building designed to control every other rhythm.

The first man she saw that day, sat on the edge of his bed, shoulders rounded, hands shaking just enough to betray him. Diabetes, poorly controlled. Trauma going back decades. He avoided her eyes, as if shame were another condition she might diagnose.

"How's the feet today?" she asked, squatting to his level careful to keep her hands visible to the guard behind her.

He shrugged. "Numb. Same as yesterday."

She examined them anyway, because numbness could mean neglect, or infection, and infection could mean losing a toe. Or worse. Complex care was often just quiet persistence, checking again, asking again, refusing to rush when the system insisted on speed.

Down the corridor, a call bell rang sharply. A man in his forties, remanded, withdrawing from alcohol. His blood pressure was rising, his fear even more so. He cried not because of the cramps or the nausea, but because he thought no one would come.

Emma came.

She sat at the bedside while the guard stood back, arms folded, posture rigid. She explained every step, every tablet, every observation, because dignity and mana enhancing care matters. Especially here. The man whispered, "You don't talk to us like we're nothing."

Emma smiled gently. "You're not nothing. You're sick. And that's my job." Later, a lockdown. Someone had thrown a chair. Healthcare waited. Hearts didn't.

A man with chest pain pounded on the door of his cell. When they opened it, Emma asked he be brought to the health center for urgent assessment. Heart disease was common here, poverty, stress, poor access to care, long before the sentence was ever handed down.

She did a comprehensive assessment and then they waited for the ambulance and she reassured him about the process at the ED.

That was the hardest part of prison nursing, not the violence or the noise or the endless forms, but the need to see humanity where others had learned not to. To hold clinical

judgment free from moral judgment. To care for people whose lives may have been affected by addiction, mental illness, colonisation, institutional racism, abuse, systemic failure. To provide care in a place not built for healing.

When her shift ended, Emma stood by the sally port and handed over her keys. The weight fell away from her hip, but not from her chest. She carried the stories home with her: the man who smiled because his wound was finally healing, the man who slept for four uninterrupted hours for the first time in weeks, the patient who trusted her just enough to say he was scared.

Tomorrow, she would return. The care would still be complex. The place would still be hard and challenging.

But healing, she knew, did not require perfect conditions, only persistence, compassion, and the stubborn belief that every person, no matter why they were incarcerated, was worthy of care. And so she walked back down the corridor, the echo of keys fading behind her, already preparing to begin again.

Empowerment in nursing is not a slogan. It is visible in the everyday decisions nurses make when they assess risk, advocate for a patient, challenge unsafe practice, ensure safety in an unsafe high risk situation or lead change within complex systems. It is found in the confidence to speak, the authority to act, and the trust placed in professional judgement-critical reflection.

Across our correctional settings i.e. primary care and mental health services, nurses can save lives not only through clinical intervention, but through presence, relationships, and continuity. Over time, nurses become the custodians of people's health stories. They notice what others cannot. They hold risk, hope, and humanity in equal measure. People often come to prison in a vulnerable health state - they may not have had a health assessment or much needed treatment for a long time. It is our role to ensure when they leave our care they have demonstrably improved health care outcomes, health literacy and with referrals to community providers.

To achieve this takes passion, energy, team work and strong nursing leadership with empowerment and it does not happen by chance. It is cultivated deliberately and sustained over time.

It grows where nurses have access to high-quality education, supervision, and ongoing professional development. It is strengthened when leadership is visible and listens to nursing

insight. It is sustained when systems are designed not only to withstand pressure, but to support our staff who carry it.

Nurses in prisons, advocate for people whose voices may be marginalised, for access to primary care, for access to mental health support, and for continuity of care across transitions in and out of custody, with multi-disciplinary health professionals both in and outside the wire. This can involve creative documentation and occasionally a very well timed phone call or 3!. Advocacy is also about advocating for each other as health professionals—safe practice environments, wellbeing, and sustainable workforce models.

Primary care is the backbone of correctional Pae Ora health services. For many people in custody, prison health services provide their most consistent contact with healthcare. Nurses identify untreated physical conditions, manage long-term illness, and focus on prevention and health promotion. Alongside this, nurses play a critical role in mental health care. Mental distress, trauma, substance use, and neurodiversity are common in prisons, and nurses are often the first to assess, recognise risk and initiate support. We use a number of assessment tools such as the Columbia suicide tool, and Te Whare Tapa wha, etc ,bringing holistic culturally appropriate assessment, coordination, and continuity of care. Nursing leadership is often the connector or the glue that ensures teams function safely and effectively.

