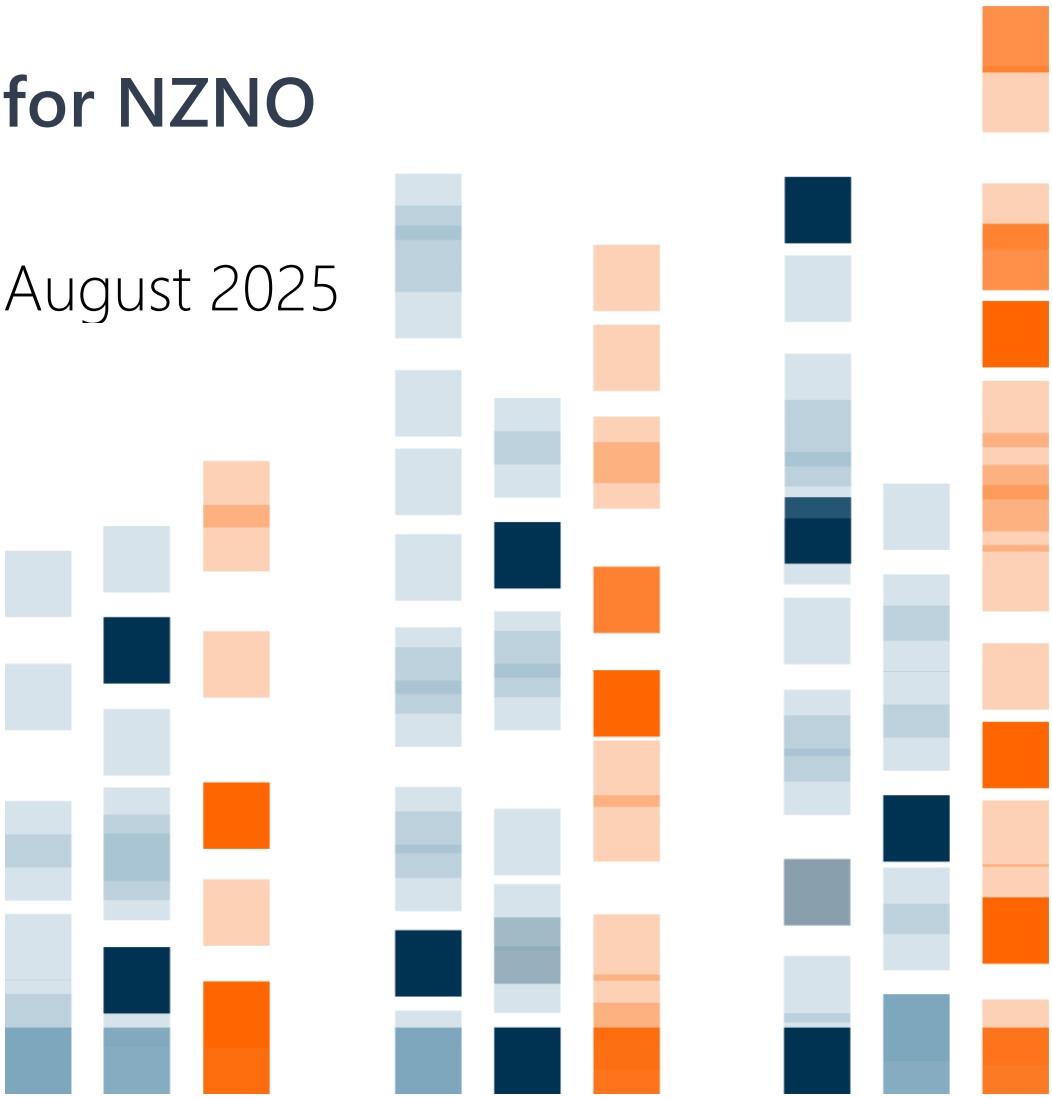
How many more nurses does New Zealand need?

for NZNO

August 2025



Infometrics

Economics put simply

Authorship

This report has been prepared by Rob Heyes.

Email:

Rob.Heyes@infometrics.co.nz

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Summary

The New Zealand Nurses Organisation (NZNO) commissioned Infometrics to quantify the current nursing shortage in New Zealand based on current funding levels and on safe staffing funding levels. The scope of this research includes registered nurses (RNs), enrolled nurses (ENs) and nurse practitioners, although available the nursing workforce data doesn't always cover all three scopes of practice.

Genuine verses funded shortages

Nurse vacancy numbers and vacancy rates provide estimates of the nursing shortage based on currently funded positions. However, if current funding levels constrain access to healthcare or are not sufficient for safe staffing (as feedback and studies across several settings such as general practices, mental health and addiction services, and hospices have found), then vacancies will under-estimate the genuine nursing shortage.

To estimate the genuine shortage, we have applied different methods to different employment settings depending on the nature of care, the nursing workload, and available data germane to each setting.

Vacancy rates vary across settings

Table 1 summarises the data we have been able to collate across several healthcare settings. The table excludes much of the nursing workforce headcount and FTE by employment setting data published by NCNZ in their annual reports because in some cases the settings were not specific enough for our needs.

We were able to access vacancy data for Te Whatu Ora funded services, aged residential care, Corrections, Plunket and mental health and addiction services. We estimate that these settings cover around two-thirds of the nursing workforce.

- Vacancy rates ranged from 2.3% in Corrections to 15% in aged residential care.
- Across these settings, vacancy numbers amounted to just under 2,500 FTEs.[1]

[1] The vacancy headcount in Te Whatu Ora funded services was converted to FTEs based on the RN mean FTE in the Te Whatu Ora clinical (hospital) setting of 0.86, as reported by NCNZ in The New Zealand Nursing Workforce 2022-23 publication.

Table 1

Nursing workforce and vacancy FTEs

		(employed + vacant)			Vacancy rate			Vacancies
	Year	RNs	ENs	All nurses	RNs	ENs	All nurses	All nurses
Te Whatu Ora services	2024	Unknown	Unknown	29,488	Unknown	Unknown	4%	1,250
Aged residential care (ACANZ members)	2023	4,581	356	4,937	15%	6%	15%	741
Corrections	2024	239	17	256	2%	6%	2%	6
Plunket	2024	Unknown	Unknown	437	Unknown	Unknown	5%	20
Mental health and addiction	2022	Unknown	Unknown	3,910	Unknown	Unknown	12%	458
Total				39,028				2,474

Source: Te Whatu Ora, NCNZ, ACANZ, Corrections, Plunket, Te Pou

We were able to access employment data for general practices and Māori health providers. However, without vacancy data we were unable to calculate the number of funded positions (employed plus vacant positions), or vacancy rates. We also accessed vacancy data for nurses in schools. However, without total FTE or headcount data we were unable to calculate vacancy rates.

Nurses required for safe staffing

Table 2 collates the estimates we have made of how many additional nurses are required for safe staffing. We have been able to do this for Te Whatu Ora funded hospitals, aged residential care, general practices, mental health and addiction services. In these four settings, which cover just over half of the nursing workforce, the workforce would need to increase by almost 2,800 FTEs (8.0%) to achieve safe staffing — 2.9% in Te Whatu Ora funded hospitals, 34% in aged residential care, 6% in general practices, and 8% in mental health and addiction services.[2]

In Te Whatu Ora funded hospitals, safe staffing is defined as that recommended by the CCDM system. We estimate the shortage by summing the daily care hours variance for all shifts in all wards that had a negative variance between 1 January 2022 and 30 November 2024. Care hours variance represents the difference between the number of care hours available by nursing staff (capacity) and the care hours required (demand). We then find the average the daily variance between these dates, which equates to **635 nurse FTEs**, a **2.9%** increase on current staffing levels.

In aged residential care, safe staffing is defined as that required to deliver direct patient care minutes equivalent to those mandated in Australia as the minimum for safe staffing in October 2024.

- We find that applying minimum care standards would require an estimated additional **8,232 carer (RNs, ENs, caregiver/kaiāwhina) FTEs** (a 38% increase on current levels), of which **1,550 FTEs would be RNs** (a 34% increase on current levels).

[2] We have also attempted to estimate how many school nurses would be required to increase the coverage across all schools and to reduce nurse-to-student ratios for higher-needs students. The results are outlined in the Schools section, but not in this summary because they disproportionately skew the results.

For general practices, safe staffing is ensuring general practices are able to enrol the 5.6% of the population who are currently unenrolled.

- We estimate that an additional **274 nurse FTEs** would be required to cover the needs of the unenrolled population.

For mental health and addiction, safe staffing is meeting the needs of the 9.7% of the population whose mental health needs are currently not being met. We estimate that **330 nurse FTEs** would be needed meet the unmet mental health needs of the population. This estimate is in additional to vacant positions, which would also need to be filled.

Table 2

Estimates of nurses needed for optimal care

Nursing shortage	Year	Metric	Funded FTEs	Shortage	Increase required	Method
Te Whatu Ora funded hospitals	2022-24	Total FTEs	21,689	635	3%	To meet CCDM recommended staffing
Aged residential care	2024	RN FTEs	4,581	1,550	34%	Australian mandated care minutes
General practice	2024	Total FTEs	4,884	274	6%	To cover unenrolled population
Mental health and addiction	2022	Total FTEs	3,910	330	8%	To meet unmet mental health population needs
Total			35,064	2,789	8%	
Alternative measures of shortage						
Te Whatu Ora funded services	2023			28%		Ward shifts below target
Aged residential care (ACANZ members)	2023			83%		Facilities not fully staffed

Source: Infometrics calculations

Te Whatu Ora vacancies underestimated

Our understanding is that the Te Whatu Ora vacancy count is a count of vacancies for which hospitals and other Te Whatu Ora services have Approval to Recruit (ATR). Actual vacancies might be much higher because at any given time a number of vacancies exist in services but are in the process of getting ATR. These vacancies do not show up in the Te Whatu Ora vacancy figures. In mid-2024, it was also reported that nursing jobs at Te Whatu Ora services were going unfilled because of a hiring freeze.[3]

Overlap between vacancies and shortage estimates

The FTEs needed for safe staffing are not necessarily additional to the vacant FTEs. In some cases, such as Te Whatu Ora Hospitals and General Practices, the vacancy and the shortage numbers most likely overlap.

There were 1,250 vacancies across all Te Whatu Ora services on 30 June 2024. We don't know how many vacancies were in Te Whatu Ora hospitals but much of the CCDM care hour variance was probably caused by vacancies, as well as nurses taking sick leave and other types of leave. On the other hand, some of the CCDM shortfall might also have been caused by there not being enough funded nursing positions. In this case, the vacancy figure would underestimate the shortfall. Furthermore, a ward that had a

[3] https://www.rnz.co.nz/news/national/522145/frontline-hospital-roles-going-unfilled-amid-hiring-freeze-despite-health-nz-saying-otherwise

shortage of nurses because some positions were vacant could have had nurses redeployed from another ward to meet the short-term need on any given day. This ward would not have had a care hours variance on those days, despite having ongoing nursing vacancies.