Change in health services and in prisons is a given. What has evolved, is the speed, the constancy and complexity of that change. Accordingly, flexibility, resilience, and adaptation from the nursing workforce, also demands careful attention for workforce sustainability.

We must challenge practices that exhaust teams rather than enable teams or mana enhancing care. We must persist with reforms that place safety, quality, and dignity at the centre—for those we care for, and for those who provide that care.

When nurses are empowered, health outcomes improve.

When nurses are trusted, systems improve.

Leanne Samuel, Chief Nurse/Director Physical Health
Ara Poutama Aotearoa, Dept of Corrections

MCaFHNA Conference 2027



REGISTER NOW

This year's conference theme, **Transforming Child & Family Health in a Changing World**, highlights the advancement of maternal, child and family health through innovative practice, emerging evidence, and new ways of working that strengthen outcomes for children, families and communities.

The conference provides an important opportunity for our profession to showcase leadership, share contemporary insights, and demonstrate the impact of our collective work across Australia and the world.

We warmly encourage you to submit an abstract that reflects your practice innovations, research, quality improvement initiatives, or collaborative models of care.

Key dates:

- **Call for Abstracts open:** 7 July 2026
- **Abstract submissions close:** 1 November 2026
- **Notification of abstract acceptance:** 23 November 2026

You can **review the submission guidelines and lodge your abstract** via the conference portal: [Call for Abstracts MCaFHNA + GNPHN International Conference 2027](#)

The conference committee looks forward to receiving your submissions.

The Price of Your Life: an American Immigrant's View on the Privatisation of New Zealand's National Healthcare. Chanteé Hale, RN, MSNc, PGCertPH, MBA



Chanteé Hale, RN - MSNc, is an immigrant from the United States of America and has been working in public and community health in the States and New Zealand for almost 15 years. She holds a Level 1 certificate in Te Reo from Te Wananga a Aotearoa and a Post Graduate certificate in Women's & Children's Health from Whitireia WelTec. She lives and works in the Auckland area and spends much of her free time either expressing her creative nature or loving on her husky and three cats

In 2025, the coalition government began floating the concepts behind deconstructing public health care: extending private outpatient surgical contracts to 10 years (Bradley, 2025), floating a \$6,000 payout to those who don't want to use the public health care system (Cueto, 2025), and testing the waters with the concept of privatisation of hospitals (Burns, 2025, 1News, 2025). As an immigrant from America, I can give first hand accounting of exactly how privatization works out for people.

Nineteen years ago I had my first experience with the American private healthcare system. Having grown up poor in the state of Virginia, I had limited experience with healthcare prior to this. Our family utilized public health clinics for vaccinations and well women checks. When major injuries or illnesses forced our hand, we would utilize hospital services and my family spent all of my childhood paying off the debt for those three incidents. But in 2007 I had the opportunity to purchase health insurance, and it wasn't too expensive so I thought I'd see what it was about. My health had to be good enough, I had to pay monthly, and there was still a per-visit fee to seek medical care. The only upshot - one I thankfully never had to use - was that it might cover me for something life threatening and I wouldn't be trapped in the medical debt cycle like my parents had been.

In 2013, I entered the United States healthcare workforce as a registered nurse. The Affordable Care Act had been in effect for about 3 years at this point and, for a short while, insurance companies were required to cover everyone regardless of their health.

Finally, people got a taste of what access to healthcare meant. But healthcare isn't a magic cure for ancient wounds and many went away disappointed and disillusioned with the experience. As a nurse, I saw people in their 40s and 50s coming into clinics in hopes of finally being able to get that damaged joint, that prolapsed spinal disc, that historical injury, tended. Accessing basic healthcare services didn't heal old wounds and navigating the referral system and co-pays for more intensive healthcare than checking blood pressure or blood sugars often took more time and money than people had to give.

While working in school health in the late 2010's I was present when ambulance services were called in, as a stand by, for a teacher who was feeling unwell. In the end, the teacher did not take the ambulance to the hospital and the emergency medical technicians simply rechecked all the vitals I had already checked for the teacher. Weeks later, the teacher reached out to ask who was responsible for paying the \$600 emergency services call-out fee. Actual transport to a hospital would have cost more, but the teacher was still dismayed to find out that they were responsible for the payment.

Over the years I watched as the access first granted by the Affordable Care Act withered away, throttled by the only true purpose of a private organization: shareholder profit (Lipton, 2020). I immigrated to Aotearoa New Zealand in 2024, and in the year prior to immigration I paid roughly \$350 usd per month for insurance in the U.S.A. This fee granted me one free visit to my GP per year. This visit only remained free if I had no concerns or complaints to discuss with my doctor. Otherwise, I paid about \$100 per visit to my GP, lab work not included. Outpatient emergency clinics for care that couldn't wait 2-6 weeks for an appointment with my GP, cost more. And at any time my insurance company could deny the bill they were sent - leaving me to pay the balance.

After moving to Aotearoa New Zealand with a permanent resident visa, I found an outstanding GP at half the visit cost of my GP from the states. I booked a half-day off work to go in for my first visit and was astounded to be seen within 15 minutes instead of 2-4 hours. I was given an order for labs with no appointments required. Even though there was a full office at the lab when I went, I was done in under half an hour. I waited for the bill in the mail for lab work, and was delighted to find out that it was free. And then there was the medications. I was told that it was expensive, unless you went to a chain pharmacy where they waived the \$5 prescription fee. So I went and stood, card in hand, at a chemist's pickup counter, wondering why the package said \$0.00 because, in America, you also pay for your medications. Not a prescription fee – an actual price on every medication you pick up. I remember texting my friends and family back home and telling them how I'd saved over \$200 in just one visit compared to what I was getting in the United States. And how quickly I received it. They pointed out that the hospital

had to be more expensive, so I asked colleagues. I was told to sign up for the Saint John's ambulance service, that it is under \$100 per year and covers any ambulance trip you might need to take with them. Several astounded expletives later, I fact checked emergency hospital care prices. For citizens and permanent residents it's free. No one is paying \$30,000 per birth – or more if things don't go well. No one is being charged towel use fees.

The first time I got sick I did the same thing here that every American would do back in the states and I went to a walk-in A&E. It was late and every child in the area was apparently sick as well, yet I was in and out in an hour, without spending any more than I would have to see my GP in the states, and with a prescription for antibiotics that I knew I wasn't going to have to find the money for. Yes, healthcare in Aotearoa New Zealand isn't perfect. There aren't enough mental health providers, not every doctor or healthcare practitioner is as good as my GP, and not every treatment is available or covered. But the same can be said in the states regarding mental health and quality healthcare practitioners and no treatment is free, even with insurance. In the states you will pay thousands in co-pays for a surgery that you'll have to wait months to have scheduled in. Here, you won't pay anything and while wait-lists are long, these are barriers that can be eroded with good policy. Policy that puts money into expanding healthcare services, hiring more practitioners, and ensuring educational access for those who want to become healthcare professionals or advance the career they already have. Each of these items takes money but I can't help wondering what are taxes meant for if not the good of the people being taxed.

As of 2026, the American healthcare system stands as a warning to other countries: corporations controlling your health will neither reduce the healthcare debt, nor the inequities you face in accessing care. In 2018 the United States spent roughly twice as much as similar high-income countries for the same amount of healthcare access (Papanicolas, 2018). Meanwhile almost 20 million adults in the United States owe a collective \$220 billion in medical debts and the average person has to put 10-25% of their income towards their medical care (Kazi, et. al, 2026). Yet, the business of healthcare is thriving, according to shareholder profits (Tachibana, 2025) and when it's not, the private companies will cut their losses, as the actions of the US-based Leonard Green & Partners firm showed in their 2022 closure of 17 safety net hospitals (O'Grady, 2022). These hospitals were ones for which there are no other options available to the communities living near them, and because a corporation was not profiting, these communities no longer have access to life-saving services.