Projected demand

Table 3 collates various nurse demand projections across several settings detailed in the main body of this report. Across the aged residential care, general practice, mental health and addiction, and Māori health settings provider demand for nurses is projected to rise by around **3,000 FTEs** by 2034 or **21%** of the existing workforce. This analysis covers just under one-quarter of the nursing workforce.

Table 3

Projected demand for nurses

Projected increase in nurse FTE

Setting	Methodology	2024	2034	2024-34	
Aged residential care	EY population change scenario	4,741	6,957	2,216	47%
General practice	Constant nurse-to-population ratio	4,884	5,261	377	8%
Mental health and addiction	Constant nurse-to-population ratio	4,079	4,393	314	8%
Māori health providers	Constant nurse-to-Māori population ratio	562	679	117	21%
Total		14,266	17,290	3,024	21%

Source: Infometrics projections

In some cases, projection years have had to be aligned. For example, the aged residential care projections were based on the years 2023 (because this was the latest year of historical data) and 2031 (because this was the latest projection year of the bed day projections which drive our workforce projections). We calculated the average annual growth rate between these two years and used to it calculate the FTE requirements in 2024 and 2034.

Current workforce projections fall short of projected demand

Based on Te Whatu Ora's current projections of the size of the RN and EN workforce, the workforce will fall short of the projections outlined in Table 3.

Between 2024 and 2034:

- The aged residential care nursing workforce is projected to contract **9%**, demand is projected to grow **47%**,
- The mental health nursing workforce is projected to grow just **2.2%**, demand is projected to grow **7.7%**,
- The primary health care related nursing workforce is projected to grow **4.5%**, demand is projected to grow **7.7%**.

These comparisons should be treated with caution for a number of reasons. Aside from the relatively crude methodologies for projecting demand (as outlined in the main body of this report), the supply projections relate to a mental health nursing workforce which is broader than the mental health and addiction workforce on which the demand projection is based. Similarly, the primary health workforce on which the supply

projection is based is much broader than the general practice workforce on which the demand projection is based.

Meeting needs

Vacancies need to be filled quickly

A proportion of vacancies will be caused by regular turnover of nursing staff. Vacancies that represent a genuine shortfall of nurses are mostly likely to be filled by internationally qualified nurses (IQNs) or possibly any New Zealand Qualified Nurses (NZQNs) that are unemployed. However, not all vacancies will be for graduate positions, and not all will be suited to an IQN practicing in New Zealand for the first time.

Using the training pipeline to achieve safe staffing

If we tried to meet our estimates of safe staffing of **2,789** additional nursing FTEs, (a **2,975** nursing headcount) with NZQN RNs, we would need to increase the number of nurses graduating from a nursing degree by **638 per year over five years**. The earliest this could begin would be 2028 based on increasing enrolments in 2026. To put this in context, 2,055 nurses completed a bachelor degree in 2023.[4] We would need a **31% increase** on this figure.

The 638 figure assumes nursing workforce re-entry and exit rates remain the same as they are currently. Workforce exit rates could rise as the workforce ages and as the recent surge in IQNs start to exit the workforce to practice in other countries. Which means the 638 figure could be an under-estimate.

The three-year completion rate for nurses studying level 7-10 Bachelor's and above is 51% (for nurses enrolling in 2021; the figure has remained at around 50% since 2013). This completion rate means enrolments would need to increase by roughly **1,251 per year** for five years. To put this in context, in 2023, 3,230 people enrolled in RN training and 396 enrolled in EN training, 3,626 in total. Enrolments would therefore need to increase by **39%**.

This nursing bachelor degree enrolment figure would be lower if we tried to meet some of the need with IQNs, ENs, or by increasing re-entries. This is probably necessary. Some of the positions required to be filled for safe staffing will probably not be suitable for a graduate nurse.

In addition to increasing nursing workforce entrants, the distribution of nurses across employment settings needs to be considered. As we see later on in this report, services such as aged residential care and mental health and addiction services struggle to attract and retain nurses, in part due to pay disparities with Te Whatu Ora funded services.

[4] Source: Education Counts

Implications for Māori population parity

In a recent Infometrics report[5] that looked at the Māori nursing workforce, we reported that Te Whatu Ora estimate that to reach population parity by 2034 the annual number of newly registered Māori nurses would need to increase from 302 currently to 1,653. In other words, an additional 1,351 new Māori nurses each year.

We calculated that to graduate 1,653 Māori RNs a year from nurse training (assuming the seven-year completion rate remains at 62% as it is currently) would require 2,666 Māori enrolments. To put this 2,666 enrolments figure in perspective, in 2023, a total of 3,230 nurses enrolled in RN training, 435 of whom were Māori.

Achieving safe staffing levels as well as population parity would require even more Māori to be trained as nurses than we originally estimated. Trying to achieve population parity also means that safe staffing needs to be met largely by NZQNs because increasing the number of IQNs in the New Zealand nursing workforce reduces the Māori proportion of the workforce, which makes population parity harder to achieve.

A challenging exercise

This has been a challenging exercise due to a lack of data across most settings.

We acknowledge that a considerable amount of nursing workforce data, such as employment by health setting, is available from the Nursing Council of New Zealand (NCNZ) and Health New Zealand — Te Whatu Ora. There are also several workforce surveys carried out by organisations representing providers in certain settings such as Te Pou — a national workforce centre for mental health, addiction and disability, and the General Practice Owners Association (GenPro). However, as Table 1 showed, pulling together even basic nurse vacancy data has been time-consuming and patchy in its success.

Developing methodologies for determining the genuine nursing shortage in different settings, and accessing relevant data, has been even more difficult due to a lack of data measuring the nursing workload and due to the absence of benchmarks for what the staff staffing workload should be.

These challenges reflect the fragmented nature of New Zealand's health system. In terms of data availability there is a clear divide between Te Whatu Ora and non-Te Whatu Ora funded services with the former having a central agency responsible for data and monitoring. Among non-Te Whatu Ora funded services, the status of general practices as private enterprises means nursing workforce or workload data is not routinely collected. Among community services such as Māori and Pacific health providers, the fragmented nature of these services is reflected the lack of centralised workforce or workload data collection.

An evidence base is needed

Given the critical implications that nursing shortages have on patient care and the welfare of nurses themselves, there needs to be an evidence base on the extent of New

[5] 'Growing but not fast enough', Infometrics, (2024)

Zealand's nursing shortages and the nursing workload. This evidence base should be available to anyone who needs it. Availability should not become entangled with pressures within the health system such as pay negotiations. The evidence base should cover all the employment settings in which nurses practice. It needs consistent workforce metrics and data collection methodologies.

- As a minimum, the evidence base needs to include nurse headcounts and FTEs, vacancy numbers and rates as measured at a point in time, as well as resignation and recruitment numbers and rates over consistent periods of time.
- Pay rates as measured at a point in time need to be recorded to monitor pay disparities between settings.
- Measures of nursing workloads such as counts of patient numbers, patient characteristics, patient turnover, caseloads, patient appointments and time spent with patients are needed to monitor nurse workloads over time. These measures will differ according to the nature of service being provided.
- Quarterly data would be ideal. Annual data would be sufficient.

This research has made progress on determining nurse shortages and safe staffing levels in certain settings. It now needs to be built upon. In some cases, the calculations of shortages and projected demand in this report are crude. Better data will enable more sophisticated analysis.

Introduction

The New Zealand Nurses Organisation (NZNO) commissioned Infometrics to quantify the current nursing shortage in New Zealand based on current funding levels and on safe staffing funding levels.

Genuine verses funded shortages

Nurse vacancy numbers and vacancy rates provide estimates of the nursing shortage based on currently funded positions. A proportion of vacancies will be caused by staff turnover and would exit even if there were no shortage of nurses. Some vacancies will be caused by a genuine shortage of nurses. These vacancies tend to be long-standing and hard to fill. We don't know how many of the total vacancies are caused by a genuine shortage of nurses, but we acknowledge that it is probably not all of them.

Looking beyond vacancies, if current funding levels constrain access to healthcare or are not sufficient for safe staffing (as feedback and studies across several settings such as general practices, mental health and addiction services, and hospices have found), then vacancies will under-estimate the genuine nursing shortage.

To estimate the genuine shortage, we have applied different methods to different employment settings depending on the nature of care, the nursing workload, and available data germane to each setting. Some methods use population-based measures of unmet health needs. Some, such as those relating to public hospitals and aged residential care are based on safe staffing required for a given number of patients. In these settings, we have not been able to take into account any possible shortfall in the number of beds based on population needs.[6] Measures based on patients or beds are arguably more precise than measures based on, say, surveys of unmet health needs. However, we acknowledge that our bed/patient measures could well be underestimates.

This remainder of this report addresses different employment settings in turn based on the data available about each setting. If a setting has been excluded from the report, it is because we have been unable to access any useful nursing shortage data about that setting.

[6] In April 2025 it was reported that New Zealand is currently short 500 hospital beds.

Public hospitals

This section looks at hospitals funded and managed by Te Whatu Ora to provide acute care and elective (non-acute) services such as medical, surgical, maternity, diagnostic and emergency services.

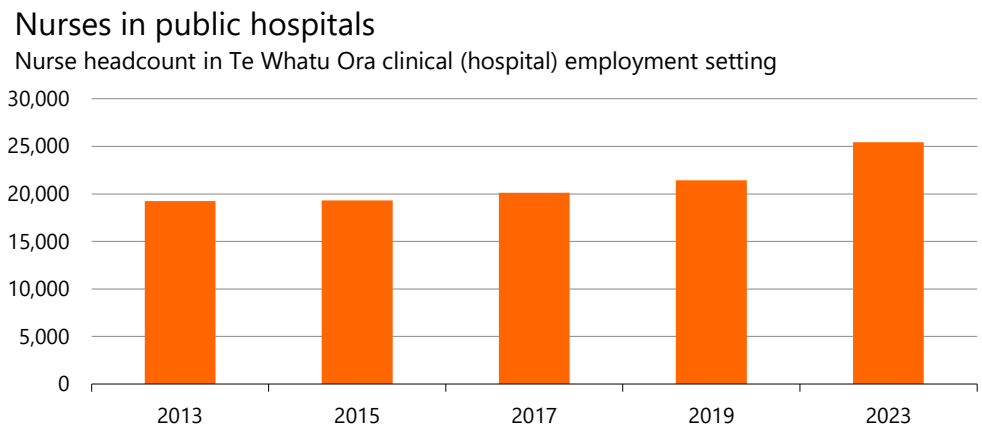
We compare the care hours that patients need based on their acuity and other characteristics, with the care hours able to be provided by nurses across all shifts in public hospital wards nationally. We found from 1 January 2022 to 30 November 2024, over one-third (**38%**) of shifts were understaffed. That's over **650,000** shifts out of a total of 1.69 million. Day shifts were the most likely to be understaffed, with 52% having a care hours shortfall.