Unsurprisingly, Americans are avoiding health care - even to the point of death - as the cost of staying alive in the United States has become unaffordable. Amenable mortality, the term New Zealand uses for deaths that could have been avoided if healthcare was

available and/or timely (Manatū Hauora | Ministry of Health, 2019), has increased in the

2019 Median Amenable Deaths

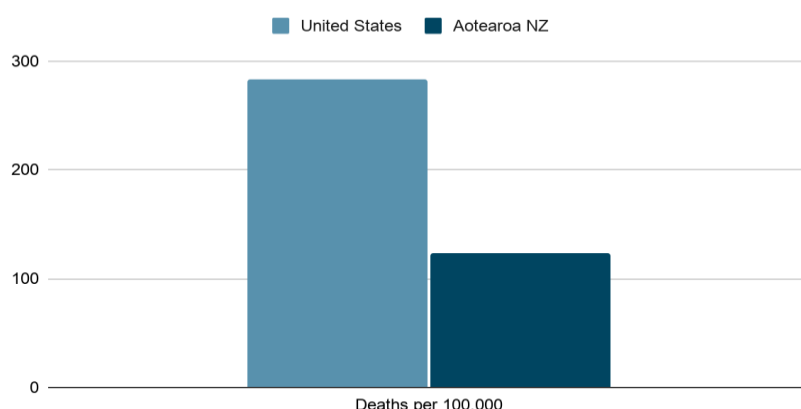
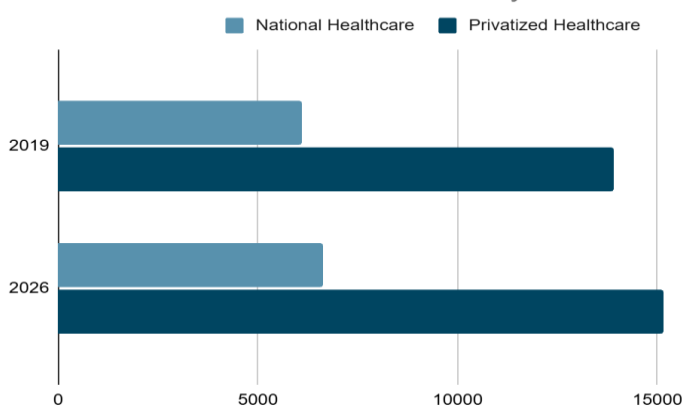


Table 1: Combined median data points from NZMJ & Papanicolas et. al 2025)

United States almost 30% while it has fallen in comparable European countries (Papanicolas, et. al. 2025). According to research conducted by Papanicolas, et. al. (2025), a median count of 282.8 persons per 100,000 persons died from amenable causes in the United States in 2019.

This number, when applied to Aotearoa New Zealand and adjusted for the estimated 2026 population would mean around 15,161 preventable deaths per year based solely on healthcare access. Given that New Zealand estimates their amenable mortality at 124 individuals per 100,000 (New Zealand Medical Journal, 2026), this would result in a 228% increase in deaths. And yet, this is the future that the current National-ACT-First coalition would have kiwis take.

NZ Est Individual Amenable Deaths by Healthcare System



I do not pretend to have the answers to making healthcare feel like it works fairly across Aotearoa. I can only offer the warnings that my birth country has modelled for the world: make your health a commodity through the corporate takeover of healthcare and you'll have to decide how much you are willing to pay to stay alive.

References:

- 1News. (24 Jan, 2025). Seymour pushes for privatisation: 'Govt hopeless at owning things'. 1News. Retrieved from: <https://www.1news.co.nz/2025/01/24/seymour-pushes-for-privatisation-govt-hopeless-at-owning-things/>
- Bradley, A. (17 Jun, 2025). Health NZ told to give private hospitals 10-year outsourcing contracts. RNZ. Retrieved from: <https://www.rnz.co.nz/news/politics/564316/health-nz-told-to-give-private-hospitals-10-year-outsourcing-contracts>
- Burns, A. (25 Jan, 2025). Privatising health care would hurt those on lower incomes - Advocate. RNZ. Retrieved from: <https://www.rnz.co.nz/news/politics/539945/privatising-health-care-would-hurt-those-on-lower-incomes-advocate>
- Cueto, J. (25 Jan, 2025). ACT leader calls for insurance shake-up. Insurance News. Retrieved from: <https://www.insurancebusinessmag.com/nz/news/breaking-news/seymour-opt-out-of-public-healthcare-for-private-insurance-522020.aspx>
- Kazi, D.S, Beckman, J.A., Benjamin, R.M., Firestone, G., Johnson, J.C., McClellan, M.B, et. al. (30 April 2026). Health Care Affordability in the United States, From Crisis to Action: A Presidential Advisory From the American Heart Association. *Circulation*, 153:22. American Heart Association. Retrieved from: <https://www.ahajournals.org/doi/10.1161/CIR.0000000000001442>
- Lipton, M. (17 Sep, 2020). The Friedman Essay and the True Purpose of the Business Corporation. Harvard Law School Forum on Corporate Governance. Retrieved from: <https://corpgov.law.harvard.edu/2020/09/17/the-friedman-essay-and-the-true-purpose-of-the-business-corporation/>
- Manatū Hauora | Ministry of Health. (Aug 2019). Health Systems Indicators. Manatū Hauora | Ministry of Health. Retrieved from: https://www.health.govt.nz/system/files/2024-05/health_system_indicators_hp_7049_31_july19.pdf
- New Zealand Medical Journal (30 Jan, 2026). Te ara tika o te hauora hapori. Pacifika Medical Association. Retrieved from: <https://nzmj.org.nz/media/pages/journal/vol-139-no-1628/is-ethnicity-an-independent-predictor-of-health-need-linked-cohort-logistic-regression-analysis-to-predict-amenable-mortality/4dde68eef5-1769386264/7002-table-13.pdf>
- O'Grady, E. (Nov 2022). How Private Equity Raided Safety Net Hospitals and Left Communities Holding the Bag. Private Equity Stakeholder Project. Retrieved from: https://pestakeholder.org/wp-content/uploads/2022/11/Prospect_Primer_Nov-2022.pdf
- Papanicolas I., Niksch M., Figueroa J.F. (24 Mar, 2025) Avoidable Mortality Across US States and High-Income Countries. *JAMA Intern Med*. 2025;185(5):583–590. doi:10.1001/jamainternmed.2025.0155 Retrieved from: <https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2831735?resultClick=1>
- Papanicolas, I., Woskie, L.R., Jha, A.K. (13 Mar 2018) Health Care Spending in the United States and Other High-Income Countries. *JAMA (Journal of the American Medical Association)*. doi: 10.1001/jama.2018.1150. Retrieved from: <https://pubmed.ncbi.nlm.nih.gov/29536101/>
- StatsNZ. (15 Aug, 2019). National population estimates: 30 June 2019. New Zealand Government. Retrieved from: <https://www.stats.govt.nz/information-releases/national-population-estimates-at-30-june-2019/>
- StatsNZ. (18 May, 2026). National population estimates: 31 March 2026. New Zealand Government. Retrieved from: <https://www.stats.govt.nz/information-releases/national-population-estimates-at-31-march-2026/>
- Tachibana, C. (13, Mar 2025). Health Care Profits Increasingly Support Shareholder Payouts. Leonard Davis Institute of Health Economics, University of Pennsylvania. Retrieved from: <https://ldi.upenn.edu/our-work/research-updates/chart-of-the-day-health-care-profits-increasingly-support-shareholder-payouts/>
-

Primary Health Care: How we got here Michael Brenndorfer



Michael Brenndorfer is a Matanga Tapuhi/Nurse Practitioner working in youth health and primary care in Tamaki, and is the publisher for the LOGIC Journal

Primary Health Care Nurses are returning to the negotiating table with employers to push for pay parity and recognition of advanced nursing practice, and election season is ramping up yet again with more promises flying in every direction. At times like these it's useful to take a moment and look back at history to understand how this system we find ourselves struggling with was developed. How did we end up with a primary care system that has allowed the growth of corporate and for-profit PHOs, with private equity owned corporations buying up and buying out practices across the country, while refusing to pay nurses what they are worth or recognize the advanced practice of nurse prescribers? Understanding the context and history is the best chance we have as Primary Health Care Nurses of pushing for a more equitable, accessible, and appropriate health care system that respects the nurses who work within it.