Over the same period, the daily nursing shortage averaged 635 FTEs and varied between a maximum of 937 FTEs and a minimum of 266 FTEs. The shortage was greatest in 2023. Based on an estimated 21,233 RN FTEs[7] practicing in public hospitals as of 31 March 2023, the average shortage in 2023 equates to 2.9% of RNs, varying between a maximum of 4.3% and a minimum of 1.2%.

The growing public hospital nursing workforce

The number of nurses in the Te Whatu Ora clinical (hospital) employment setting grew from **19,252** in 2013 to **25,437** in 2023 (see Chart 1).[8]

Chart 1



Source: Nursing Council of New Zealand

[7] Based on Nursing Council of New Zealand workforce statistics that show a headcount of 24,689 RNs practicing in a Te Whatu Ora clinical (hospital) setting as of 31 March 2023, and a mean FTE of 0.86. Source: 'The New Zealand Nursing Workforce 2022-23', https://nursingcouncil.org.nz/common/Uploaded%20files/Public/Publications/Workforce%20Statistics/workforce_statistics/Workforce%20statistics%202022%E2%80%9323.pdf

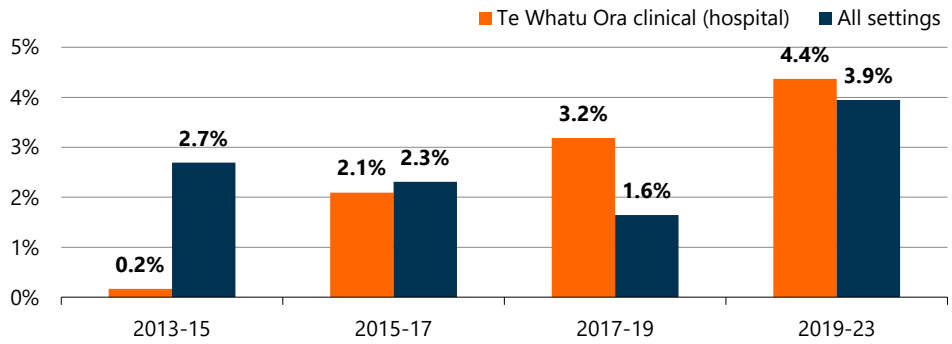
[8] Nursing Council of New Zealand Workforce Statistics, https://nursingcouncil.org.nz/Public/NCNZ/publications-section/Workforce_statistics.aspx

Growth in the number of nurses in the Te Whatu Ora clinical (hospital) employment setting has been accelerating which contrasted with decelerating growth in the number of nurses across all settings between 2013 and 2019 (see Chart 2).

Chart 2

Growth in public hospital nurses accellerates

Annual average % growth in nurse headcount



Source: Nursing Council of New Zealand

The period 2019-23 saw an acceleration in the growth rate of nurses in the Te Whatu Ora clinical (hospital) employment setting as well as across all settings, due mainly to a spike in the number of internationally qualified nurses (IQNs) gaining employment in New Zealand. In 2019, internationally qualified nurses made up 29% of the Te Whatu Ora clinical (hospital) workforce. By 2023, the proportion had risen to 37%. Across all settings, the proportion rose from 27% in 2019 to 33% in 2023.

Despite differing annual growth rates, over the period 2013 to 2023, the number of nurses in the Te Whatu Ora clinical (hospital) employment setting grew 32%, which was similar to the 33% growth in nurses across all settings.

In 2023, a total of **24,689** RNs, **557** ENs and **191** nurse practitioners worked in the Te Whatu Ora clinical (hospital) employment setting. That's a staffing mix of **97%** RNs, 2.2% ENs and 0.8% Nurse practitioners. The headcounts equate to **18,220** RN FTEs and **383** EN FTEs.[9]

Nursing shortages a contested issue

As of 30 June 2024, there were **1,250** nurse FTE vacancies out of a funded nursing workforce (employed plus vacancies) of 29,488, which is a vacancy rate of **4.1%**.[10] These vacancies relate to Te Whatu Ora funded services, which are broader than public hospitals. However, nurses in public hospitals make up the bulk of nurses practicing in Te Whatu Ora funded services, therefore the 4.1% vacancy rate is probably a close approximation of the nurse vacancy rate in public hospitals.

The extent to which there is a shortage of nurses in public hospitals is a contested issue. Te Whatu Ora reported a significant increase in staffing in early 2024, attributed to the

[9] All the data in this workforce section is sourced from the Nursing Council of New Zealand workforce statistics reports, https://nursingcouncil.org.nz/Public/NCNZ/publications-section/Workforce_statistics.aspx

[10] Te Whatu Ora data obtained by NZNO by OIA

hiring of a significant number of NZQNs and IQNs. However, the recruitment drive raised concerns about financial sustainability. In response, from mid-2024, Te Whatu Ora implemented cost-control measures such as hiring freezes, stating its intention was to manage back to budget by not replacing those nurses who leave the workforce as well as freezing the hiring of graduate nurses into the hospital system.

A key issue in the debate centres around whether budget nurse numbers are sufficient to provide patients with safe medical care. In October 2024, Te Whatu Ora's commissioner, Lester Levy, indicated that a clinical patient and safety review had been commissioned to assess whether the recruitment of over 3,000 nurses beyond Te Whatu Ora's budgeted numbers were sufficient for safe medical care. This was amid well-publicised claims from nurses practicing in hospitals, such as Waikato Hospital, that lives were being put at risk every day due to staff shortages[11]

The hiring freeze could mean that the 2024 vacancy numbers are an under-estimate of the actual nursing shortage. Another reason why the vacancy numbers could be under-estimates is that the Te Whatu Ora vacancy count is a count of vacancies for which hospitals and other Te Whatu Ora services have Approval to Recruit (ATR). Actual vacancies might be much higher because at any given time a number of vacancies exit in services but are in the process of getting ATR. These vacancies do not show up in the Te Whatu Ora vacancy figures.

Measuring the public hospital nursing shortage

Following the 2005 NZNO and DHB MECA negotiations, an independent Committee of Inquiry into safe staffing developed the Care Capacity Demand Management (CCDM) Programme. This is a staffing methodology that provides an FTE calculation that matches the care a patient requires with the corresponding nursing capacity to meet this demand 24/7. The CCDM Programme records when shifts are understaffed and cannot meet patient need.

Through an OIA request, NZNO received CCDM shift below target data from Te Whatu Ora for 540 public health wards over the reporting period 1 January 2022 to 31 December 2023. Emergency Departments, discharge lounges, retired wards and day units were excluded from this data by Te Whatu Ora due to poor quality and incomplete data sets. Aggregate data was incomplete for Taranaki, Waikato, and West Coast districts for the reporting period 2020 – 2023

A shift is deemed below target when care hours needed by patient acuity are greater than staffing hours supplied by 8.5% (or 40 minutes per FTE). Shifts below target data therefore measure whether the staffing levels for a shift are safe for both staff and patients. The 8.5% is considered to be a buffer which takes into account staff breaks. When care hours needed exceed staffing hours supplied by 8.5%, this means there is no time for staff to take breaks.

NZNO found that on average, one in four (28%) Te Whatu Ora hospital shifts included in the dataset were understaffed in 2023. The proportion varied across Te Whatu Ora Districts with 41% of shifts in Waitemata District and 40% of shifts in Counties District

[11] https://www.waikatotimes.co.nz/nz-news/350403578/lives-risk-every-day-due-staff-shortages-waikato-hospital-nurse-claims

below target in 2023 and only 7% of shifts in Taranaki District and 2% of shifts in West Coast District below target (see Table 4).

Table 4

Te Whatu Ora hospital shifts below target by district, 2023

	Shifts below target	% of total shifts
Waitemata	18,631	41%
Counties	19,775	40%
Capital, Coast And Hutt Valley	22,163	39%
Waikato	20,273	37%
Whanganui	3,719	28%
Auckland	16,428	27%
Canterbury	21,737	26%
Lakes	2,951	22%
Southern	8,109	22%
Midcentral	5,231	21%
South Canterbury	1,746	20%
Tairawhiti	1,672	19%
Nelson Marlborough	3,503	17%
Bay of Plenty	5,393	16%
Wairarapa	785	14%
Northland	2,929	14%
Hawke's Bay	2,636	13%
Taranaki	1,144	7%
West Coast	141	2%
Total New Zealand	158,966	28%

Source: Infometrics analysis of Te Whatu Ora data

The proportion of shifts that were below target in 2023 also varied by ward type. Although, the variation was less than the variation seen across districts. In 2023, 34% of cancer ward, 33% of cardiovascular ward and 32% or critical care ward shifts were below target compared with 24% of older people, 24% of women's health[12] and 22% of medical ward shifts (see Table 5).

[12] The data included wards providing a range of medical, maternity and specialists services related to women's health. These services are often categorised within Te Whatu Ora hospital services under women's health. However, these are available to a diverse range of people and genders.

Table 5

Te Whatu Ora hospital shifts below target by ward type, 2023

	Shifts below target	% of total shifts
Cancer	2,955	34%
Cardiovascular	10,096	33%
Critical Care	692	32%
Children	20,024	29%
Mental Health	28,110	29%
Surgical	30,148	28%
Medical	30,518	27%
Critical Care	7,503	26%
Older People	8,191	24%
Women's Health	20,238	24%
Medical	491	22%
All wards	158,966	28%

Source: Infometrics analysis of Te Whatu Ora data

CCDM care hours variance

To be able to quantify the extent of nursing shortages, we requested data on the 'Care hours variance' for every shift in every hospital ward over the reporting period 1 January 2022 to 30 November 2024 from Te Whatu Ora.

Care hours variance represents the difference between the number of care hours available by nursing staff (capacity) and the care hours required (demand). Care hours variance relies on accurate information being entered for patient acuity and staff allocation. Te Whatu Ora believes wards do this to the best of their ability. But inevitably, on some shifts, this is not achieved.

A positive variance indicates that a ward has the capacity to deliver more patient care safely. A shift with a negative variance does not necessarily indicate that it was 'unsafe'. Additional factors that need to be considered in determining whether a shift was safe include the relative experience of individual staff members on the day, the size of the ward, and the total staff numbers on the shift. There are benchmarks for variances ranging from slightly negative but manageable to a severe shortage. However, they are not nationally consistent or even consistent within facilities, therefore they cannot be used in this analysis.