It might seem impossible in our current political climate to imagine a political party campaigning on radical social services reforms and actually delivering on their policies when elected. However, in the 1930s New Zealand was experiencing the ongoing impacts of the Great Depression, which created the ideal political environment for a small but growing political party, the Labour Party, to propose social democratic solutions to the rising inequality and poverty of the time. They proposed a cradle to grave Social Security Bill, which would provide unemployment benefits, free universal

health care, and a universal superannuation from age 65. At the time, doctors were an expensive privilege, mostly accessible only to the wealthy, while the rest of the population were left to rely on home remedies. Their campaign was successful, leading to the first Labour government and the formation of New Zealand's universal healthcare system. But looking back, you might notice a confusing outcome – while secondary and tertiary level health care is universal, we have been stuck with a private, business approach to primary care. This might seem incredibly illogical that the preventative health care system continues to be user-pays to some degree, while the secondary and tertiary level care, arguably much more expensive, remains entirely publicly funded. This inconsistency was the result of strong opposition from the British Medical Association of the 1930s who campaigned hard against universal healthcare, in defence of private profits, and as a compromise Prime Minister Michael Savage granted them the concession of being able to operate their own general practice clinics for profit, with opportunity to charge a fee, while also receiving a fee-for-service from the government to increase accessibility. Thus, New Zealand was left with an awkward two tier system, primary care run as businesses, secondary and tertiary care as universal, free, and publicly funded.

The consequences of this approach have had an ongoing impact on nurses, and the disparity that developed between nurses working in primary care clinics and our colleagues working within the publicly funded services. The primary care model with fee-for-service for doctors' appointments created further entrenchment of a doctor-lead approach to primary care, as clinics were primarily owned and operated by doctors, and fee-for-service funding applied to doctors appointments only. From the outset the system was designed in a way which would minimize and limit the potential input of nurses within primary care. Meanwhile, the public universal healthcare system managed, without these structural barriers, to continue to advance and develop the potential utilization of nurses and over the decades allowed the evolution of advanced clinical nurse specialist roles.

This fee-for-service funding model continued for many decades, resulting in some disparities in services and costs over time, leading to some lobbying by GPs of the government for a new funding model which allowed for more sustainable clinic funding. Change came under the fifth Labour Government, led by Helen Clarke. This reform saw the Primary Health Care Strategy of 2001 and the development of Primary Health Organisations which oversaw capitated funding on an enrollment basis – funding was applied when a patient enrolled at a clinic, rather than being based exclusively on fee-for-service funding. This allowed for targeted funding based on health needs and had the potential to increase the involvement and scope of nurses within primary care settings. These PHOs initially also had the potential to increase community involvement in funding and planning around primary health care, as they were

inherently non-profit organisations, often located within the communities they served. Through some funding approaches, increased nurse-led clinics were able to develop in some clinics, allowing funding for nurses supporting patients navigating long term conditions such as asthma and diabetes. While not entirely revolutionary, the potential was slightly reduced when the subsequent National Government Minister of Health Tony Ryall moved to reduce the total number of PHOs, limiting the potential of some of the community-based PHOs, which either had to merge with larger PHOs, shift into NGOs, or dissolve entirely.

As a result of these historic decisions around the structures and systems of primary care in New Zealand, we, as Primary Health Care nurses, have unique structural barriers to navigate. Our funding models still do not currently provide incentives to our employers for the inclusion of nurse specialist roles within for-profit primary care clinics, limiting the potential of our profession. Despite the growing number of Nurse Practitioners in primary care, the lack of steppingstones to grow from practice nurse to Nurse Practitioner makes the journey difficult and can make the transition jarring. Compounding this, our potential to negotiate collectively as a workforce is difficult, as we are spread across a thousand different employers. We are isolated, and pushing for a strong collective agreement that gives Primary Health Care Nurses pay parity and recognition of advanced clinical roles is a constant frustration.

Over the past three years, we've seen a new movement within the primary care space – the rapid expansion of corporate interests, and the allowance by the government of the establishment of explicitly for-profit Primary Health Organisations. What this has looked like is investor-owned entities buying out previously owner-operator clinics, often restructuring these clinics with overt profit motives. In some cases this includes overseas private equity investors backing these NZ-based companies, expanding their control of the primary care market. This corporate privatization expansion should be signaling alarm bells to everyone in New Zealand, and should especially be of concern to Primary Health Care Nurses. These moves alongside ministry meddling in the Nursing Council and the Health Practitioners Competency Assurance Act to expand the presence of non-registered health workers in task based roles instead of registered nurses, signal a very big shift towards profit priorities in primary care, for the benefit of private investor benefits.