The care hours variance data is provisional and was designed to be used for operational purposes rather than research. It has not been through the full quality assurance process that Te Whatu Ora usually uses and is therefore subject to change.

In mid-2024, Te Whatu Ora stopped using the CCDM as the basis for determining safe staffing levels, stating that their preference is to uncouple CCDM from views of what constitutes safe staffing.[13]

The following analysis looks at shifts where there was a negative care hours variance. This is different to the shift below target benchmark of -8.5%. At the time of writing, we didn't have the data to calculate a care hours variance percentage, only absolute variances. Also, in principle even a small negative variance means the nurses on duty are unable to take breaks, which we consider to be sub-optimal to safe staffing. This analysis is limited to cancer, cardiovascular, paediatric, critical care, emergency, medical, mental health, geriatric, surgical and women's health wards. Day stay and day unit wards are excluded.

The nursing shortage

To estimate the nursing shortage in public hospitals, we focus on shifts that have a negative care hours variance. In other words, shifts that were understaffed. For these shifts, we sum the care hours variance across all shifts in all wards nationally each day. We then divide the care hours by 8.7[14] to estimate the nurse FTE shortage. Table 6 contains the results. Over the period 1 January 2022 to 30 November 2024, the daily nursing shortage averaged **635 FTEs** and varied between a maximum of 937 FTEs and a minimum of 266 FTEs. The shortage was greatest in 2023.

Based on an estimated 21,689 nurse FTEs[15] practicing in public hospitals as of 31 March 2023, the average shortage in 2023 equates to **2.9%** of nurses, varying between a maximum of 4.3% and a minimum of 1.2%.

Table 6

The nursing shortage in public hospitals

Nurse FTE shortfall based on shifts with a negative care hours variance

	Jan 22-Nov 24	2022	2023	Jan-Nov 24
Minimum	-266	-325	-266	-372
Maximum	-937	-877	-937	-848
Average	-635	-631	-684	-587

Source: Te Whatu Ora, CCDM data

This analysis assumes that nurses on wards with a positive care hours variance are not shifted to wards with a negative care hours variance. Shifting does happen to mitigate shortages, but facilities are limited in their ability to do so for several reasons such as

[13] https://thespinoff.co.nz/politics/10-10-2024/how-did-a-chronic-shortage-of-nurses-became-too-many?

[14] Eight hours for a nurse shift, plus 8.5% to cover breaks and unexpected increases in workload due to admissions or changes in patient acuity.

[15] Based on Nursing Council of New Zealand workforce statistics that show headcounts of RNs and ENs practicing in a Te Whatu Ora clinical (hospital) setting as of 31 March 2023, and their mean FTE. Source: 'The New Zealand Nursing Workforce 2022-23', https://nursingcouncil.org.nz/common/Uploaded%20files/Public/Publications/Workforce%20Statistics/workforce_statistics/Workforce%20statistics%202022%E2%80%9323.pdf

some wards needing specialist nursing skills, facilities not having Variance Response Management Teams (VRMTs) or having understaffed VRMTs.

Over one-third of shifts understaffed

Table 7 shows that over the period 1 January 2022 to 30 November 2024, over one-third (**38%**) of shifts had a negative care hours variance. That's over **650,000** shifts out of a total of 1.69 million. Day shifts were the most likely to be under-staffed, with 52% having a negative care hours variance. Figures for the year to 30 November 2024 were very similar to the 2022 and 2023 calendar years. This trend through 2024 is significant given the claims in Te Whatu Ora's March Quarterly report that nursing FTE was 2,079 ahead of budget.[16] This over-recruitment of nurses ahead of budgeted numbers should be reflected in the 2024 CCDM data which remain consistent with 2022 and 2023 levels.

The nursing workload is higher on day shifts with, for example, doctors' rounds and medication rounds. Admissions are more likely to occur during day shifts which can change the patient acuity on a ward. Busier day shifts mean nurses are subject to more interruptions. By contrast, on night shifts patients are asleep, and the workload is less. Consequently, night shifts tend to utilise fewer nursing staff.

Table 7

Shifts understaffed

Shifts with a negative care hours variance

Shift	Jan 22-Nov 24	2022	2023	Jan-Nov 24
Day	52%	52%	53%	51%
Evening	36%	36%	37%	35%
Night	26%	26%	28%	25%
Total	38%	38%	40%	37%

Source: Te Whatu Ora, CCDM data

It is also worth noting that many shifts had a positive care hours variance. Over the period from 1 January 2022 to 30 November 2024, 62% of shifts had a care hours variance of 0 or more, which means staffing either met requirements for safe staffing or surpassed them.

Over 1 in 20 shifts understaffed 80% or more of the time

Over time, some shifts in some wards were more likely to be understaffed than others. Over the period 1 January 2022 to 30 November 2024, **5.7%** (over 1 in every 20) of day, evening or night shifts were understaffed 80% or more of the time, **22%** were under-staffed 60% or more of the time and **45%** were under-staffed 40% or more of the time (see Table 8).

[16] https://www.tewhatuora.govt.nz/publications/quarterly-performance-report-1-january-to-31-march-2024, p.47.

Table 8

Shifts regularly understaffed, Jan 22-Nov 24

Shifts with a negative care hours variance

	% of shifts understaffed at least 20%, 40%, 60%, 80% of time			
Shift	20%+	40%+	60%+	80%+
Day	84%	66%	42%	13%
Evening	68%	40%	15%	2.5%
Night	49%	25%	8.8%	1.2%
Total	69%	45%	22%	5.7%

Source: Te Whatu Ora, CCDM data

The extent of understaffing varies

The extent of under-staffing varies and is probably influenced by the size of the ward. Bigger wards with more patients employing more nurses have the potential to have greater hours variance than smaller wards, although the variance on larger wards might be proportionately smaller than on smaller wards.

We don't know how many nurses were required to be on the wards on each shift, so we can't calculate the care hours variance as a proportion of the required staff. However, we do know the care hours variance in absolute terms. Over the period from 1 January 2022 to 30 November 2024, **6.0%** of shifts averaged a care hours variance of 8.7 hours or more — effectively one nurse FTE plus cover for breaks, **29%** of shifts averaged a care hours variance of between 0 and 8.7 hours. Among day shifts, the proportion was even higher: **13%** averaged a care hours variance of 8.7 hours or more over the period from 1 January 2022 to 30 November 2024 and **46%** of shifts averaged a care hours variance of between 0 and 8.7 hours.

Individual shifts could have a care hours variance much larger than these averages. The largest over the period from 1 January 2022 to 30 November 2024 was -235 hours.

Care hours variance worst in winter

Shifts are more likely to have a negative care hours variance, and the variance is greater in the winter months. Focussing on day shifts (because they are more likely than evening and night shifts to have a negative care hours variance), in Chart 3 we have summed the care hours variance (both positive and negative) across all wards in all facilities for each of the 12 months of the year between 1 January 2022 and 30 November 2024. For example, the January figure includes January 2022, 2023, and 2024.

Chart 3 shows that for day shifts across all wards, there is a net negative care hours variance every month of the year, but the negative variance is greatest in July and almost as high in May, June, August and September. In July, 57% of all day shifts had a negative care hours variance compared with 48% in March and 49% in December and April (the three months with the lowest proportions). In July, the average variance was -3.0 hours compared with -1.1 hours in March, April and December.

Chart 3

Source: Te Whatu Ora, CCDM data

We did a similar analysis for evening and night shifts. The sum of care hours variance across all wards was positive in every month of the year for both evening and night shifts, but the positive sum was lowest in July which again indicates that staffing wards is more challenging in winter.

Care hours variance worst on weekdays

Repeating the analysis that we did on months of the year but this time for days of the week, Chart 4 shows that day shifts on weekdays are more likely to be understaffed than at weekends. Summing the care hours variance across all wards for each day of the week between 1 January 2022 and 30 November 2024, Monday and Friday had the highest net negative variance with the other three days of the week almost as high. Sundays are roughly three-quarters as bad as Fridays and Mondays. Saturdays have by far the lowest negative care hours variance.

Workload is lower at the weekend and is therefore less likely to result in a care hours variance. Routine admissions (such as planned surgery) and discharges generally only take place Monday to Friday. Also, some wards rotate taking on acute admissions at weekends. For example, if there are two orthopaedic wards in a hospital, each ward will accept acute admissions every other weekend.

Chart 4

Source: Te Whatu Ora, CCDM data

Some 54% of Friday and Monday day shifts are under-staffed with an average care hours variance of -2.5 on Fridays and -2.4 on Mondays. By comparison, 47% of Saturday day shifts are understaffed with an average variance of -0.9.

Ten facilities understaffed at least 80% of their day shifts

Over the period from 1 January 2022 to 30 November 2024, **59%** of the 59 facilities included in the dataset were understaffed at least 20% of their shifts. That includes day, evening, and night shifts (see Table 9).

Focussing on day shifts, for ten facilities (17% of all facilities), 80% or more of their day shifts were understaffed. Porirua Mental Health Services was understaffed 99% of the time, Middlemore Hospital 98%, North Shore Hospital 97%, Wellington Hospital 94%, Hillmorton Hospital 94%, Waitakere Hospital 92%, Auckland City Hospital 91%, Waikato Hospital 87%, Starship Hospital 87% and Wellington Hospital (Mental Health Services) (83%).

Analysing by facility sums the care variance over all the wards in a hospital. Some wards might have a positive care hours variance on a given shift, others might have a negative variance on the same shift. We don't make any assumptions about facilities' ability to distribute their nursing staff differently, for example by taking staff from wards with a positive variance and utilising them on wards with a negative variance. This can happen but facilities' ability to do this can be limited by specialist nursing skilled being needed on some wards, and the extent to which Variance Response Management Team (VRMTs) are staffed at different facilities.

Table 9

Proportion of facilities regularly understaffed, Jan 22-Nov 24

Facilities with a negative care hours variance, net sum across all wards

	% of facilities whose shifts are understaffed at least 20%, 40%, 60%, 80% of time			
Shift	20%+	40%+	60%+	80%+
Day	88%	61%	32%	17%
Evening	51%	25%	17%	1.7%
Night	19%	10%	3%	1.7%
Total	59%	29%	14%	1.7%

Source: Te Whatu Ora, CCDM data

Cancer and cardiovascular wards most likely to be understaffed

The extent of understaffing varies by ward type. At the top end, 49% of shifts on cancer wards and on cardiovascular wards were understaffed over the period 1 January 2022 to 30 November 2024, compared with 36% of critical care and emergency wards (see Table 10). Again, day shifts are more likely to be understaffed. Some 66% of day shifts on cancer wards, 62% on cardiovascular wards and 59% on medical wards were understaffed over the period 1 January 2022 to 30 November 2024.

Table 10

Shifts understaffed by ward specialisation, Jan 22-Nov 24

Shifts with a negative care hours variance as % of total

	Total	Day	Evening	Night
Cancer	49%	66%	40%	40%
Cardiovascular	49%	62%	40%	33%
Children	45%	48%	35%	23%
Critical care	36%	40%	35%	33%
Emergency	36%	36%	39%	29%
Medical	35%	59%	40%	33%
Mental Health	44%	54%	35%	22%
Older People	37%	52%	38%	28%
Surgical	39%	58%	37%	29%
Women's Health	42%	42%	29%	15%

Source: Te Whatu Ora, CCDM data

We make no assumptions about the importance of adequate staffing across different ward types based on, for example, the differing acuity of patients.

Understaffing most common in Capital & Coast and Hutt Valley District

The extent of understaffing varies by district. Across all shifts, understaffing was most common in Capital & Coast and Hutt Valley District with 51% of shifts understaffed over the period 1 January 2022 to 30 November 2024, followed by Counties Manukau on 48%. Taranaki District was the lowest on 19%. Among day shifts, 64% of Capital & Coast and Hutt Valley District were understaffed, followed by Auckland District on 63% and Counties Manukau and Waikato on 62%. Again, Taranaki was the lowest on 29% (see Table 11).

Table 11

Shifts understaffed by district, Jan 22-Nov 24

Shifts with a negative care hours variance as % of total

	Total	Day	Evening	Night
Auckland	45%	63%	40%	32%
Bay of Plenty	31%	41%	29%	22%
Canterbury	38%	53%	34%	25%
Capital & Coast and Hutt Valley	51%	64%	49%	39%
Counties Manukau	48%	62%	49%	31%
Hawke's Bay	29%	43%	21%	24%
Lakes	34%	47%	32%	24%
Midcentral	29%	36%	27%	25%
Nelson Marlborough	30%	46%	30%	15%
Northland	32%	48%	26%	22%
South Canterbury	27%	39%	23%	18%
Southern	33%	50%	29%	20%
Tairawhiti	21%	32%	15%	16%
Taranaki	19%	29%	17%	11%
Waikato	47%	62%	47%	32%
Wairarapa	27%	41%	27%	11%
Waitemata	46%	61%	45%	31%
West Coast	7%	10%	6%	4%
Whanganui	38%	54%	35%	25%

Source: Te Whatu Ora, CCDM data

The most frequently understaffed wards in the country

Table 12 provides a list of wards that were understaffed at least 90% of the time between 1 January 2022 and 30 November 2024. Day shifts dominate, which reflects the finding in Table 8 that day shifts on the whole are more likely to be understaffed than evening or night shifts.

In terms of facilities, the prevalence of North Shore Hospital in Table 12 reflects the fact that day shifts at this facility were found to be understaffed 97% of the time. Porirua Mental Health Services, Hillmorton Hospital, Hutt Hospital, Middlemore Hospital, Waitakere Hospital and Waikato Hospital day shifts were also found to be understaffed a large proportion of the time. The absence of Starship Hospital and Auckland City Hospital from Table 12 suggests that while a large proportion of the day shifts at these facilities were frequently understaffed, no single ward was in the 90%+ bracket.

No cancer wards are in Table 12, despite cancer wards as a whole being frequently understaffed. However, the prevalence of medical day wards in Table 12 aligns with the finding in Table 10, that 59% of day shifts on medical wards were understaffed between 1 January 2022 and 30 November 2024.

The prevalence of Waitemata district in Table 12 aligns with Table 11 which shows that 61% of day shifts in Waitemata District were understaffed.

Table 12

The most frequently understaffed wards in the country, Jan 22-Nov 24

Shifts with a negative care hours variance as % of total

District	Ward type	Facility	Shift type	% of shifts understaffed
Capital & Coast and Hutt Valley	Mental Health	Porirua Mental Health Services	Night	100%
Capital & Coast and Hutt Valley	Mental Health	Hutt Hospital	Night	99%
Canterbury	Mental Health	Hillmorton Hospital	Evening	98%
Waitemata	Medical	North Shore Hospital	Day	98%
Capital & Coast and Hutt Valley	Mental Health	Porirua Mental Health Services	Day	98%
Canterbury	Mental Health	Hillmorton Hospital	Day	98%
Capital & Coast and Hutt Valley	Mental Health	Porirua Mental Health Services	Day	98%
Waitemata	Medical	North Shore Hospital	Day	96%
Capital & Coast and Hutt Valley	Mental Health	Hutt Hospital	Evening	95%
Capital & Coast and Hutt Valley	Mental Health	Hutt Hospital	Day	95%
Canterbury	Mental Health	Hillmorton Hospital	Night	95%
Waitemata	Older People	Waitakere Hospital	Day	94%
Waikato	Cardiovascular	Waikato Hospital	Day	94%
Waitemata	Medical	North Shore Hospital	Day	93%
Counties Manukau	Women's Health	Middlemore Hospital	Day	93%
Waitemata	Medical	North Shore Hospital	Day	93%
Waitemata	Medical	Waitakere Hospital	Day	93%
Capital & Coast and Hutt Valley	Mental Health	Porirua Mental Health Services	Day	93%
Waitemata	Cardiovascular	North Shore Hospital	Day	92%
Waitemata	Surgical	North Shore Hospital	Day	92%
Waitemata	Surgical	North Shore Hospital	Day	92%
Counties Manukau	Surgical	Middlemore Hospital	Day	92%
Waitemata	Medical	North Shore Hospital	Day	91%
Counties Manukau	Women's Health	Middlemore Hospital	Evening	91%
Waitemata	Medical	Waitakere Hospital	Day	91%
Waitemata	Surgical	North Shore Hospital	Day	90%
Bay of Plenty	Emergency	Tauranga Hospital	Evening	90%
Counties Manukau	Surgical	Middlemore Hospital	Day	90%
Southern	Emergency	Southland Hospital	Evening	90%

Source: Te Whatu Ora, CCDM data

Causes of nursing shortages

As the biggest employer of nurses in New Zealand, public hospitals are subject to the broader workforce development issues facing the entire nursing workforce.

A lack of coordinated planning

The past 12 months have provided a deeply concerning example of how uncoordinated nurse workforce planning is in New Zealand. Te Whatu Ora's sudden decision to freeze the hiring of nurses in mid-2024, including nurse graduates and internationally qualified nurses reportedly left one in four graduate nurses unemployed as of August 2024[17] and hundreds of international nurses jobless.[18] Ideally, decisions about nurse recruitment

[17] https://thespinoff.co.nz/politics/10-10-2024/how-did-a-chronic-shortage-of-nurses-became-too-many?

[18] https://www.rnz.co.nz/news/indonz/518006/hundreds-of-experienced-international-nurses-jobless-amid-nursing-shortage

should be made several years in advance. These decisions should inform the number of funded nurse training places, and the number of international nurses granted visas.

Visa settings can be changed to influence the number of international nurses granted visas, such as when nurses were added to the immigration Green List in 2022. However, current immigration settings cannot control the number of nurses applying for a visa, how many come to New Zealand having been granted a visa, or how long they stay when they get here.

Demand pressures

The past year has demonstrated that health funding constraints are a key contributor to the shortage of nurses in hospitals. Against the backdrop of funding constraints, demand for health services, particularly hospital services, continue to increase. This growth is driven by population growth, an aging population, increasing acuity and comorbidities of patients, seasonal illnesses such as influenza, the COVID-19 pandemic, and an increasing range of available health care treatments and services.

Internationally qualified nurses

New Zealand is reliant on IQNs, ranking amongst the top OECD countries in terms of the proportion of the nursing workforce that was trained overseas. Reliance on IQNs can lead to shortages because IQNs tend to exit the workforce at a higher rate than domestically qualified nurses, often to move overseas to practice nursing elsewhere. Only 71% of IQNs continue to work in New Zealand after 3 years.[19]

Some nurses who are considering moving to New Zealand find the immigration and nursing registration processes slow and expensive. This issue was highlighted in 2024 when numerous IQNs were unable to get employment in New Zealand despite having gained registration and completed the Nursing Council's Competence Assessment Programme (CAP).[20] IQNs often come to New Zealand on a visitor visa. They are unable to apply for a work visa until they have secured employment. When vacant funded positions are plentiful, employers are usually willing to but to sponsor IQNs to get work visas. However, when vacant funded positions dry up, as they have recently, employers are much less willing to go to the trouble of sponsoring IQNs.

The aging workforce

Like much of the New Zealand workforce, the nursing workforce is aging. In 2023, 29% of all nurses were aged 55 years or older. The aging workforce is less of a concern for public hospitals. Here, 21% of the nursing workforce was aged 55 years or older in 2023. The hospital workforce tends to be younger because many domestically trained graduates practice in hospitals after graduation. Employment settings such as primary health, hospices, Corrections and mental health and addiction tend to employ older

[19] https://www.tewhatuora.govt.nz/corporate-information/planning-and-performance/health-workforce/health-workforce-plan-2024/profession-specific-analysis/nursing

[20] In December 2024, the Nursing Council announced that migrants from countries other than the US, UK, Ireland, Singapore, and the Canadian provinces of British Columbia and Ontario would need to pass an Objective Structured Clinical Examination (OSCE) before working in the country's healthcare sector. The new assessment, consisting of both theoretical and clinical components, replaced the CAP pathway.

nurses who have more experience and are therefore better able to work independently and practice in environments that are, in some ways, more challenging.

Workforce attrition

Many nurses take sick leave, reduce their hours, or leave the nursing workforce due to heavy workloads, stress, burnout, bullying, challenges maintaining a work-life balance and to earn higher wages in other professions or by practicing as nurses overseas in countries such as Australia, the UK or Canada. New Zealand's high living costs, especially housing affordability in metro areas, can put pressure on nurses to seek higher wages. The shortage of nurses is a key cause of high workloads, which leads to further attrition. The nursing workforce is a female dominated workforce. Maintaining a work-life balance during the child-rearing years can be particularly challenging.

Recruitment difficulties

In addition to funding constraints, and attrition rates of nurses which make nurse recruitment challenging, rural hospitals find it particularly challenging to recruit nurses due to poorer lifestyle attractions in remote areas, lower pay, longer-travel times, greater on-call requirements, fewer opportunities for career progression, limited peer support due to rural hospitals employing smaller teams, and professional isolation due to fewer medical specialists being available in rural hospitals. The nursing workforce is also older in rural areas, which places greater pressure on rural hospitals to attract younger nurses to replace those that are about to retire.