As we approach the election it's also important to understand the policy proposals of different parties in relation to primary care. While the proposal of 3 free GP visits that Labour is pushing forward, without ever mentioning the existence of RNs or NPs in their discussion of this policy, may sound like a positive shift, it's important to consider the reality of this proposal in the context of the expanding corporate ownership of primary care – such a policy adds a layer of fee-for-service back into the funding system, but

now with profits going from tax-payers into the pockets of private equity investors rather than locally owned clinics.

Without addressing the structural issues and foundations within our primary care system, we will struggle, as nurses, to achieve pay equity, to see the respect and expansion of advanced nursing roles within primary care, and we'll struggle to prevent the expansion of privatized corporate ownership of our sector. We need to use our collective voice whenever possible to call for a brave re-imagining of the primary care system, one that returns to the original intention of Michael Savage and the first Labour Government, who sought equitable and accessible healthcare for everyone throughout their lives, and fight for a primary health care system that allows the full potential of nurses to support the health of our communities.

Michael Brenndorfer

Primary care at the ballot box: why health policy matters to nurses

Vanessa May, RN.



Vanessa May, RN, is Associate Director of Nursing at Well Women & Family Trust. She works in primary health care with a focus on women's health, cervical screening, contraception, health education, workforce development and improving equitable access to nurse-led services

This article aims to help primary health care nurses assess election health policy through the lens of access, equity, workforce sustainability and care closer to home.

It is not just something discussed in Parliament or written in a policy document. It affects whether someone can get an appointment, afford their medication, access screening, find a service close to home, or get help early enough to prevent a health problem becoming something more serious.

With the 2026 General Election approaching, I thought it was worth taking a look at what the major political parties are saying about health, particularly primary care, and what this might mean for us as nurses.

This is not about telling anyone who to vote for. It is about encouraging nurses to look at the policies, ask questions and have a say in the direction of our health system.

Why primary care matters

Primary care is often where health care starts. Nurses are providing screening, immunisation, contraception, health education, chronic disease care, mental health support, prevention and early intervention every day.

We also know what happens when access is difficult. People delay care, conditions become more complex and pressure is pushed further into hospitals and emergency departments.

Access is a real issue. Recent health sector reporting continues to identify difficulty getting timely GP appointments as one of the pressures facing New Zealand's primary care system. At the same time, the way primary care is funded is changing, with funding increasingly taking account of factors such as age, health need, rurality and deprivation.

For those of us working in primary care, these are not abstract issues. They affect our patients, our workloads and the services we are able to provide.

What are the parties proposing?

There are some common themes across the major parties. Most acknowledge that primary care is under pressure, that the health workforce needs support and that we need to find better ways of providing care closer to home.

The differences are in how they propose to get there. When comparing the policies, it is useful to look at four questions: will care be more affordable, will there be enough workforce capacity, will services reach people facing the greatest barriers, and will funding support sustainable community-based care?

National has focused on increasing access and workforce capacity. Current initiatives include pathways for overseas-trained doctors into general practice, additional primary care training places and support for nurses entering primary and community care. The Government has also increased the prescribing scope of nurse practitioners and introduced longer prescriptions for some people with stable, long-term conditions.

For nurses, the question is whether these initiatives will translate into enough people working in primary and community care to meet demand. Workforce numbers matter, but so do retention, working conditions, skill mix and having the right people in the right roles.

Labour has made affordability a major part of its health platform. Its proposed Medicaid would provide three free GP visits each year, free prescriptions and free cervical screening for people aged 25–69. Labour is also proposing guaranteed employment for nursing graduates and changes to the way general practice is funded.

From a primary care perspective, making care more affordable is important. But we also need to ask whether there will be enough clinicians and appointment capacity to meet increased demand. Making an appointment free does not create an appointment where one does not exist.

The Green Party is proposing a significant expansion of publicly funded primary care, with a focus on prevention, community-based services and reducing inequities. The Greens have also called for greater investment in the health workforce, including paid nursing placements.

Their approach puts strong emphasis on keeping people well and providing care in the community rather than waiting until people become unwell enough to need hospital care.