Nurse-to-patient ratios

Nurse-to-patient ratios have been implemented overseas in the state of California in the US (in 2004), in the states of Victoria (in 2001) and Queensland (in 2016) in Australia, and in Wales, in the UK (in 2018).[21]

Ratios improve nurse and patient outcomes

Research to date has found that higher nurse staffing levels are associated with improved patient and nurse outcomes. However, determining safe nurse staffing levels for a given patient mix remains problematic.

- A recent meta-analysis[22] examined the association between nurse staffing levels and nurse-sensitive patient outcomes in acute specialist units and found that higher staffing levels were associated with reduced mortality, medication errors, ulcers, restraint use, infections, and pneumonia, higher aspirin use, a greater number of patients receiving percutaneous coronary intervention within 90 minutes, and a decreased the risk of in-hospital mortality.[23]

[21] Source: 'The impact of nurse staffing methodologies on nurse and patient outcomes: A systematic review' Twigg, D, et al, 2021, https://onlinelibrary.wiley.com/toc/13652648/2021/77/12

[22] A meta-analysis examines of data from a number of independent studies of the same subject, in order to determine overall trends

[23] 'The effect of nurse-to-patient ratios on nurse-sensitive patient outcomes in acute specialist units: a systematic review and meta-analysis', Driscoll, A, et al, (2018), https://academic.oup.com/eurjcn/article-abstract/17/1/6/5925020

- Another recent meta-analysis[24] assessed the evidence for an association between nurse staffing levels and patient outcomes in acute care settings from longitudinal studies.[25] The researchers reported that their findings were consistent with an overall beneficial effect from higher RN staffing on preventing patient death.

Two recent studies have carried out meta-analyses of the relationship between nurse staffing and nurse outcomes.

- In one study researchers found that a higher nurse-to-patient ratio (more patients per nurse) was consistently associated with a higher degree of burnout among nurses, increased job dissatisfaction, and a higher intent to leave.[26]
- In the second study[27] the researchers found that nurse outcomes improved with the implementation of mandated minimum nurse-to-patient ratios, although they noted that the evidence to date was limited.
- The researchers in the second study also noted that the ability to determine the number of nurses required over time remains problematic, which indicates that mandated ratios that allow for professional judgement in daily staffing decisions might be better for patient outcomes.
- Other concerns about ratios are that they do not account for nuances around skill mix such as the balance between senior and junior nurses on a ward at a given time.

Incorporating cultural overlay is crucial

The implementation of nurse-to-patient ratios would also need to take into account the additional staffing requirements of cultural overlay. The additional staffing required to meet the cultural needs of Māori, Pacific Peoples and other patients from ethnic minorities has not been studied in New Zealand and remains a major empirical gap in the understanding of health workforce needs.

Ratios can bring cost savings

Although the implementation of nurse-to-patient ratios usually results in an increase in nurse staffing, incurring an additional cost on healthcare providers, cost savings can potentially occur if ratio implementation results in nurse overtime, use of agency staff, and nurse turnover decreasing. If ratios mean nurses are more inclined to delay retirement, this can help ensure there are enough senior nurses in the workforce to help train and support more junior nurses.

Studies generally find that the implementation of nurse-to-patient ratios lead to increased nurse staffing levels in facilities where the ratios are implemented. However,

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[24] 'Nurse staffing levels and patient outcomes: A systematic review of longitudinal studies', Dall'Ora, C, et al, (2022), https://www.sciencedirect.com/science/article/pii/S0020748922001407?via%3Dihub

[25] Cross-sectional studies were excluded because of their intrinsic limitations including an inability to establish that presumed cause (staffing) precedes the effect.

[26] 'Nurse staffing and nurse outcomes: A systematic review and meta-analysis' Shin, S, et al, 2018, https://www.nursingoutlook.org/article/S0029-6554(17)30265-8/abstract

[27] 'The impact of nurse staffing methodologies on nurse and patient outcomes: A systematic review' Twigg, D, et al, 2021, https://onlinelibrary.wiley.com/toc/13652648/2021/77/12

we have been unable to find any studies that examine the effect on the overall nursing workforce. This includes studies that examine the effects that implementation of ratios has on the number of nursing school applications and on the number of ex-nurses returning to the profession. The implementation of nurse-to-patient ratios could increase the overall size of the nursing workforce if ratios encourage more people into the nursing profession and more nurses who have left the profession to re-enter. However, implementation in certain facilities could also draw nurses into those facilities from other parts of the health system, leading to shortages elsewhere.

Aged Residential Care

Aged residential care (ARC) is a residential setting for older people who need long-term care. Facilities are also known as nursing homes or rest homes. In New Zealand, ARC covers four levels: rest home care, age-related hospital care, dementia care, and psychogeriatric care.

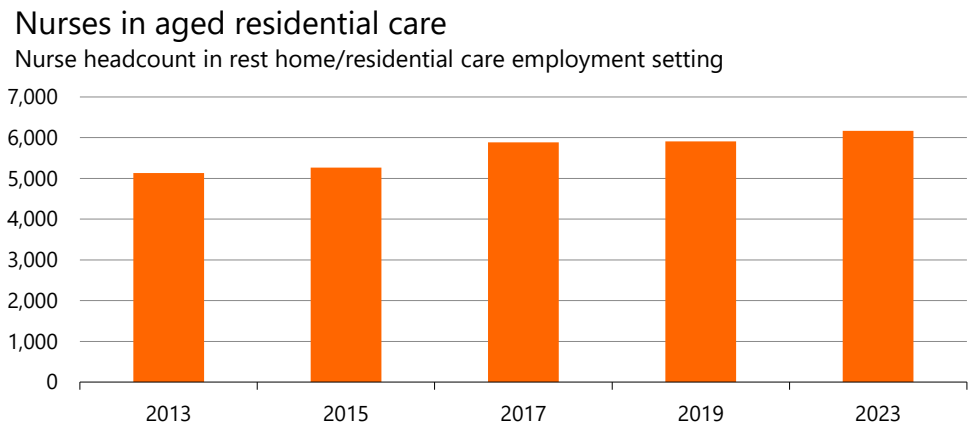
A sector survey[28] found that ARC facilities had a vacancy rate of **15%** for RNs, **6%** for ENs and **4%** for caregiver/kaiāwhina in 2023, which suggests that there were an estimated **1,380** vacant RN, EN and caregiver/kaiāwhina positions in the ARC sector in 2023.

In addition to the existing vacancies, we find that applying minimum care standards would require an estimated additional **8,232 carer (RN, EN caregiver/kaiāwhina) FTEs** (a 38% increase on current levels), of which **1,550 FTEs would be RNs** (a 34% increase on current levels). To provide optimal staffing would require an estimated additional **14,224 carer (RN, EN caregiver/kaiāwhina) FTEs** (a 65% increase on current levels), of which **6,288 FTEs would be RNs** (a 137% increase on current levels)

New Zealand's ARC sector workforce

The number of nurses in the rest home/residential care employment setting grew from 5,129 in 2013 to 6,170 in 2023 (see Chart 5).[29]

Chart 5



Source: Nursing Council of New Zealand

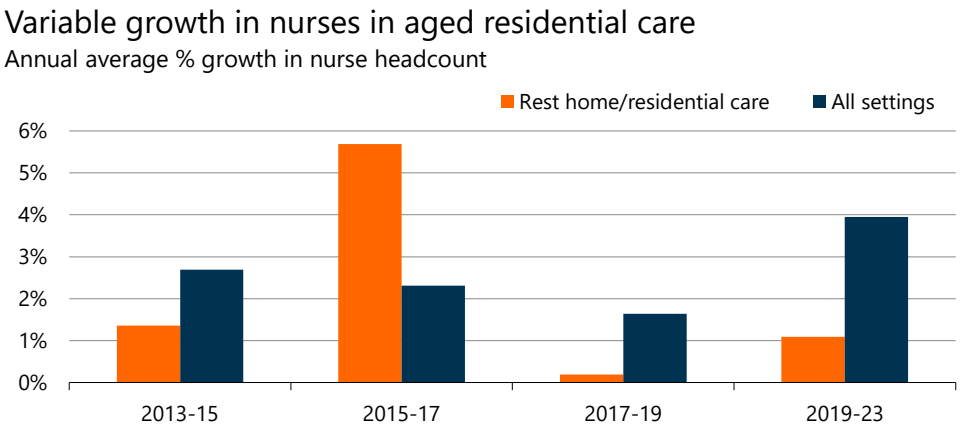
Growth in the number of nurses in the rest home/residential care employment setting has been variable with annual average growth of 5.7%pa between 2015 and 2017, preceded by annual average growth of 14%pa between 2013 and 2015, and followed by annual average growth of 0.2%pa between 2017 and 2019, and growth of 1.1%pa

[28] ARC Sector Profile 2024, NZACA, https://nzaca.org.nz/advocacy-and-policy/arc-sector-profile/

[29] Nursing Council of New Zealand Workforce Statistics, https://nursingcouncil.org.nz/Public/NCNZ/publications-section/Workforce_statistics.aspx. 'Rest home/residential care' is the terminology used by the Nursing Council.

between 2019 and 2023 (see Chart 6). Over the whole period 2013 to 2023, the number of nurses in the rest home/residential care employment setting grew 20%, compared with 33% growth in nurses across all settings.

Chart 6



Source: Nursing Council of New Zealand

In 2023, a total of 5,656 RNs, 489 ENs and 25 nurse practitioners worked in a rest home/residential care employment setting. That's a staffing mix of 92% RNs, 7.9% ENs and 0.4% Nurse practitioners. The headcounts equate to **3,894** RN FTEs and **335** EN FTEs.[30]

According to the New Zealand Aged Care Association's (NZACA) 2023 member survey[31], there were 6,720 caregiver/kaiāwhina FTEs employed in the sector in 2023. The survey also reported 1,728 RN FTEs and 35 EN FTEs (assuming part-time nurses work 0.6 FTEs). The NCNZ RN and EN FTEs employed in a rest home/residential care employment setting are 2.4 times higher than the number reported by the NZACA. We assume this is the extent of under-reporting in the NZACA survey because the 2023 survey received responses from only 52% of facilities. Taking the NZACA survey estimate of caregiver/kaiāwhina FTEs and multiplying by 2.4 gives us an estimate of **16,118** caregiver/kaiāwhina FTEs employed in aged residential care.

This brings the total FTEs able to provide direct care (RNs, ENs and caregivers/kaiāwhina) to **20,347 FTEs** in 2023. This comprises is a staffing mix of 19% RNs, 2% ENs and 79% caregivers/kaiāwhina. These workforce estimates are summarised in Table 13 below.

There is a shortage of nurses in New Zealand's ARC sector

According to the NZACA's 2023 member survey,[32] **83%** of respondents to their member survey said their facility was not fully staffed with RNs in 2023 (up from 59% in 2021). Based on Ministry of Health data, there were 679 certified rest home facilities across

[30] All the data thus far in this workforce section is sourced from the Nursing Council of New Zealand workforce statistics reports, https://nursingcouncil.org.nz/Public/NCNZ/publications-section/Workforce_statistics.aspx
[31] ARC Sector Profile 2024, NZACA, https://nzaca.org.nz/advocacy-and-policy/arc-sector-profile/
[32] IBID

New Zealand in 2024.[33] If the 83% figure were applied to all 679 facilities in the sector, **564** facilities were not fully staffed with RNs.

According to the NZACA's 2023 member survey[34], aged residential care facilities had a vacancy rate of **15%** for RNs, **6%** for ENs and **4%** for caregiver/kaiāwhina in 2023. Applying these vacancy rates to the employed FTEs estimates above suggests that there were an estimated **1,380** vacant RN, EN and caregiver/kaiāwhina positions in the ARC sector in 2023 (see Table 13 below).

The 2023 survey also found that turnover of RNs was **33%** in 2023, down from 48% in 2021. This means that, on average, facilities were losing a third of their RNs every year, which goes some way to explaining why 83% of facilities said they are understaffed. The reduction in the RN turnover rate between 2021 and 2023 could be due to reduced hiring of nurses by Te Whatu Ora.

The turnover rate for caregivers/kaiāwhina was similar to RNs at **31%** in 2023. However, a vacancy rate of just 4% suggests that vacant positions are quickly filled. The turnover rate for ENs has tended to be lower than for ENs and caregivers/kaiāwhina. The EN turnover rate was 17% when it was last measured in 2019 (see Table 13).

Table 13

Aged residential care workforce estimates, 2023

	Headcount	FTE	Vacancy rate	Vacancy FTE	Turnover rate
Registered nurses	5,656	3,894	15%	687	33%
Enrolled nurses	489	335	6%	21	17%*
Caregivers/kaiāwhina		16,118	4%	672	31%
Total		20,347		1,380	

Source:, NZNZ, NZACA, Infometrics

**Estimate from 2019*

Implications of workforce shortages

NZACA say that more than 1,200 aged residential care beds have closed in the past year due to a severe shortage of RNs.[35] In 2024, Sapere, a consultancy, reported back to Te Whatu Ora as part of its review of aged residential care funding and service. Sapere found that high needs dementia and psychogeriatric care residents were left waiting, on average, nearly six months to be admitted to an ARC facility after being assessed as high priority for moving out of a home setting. Waiting times for high priority individuals being admitted to an ARC facility ranged from 92 days in MidCentral region to 219 days in West Coast region. Some members of the Advisory Group to the Sapere research

[33] https://www.health.govt.nz/regulation-legislation/certification-of-health-care-services/certified-providers/rest-homes

[34] ARC Sector Profile 2024, NZACA, https://nzaca.org.nz/advocacy-and-policy/arc-sector-profile/

[35] https://nzaca.org.nz/pay-parity-for-aged-care-nurses-promised-but-not-delivered/

claimed that, due to staffing shortages, healthcare assistants often operate outside of their training and capabilities, doing the work of RNs.[36]

Workforce shortages are caused by funding models and pay disparity

Sapere's 2024 review of aged residential care funding and service found clear evidence that the sector was underfunded with providers building smaller care centres, facilities closing, and a shift to providers taking more revenue from residents through 'premium beds' and occupational rights agreements (ORAs) which set out a person's right to occupy a property for retirement.

A substantial increase in the price paid by Te Whatu Ora for services in ARC facilities is needed to incentivise large scale new investments.[37] A lack of national standardisation has also created significant differences in funding rates across regions. Even if funding rates are increased, a new funding model is needed to incentivise pressing issues for the sector such as supporting smaller facilities in rural locations, increasing the number of dementia and psychogeriatric beds, and better incentivising providers to accept short-term stays.

NZACA have stated that the leading cause of nurse shortages and subsequent bed closures is ARC nurses being paid up to $20,000 less than nurses who are employed by Te Whatu Ora in public hospitals.[38] Te Whatu Ora public hospitals also tend to offer better terms and conditions.

In their review of aged care funding and services, Sapere found that, despite an injection of $240m additional funding to ARC, HCSS, General Practices, Māori and Pacific providers and other community providers from 2022 to 2024 that closed pay disparities somewhat, long-standing workforce issues in the aged residential care sector have been exacerbated again by the 2023 pay equity settlement for Te Whatu Ora nurses. The 2023 settlement widened the pay difference between aged residential care nurses and those in publicly funded hospital roles to around 10%.

According to the NZACA's 2023 member survey,[39] around one-third (36%) of RNs and ENs who left their jobs at an ARC facility in 2023 went to work in a Te Whatu Ora hospital, whereas only 11% went to work at another ARC provider, 16% moved location in New Zealand and 15% left the paid workforce. The 36% of RNs and ENs who left their jobs in ARC in 2023 to work in a Te Whatu Ora hospital[40] is testament to the pay disparity.

Sapere also reported concerns that funding ARC increases are not passed through to workers, prompting calls for a separate workforce funding mechanism. Sapere also noted that stakeholders strongly supported an additional pay equity settlement between ARC RNs and Te Whatu Ora RNs to ensure current ARC nurses are not forced to leave

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[36] https://www.tewhatuora.govt.nz/for-health-professionals/clinical-guidance/specific-life-stage-health-information/health-of-older-people/aged-care-funding-and-service-models-review

[37] https://www.tewhatuora.govt.nz/for-health-professionals/clinical-guidance/specific-life-stage-health-information/health-of-older-people/aged-care-funding-and-service-models-review

38 https://nzaca.org.nz/pay-parity-for-aged-care-nurses-promised-but-not-delivered/

[39] ARC Sector Profile 2024, NZACA, https://nzaca.org.nz/advocacy-and-policy/arc-sector-profile/

[40] https://nzaca.org.nz/advocacy-and-policy/arc-sector-profile/

the sector. Sapere estimated it would cost around $89 million per year to address the pay gap.[41]

Other aspects of pay disparity

Individual ARC facilities also report challenges competing with larger or group ARC facilities which offer remuneration incentives such as weekend allowances and overtime pay. Only 7% of facilities that responded to the NZACA 2023 member survey did not offer any non-pay incentives to nursing staff; 85% reimbursed Annual Practicing Certificate costs, 80% funded education initiatives, 71% funded wellbeing initiatives, and 62% offered flexible working arrangements.[42]

Aged care nurse exit rates have been rising

Pay disparities have contributed to exit rates for aged care nurses increasing recently from 16% in 2015 to 37% in 2023. This compares with an exit rate of 32% for primary care nurses, 27% for mental health (community) nurses and 8.6% for all nurses in 2023.[43]

The migrant workforce brings its own challenges

The ARC sector employs a significant number of recent migrants. According to the NZACA 2023 member survey,[44] 24% of RNs were on visas (down from 39% in 2019). Just over one-third (36%) of these visa holders were on a Skilled Migrant Category Residence Visa or similar, the remaining two-thirds (64%) were on other visas. One quarter (26%) of RNs on a visa originated from the Philippines, and 28% from India. The next largest category was the Pacific Islands with 3.7%. Similar proportions of caregiver/kaiāwhina on a visa were also from the Philippines or India.

There is a perception that some internationally qualified nurses (IQNs) get jobs in aged residential care with sponsored visas, then leave after a short time to practice in hospitals or to practice in Australia. The available data doesn't bear this out. If it were common practice, the average tenure of IQNs would be lower than NZ qualified nurses (NZQNs). IQN RNs who worked for an ARC provider prior to registration worked, on average, for 2.3 years at the respondent's ARC facility after they attained registration. IQN RNs who were recruited by an aged residential care provider after they gained registration worked, on average, for 2.3 years at the respondent's ARC facility.

These IQN tenures are similar to the tenure of NZQN RNs who are recruited with 1-4 years of experience (they have a tenure of 2 years). The average tenure figures from the NZACA 2023 member survey don't disprove the perception that some IQNs get jobs in

[41] https://www.tewhatuora.govt.nz/for-health-professionals/clinical-guidance/specific-life-stage-health-information/health-of-older-people/aged-care-funding-and-service-models-review
[42] ARC Sector Profile 2024, NZACA, https://nzaca.org.nz/advocacy-and-policy/arc-sector-profile/
[43] Te Whatu Ora calculations based on NCNZ workforce data
[44] IBID

aged residential care with sponsored visas, then leave after a short time, but they do indicate the practice is not common.

Over the last few years, border restrictions have made it increasingly difficult to recruit and maintain a sustainable migrant ARC workforce which already had perceived issues prior to the pandemic. Stakeholders consulted as part of the Sapere report were concerned about the sector's ability to compete with Australia. In 2023, the Australian Government granted experienced ARC workers a pathway to residency. Sapere's stakeholders also expressed concerns that migrants would be less likely than the domestic workforce to join a union, and that migrants might also be paid less than domestically trained staff due to the scope of their practices being restricted because of their overseas training.[45]

In April 2023, nurses were added to Immigration New Zealand's green list, which provides faster pathways for residency. The addition seems to have increased the inflow of migrant nurses to the ARC sector. According to the NZACA 2023 member survey,[46] just under one-third (30%) of respondents said they were getting more applications from IQNs who didn't have NZ registration than they did before the addition of nurses to the green list, 8% said they were getting more applications from IQNs who did have NZ registration, and a third (34%) noticed no change in the challenges of recruiting IQNs.

The aging workforce is less of an issue

NCNZ data shows that 26% of nurses practicing in the rest home/residential care setting were aged 55 years or older in 2023, compared with 28% of nurses across all settings. The difference is most stark in the 30-39 years age group. In 2023, 46% of nurses practicing in the rest home/residential care setting were aged 30-39 year compared with 33% of nurses across all settings. This 'bulge' in the 30-39 years age group could be caused by the relatively large number of IQNs. We have already noted the ARC sector's reliance on IQNs. We don't have data in the age profile of IQNs and NZQNs in ARC. But 55% of IQNs across all settings are aged 30-39 years.

Workforce development is much broader than pay equity

In addition to addressing pay issues, Sapere found that workforce issues in ARC reflect poor working conditions (such as aggression and abuse from clients), high workloads, a lack of development opportunities, a lack of work variety, under-representation of Māori and Pacific nurses, and stress within the sector. Shortages in ARC also reflect a nationwide shortage of nurses as well as more acute nursing shortages in regional and rural areas. Rural ARC providers find it harder to attract staff, partly because younger people tend to be drawn to urban areas to study and work.

[45] https://www.tewhatuora.govt.nz/for-health-professionals/clinical-guidance/specific-life-stage-health-information/health-of-older-people/aged-care-funding-and-service-models-review
[46] ARC Sector Profile 2024, NZACA, https://nzaca.org.nz/advocacy-and-policy/arc-sector-profile/

ACANZ also commented that nursing school curriculums and placements do not prepare nurses to work in the ARC setting.