ACT is taking a different approach, particularly around making greater use of the existing health workforce. Its Pharmacy First proposal would expand what community pharmacists can provide, including treatment of more everyday conditions and management of some stable long-term health needs.

There is a sensible question here about whether we are making the best use of all our health professionals. There is also a nursing question: how do we expand the wider primary care workforce while maintaining continuity, clinical oversight, appropriate referral pathways and equity of access?

New Zealand First has proposed increased investment in primary care, reviewing the capitation model, expanding services through general practice, greater use of nurse practitioners, mobile health services and digital health clinics. It has also identified workforce shortages and the need to attract more doctors and other health professionals.

Some of these ideas will be particularly familiar to nurses working in rural and community settings, where bringing services to people rather than expecting people to travel can make a significant difference.

Te Pāti Māori places Māori health equity, Māori-led services and whānau wellbeing at the centre of its health approach. Its health policy supports strengthening Māori-led health services and improving access to culturally safe care.

For primary health nurses, this is an important part of the wider discussion about equity. We know that providing exactly the same service to everyone does not necessarily produce equitable outcomes. Cost, transport, location, previous experiences with health services, trust and cultural safety can all influence whether someone accesses care.

What should we be looking for?

As nurses, I think we need to look beyond the headline promises.

- If we want more people accessing primary care, we need enough people to provide that care.
- If we want more services delivered in the community, those services need sustainable funding.
- If we want to reduce pressure on hospitals, we need to invest in prevention and early intervention.
- And if we are serious about equity, we need to design services around the people who currently face the greatest barriers to care.

This is where the nursing voice is important.

We see the patient who cannot afford an appointment. The whānau who cannot get time off work. The person who has no transport. The woman who has disengaged from health services because previous experiences have not been positive. We also see the impact on our own teams when demand continues to increase without the workforce or resources to match it.

These experiences should be part of the health policy conversation.

We need a longer-term plan

One of the strongest messages coming from the primary care sector this election is the need to think beyond a three-year political cycle.

General Practice New Zealand has launched *Hauora 2036*, calling for a 10-year, cross-party approach to health, with sustainable funding, workforce development, prevention and a shift towards more care being provided in the community.

I think this is worth paying attention to. As nurses, we know that meaningful change takes time. We cannot simply introduce a new programme or funding stream and expect it to work without the workforce, infrastructure, education and support behind it.

Governments will change and policies will change, but some things should remain at the centre: accessible primary care, a supported workforce, prevention, equity and care that is centred around people and their whānau.

Have your say

The 2026 General Election will be held on Saturday 7 November, with voting places open from 9.00am to 7.00pm on election day.

As health professionals, we have a valuable perspective. We see the health system from the inside. We see what works, where the gaps are and what happens when people cannot access care early.

So take some time to read the policies for yourself. Think about what they could mean for your patients, your whānau, your community and your profession.

You do not have to agree with everything a party proposes.

But you do have a voice.

Check your enrolment.

Read the policies.

Ask questions.

Have your say.

Primary health care matters – and so does your vote.

References

ACT New Zealand. (2026, August 6). *Your pharmacist should be your first stop*. [ACT New Zealand](#)

General Practice New Zealand. (2026, August 27). *Election must turn primary care alignment into action*. [General Practice New Zealand – Election 2026](#)

Health Coalition Aotearoa. (2026, August 31). *HCA welcomes policy priorities evident at political panel*. [Health Coalition Aotearoa](#)

Health New Zealand. (2026). *Annual primary care funding*. [Health New Zealand – Primary care funding](#)

Labour Party. (2026). *Labour's 2026 General Election policies*. [Labour Party – Our policies](#)

National Party. (2026, July 23). *Homegrown nursing workforce continues to grow*. [National Party](#)

New Zealand First. (2026). *A healthier New Zealand*. [New Zealand First – Policy](#)

New Zealand Parliament. (2026). *Parliamentary parties*. [New Zealand Parliament](#)

RNZ. (2026). *Health policy guide*. [RNZ – Election 2026 health policy guide](#)

Te Pāti Māori. (2026). *Health policy*. [Te Pāti Māori](#)

The Women's Health Council. (2023). *Election 2023 – Health policies of the major parties*. [Women's Health Council](#)