Addressing workforce shortages

To address workforce shortages, Sapere recommended improving immigration pathways (including better orientation programmes for new migrants), and creating more domestic training places. Healthcare assistants would like to train to become RNs but cannot take time out of work to do so. Pathways to upskilling need to be easier to fit around existing work commitments. To address shortfalls of cultural safety and equity, Sapere recommended developing models of care that incorporate Te Tiriti principles, cultural safety, Māori health, and anti-racism. ACANZ commented that the NCNZ consultation on ENs' scope of practice will give more independence to ENs, which could enable them to perform some tasks currently carried out by RNs.

Sapere also found that technology could play a larger role in ARC workforce development. For example, respiratory supports and dialysis equipment can shift the demand for ARC services into public hospitals and in some cases into home support. Utilising design adaptations to equipment such as beds and wheelchairs can reduce the need for physical strength from carers.

Stakeholders that Sapere heard from suggested more could be done to market the aged care sector as a potential career, such as a presence at school expos and engagement through the Gateway programme. Gateway enables secondary schools to give senior learners access to workplace learning integrated with school-based learning. [47]

Estimating workforce shortages in ARC beyond current funding levels

The vacancy numbers in Table 13 provide an estimate of the shortage of nurses and caregivers/kaiāwhina based on the number of positions ARC facilities are able to fund. However, these funded positions do not provide for safe staffing, as reports of bed closures and long wait times for admittance to ARC facilities bear out.

What would the nursing shortage be if safe staffing levels were being funded? To answer this question, we apply ARC care minutes mandated in Australia to the New Zealand ARC sector. Australian mandated care minutes are specified as the minimum that ARC facilities should deliver to provide safe care. To determine optimal staffing, we also apply care minutes considered appropriate for an ARC facility to receive a five-star rating in Australia (the highest rating).

In addition to the estimated existing **687 RN, 21 EN and 672 caregiver/kaiāwhina FTE vacancies** (Table 13), we find that applying minimum care standards would require an estimated additional **8,232 carer (RN, EN caregiver/kaiāwhina) FTEs** (a 38% increase on current levels), of which **1,550 FTEs would be RNs** (a 34% increase on current levels). To provide optimal staffing would require an estimated additional **14,224 carer (RN, EN**

[47] https://www.tewhatuora.govt.nz/for-health-professionals/clinical-guidance/specific-life-stage-health-information/health-of-older-people/aged-care-funding-and-service-models-review

caregiver/kaiāwhina) FTEs (a 65% increase on current levels), of which **6,288 FTEs would be RNs** (a 137% increase on current levels) (Table 14).

Mandated care minutes in Australia

Mandatory direct care minutes in Australia's ARC were introduced on October 1, 2023. Residential care homes were required to deliver a sector-wide average of **200 care minutes per resident per day, including 40 minutes provided by a RN** and were required to have an **RN on site and on duty 24 hours a day**. The 200 minutes of care could be provided by RNs, ENs, personal care workers or assistants in nursing. From 1 October 2024, the care minutes responsibility increased to an average of **215 minutes** of care per resident per day, including **44 minutes** of direct RN care. The Department of Health and Aged Care recently announced that from 1 October 2024 providers will be able to meet up to 10% of their service-level RN targets with care time provided by ENs.

These mandated care minutes are considered to be the minimum required to provide safe care. The Australian Nursing and Midwifery Federation (ANMF) in its 2021 submission to the consultation on the development of Star Ratings for ARC facilities stated that a facility would receive a five-star rating (the highest rating) where staffing is able to provide **78 minutes** of RN care time and **258 minutes** of overall staff care time per resident per day from a skills mix of 30% RNs, 20% ENs, and 50% care workers.[48] We consider these recommended care minutes to be what is required for the optimal care.

In addition to the Australian sector-wide average, care minutes are mandated for each type of resident. There are 16 classes of residents based on the Australian National Aged Care Classification (AN-ACC). A description of each class and the associated mandated care minutes is outlined in Table 19 in Appendix 1 (p89).

Non-compliance with mandated care minutes is widespread

Between the September quarter 2023 (the quarter prior to the implementation of mandated care minutes) and the June quarter 2024, total care minutes per resident rose 7.2% from 194 minutes to 208 minutes — above the 200 minute requirement. Over the same time period, care minutes by RNs rose 11.6% from 37 minutes to 41 minutes — above the 40 minute requirement.

However, despite the sector-wide average exceeding the required minimum, in the June quarter 2024, 42% of services did not meet the total care minutes mandate and 59% did not meet both the total care minutes and RN minutes mandate. Services in rural areas were more likely than services in metro areas to exceed minimum care minutes, despite workforce constraints being generally lower in metro areas. Not-for-profit services were more likely than for-profit services to exceed minimum care minutes.[49]

In October 2024, the Minister for Aged Care, wrote an open letter to ARC providers outlining the extent of non-compliance and reminding providers of the 58% increase in

[48] https://www.anmf.org.au/media/0l4hlfuv/anmf_ratings_system_submission_10december2021.pdf

[49] Care Minutes in Residential Aged Care in April — June 2024, https://www.health.gov.au/sites/default/files/2024-10/care-minutes-in-residential-aged-care-dashboard_0.pdf

funding they had received over the previous two years. The Australian Government's approach is to continue to explore options to boost care minutes compliance, including funding options, working with providers that are actively working towards compliance, and using the full range of regulatory powers to enforce compliance with care minutes where providers are not making genuine attempts to increase their staffing levels.[50]

In 2024, the Aged and Community Care providers Association (ACCPA) carried out a survey of aged care providers in Australia. The survey was carried out prior to the implementation of the 215 total care minutes and 44 RN minutes mandate, and before the announcement that providers would be able to meet up to 10% of their service-level RN targets with care time provided by ENs. ACCPA found the following.

- 53% of providers agreed that new requirements resulting from the Government's response to the Royal Commission will support quality of care and safety.
- 48% of providers said they were not at all confident in their ability to meet the upcoming mandatory care minutes target of 215 minutes per resident per day.
- Only 36% of providers were confident in their ability to recruit staff to meet the increased care minutes requirements.
- 60% of providers said they would increase their use of agency staff over the next 12 months.
- Only 24% of small or very small providers agreed that they had the financial resources needed to meet the requirements of the new reforms, compared with 40% of medium or large providers.
- 69% of providers felt the transition timeframes for the commencement of new aged care reforms were too fast.
- 84% of providers believed the new requirements will put a greater strain on the aged care sector.[51]

Applying Australian mandated care minutes to New Zealand

Table 14 details how many carer (RNs, ENs and caregiver/kaiāwhina) FTEs would be required if the 2023 and 2024 sector-wide average Australian care minute regulations and the recommended five-star minutes were applied to the New Zealand ARC sector. Calculations based on patient numbers at individual facilities and then totalled.[52]

Table assumptions:

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[50] Letter to aged care providers from the Minister for Aged Care about care minutes – 1 October 2024, https://www.health.gov.au/resources/publications/letter-to-aged-care-providers-from-the-minister-for-aged-care-about-care-minutes-1-october-2024?language=en

[51] State of the Sector: Aged Care 2024, https://www.accpa.asn.au/extlink/report/ACCPA-State-of-the-Sector-Aged-Care-2024-Report.pdf

[52] We have not attempted to apply the Australian care minute mandates for the 16 different classes of patient acuity because there is no comparable patient classification in New Zealand.

- 1 FTE equates to 40 hours per week – 5 eight-hour shifts
- To provide care for 24 hours per day, 7 days per week requires 1.4 FTEs
- All nurses take 4 weeks of annual leave, to provide care for 52 weeks per year, which requires an additional 8% FTE to cover
- Nurses are entitled to two 10 minute paid breaks and one 30 minute unpaid meal break per shift. To cover these breaks requires an additional 17% FTE
- There are twelve days of public holidays every year in New Zealand; to provide care over these holidays requires an additional 3.3% FTE
- Nurses take, on average, 5 days sick leave a year, which requires an additional 1.9% FTE to cover

Other things that should be considered in determining FTE requirements:

- Additional FTEs might be required to provide non-direct care such as administrative tasks. This depends on how a facility is organised. We have assumed all non-direct care is carried out by other staff, not by RNs, ENs or caregivers/kaiāwhina.
- Additional FTEs are required to provide culturally sensitive care such as care that aligns with the values, principles, and behaviours of tikanga.

Table 14 shows that based on the 2024 Australian mandated care minutes, there would be a shortage of **1,550 RN FTEs** in the aged residential care sector over and above current funded positions. The RN workforce would need to increase **34%** to meet minimum standards. To achieve recommended five-star care minutes, the RN workforce would need to increase 137%.

Looking at the caring workforce more broadly (RNs, ENs and caregivers/kaiāwhina), based on the 2024 Australian mandated care minutes, there would be a shortage of **8,232 carer FTEs** in the aged residential care sector over and above current funded positions. The carer workforce would need to increase **38%** to meet minimum standards. To achieve recommended five-star care minutes, the carer workforce would need to increase 65%.

Table 14

Applying Australian aged care mandated and recommended care minutes to New Zealand

Calculations based on 679 facilities and 36,256 residents

RN FTEs to ensure at least 1 RN on site & on duty at each facility	3,976
2023 minimum: RN FTEs to ensure 40 RN direct care minutes per day	5,574
October 2024 minimum: RN FTEs to ensure 44 RN direct care minutes per day	6,131
Five-star recommended: RN FTEs to ensure 78 RN direct care minutes per day	10,869
2023 minimum: Carer FTEs required for 200 direct care minutes per day	27,869
2024 minimum: Carer FTEs required for 215 direct care minutes per day	29,959
Five-star recommended: Carer FTEs required for 258 direct care minutes per day	35,951
Total RN FTEs available (includes vacant positions)	4,581
2023 minimum: RN FTE shortage/surplus for 40 care minutes	-993
2024 minimum: RN FTE shortage/surplus for 44 care minutes	-1,550
Five-star recommended: RN FTE shortage/surplus for 78 care minutes	-6,288
Total carer FTEs available (includes vacant positions)	21,727
2023 minimum: Care FTE shortage/surplus 200 minutes	-6,142
2024 minimum: Care FTE shortage/surplus 215 minutes	-8,232
Five-star recommended: Care FTE shortage/surplus 258 minutes	-14,224

Source: Infometrics calculations based on ACA, MoH and NZNC data

The NZACA 2023 member survey[53] included questions aimed at obtaining an estimate of carer time per resident per day for different staff members. The survey found that the median amount of care provided by RNs was:

- 22 minutes for rest home bed residents,
- 60 minutes for hospital bed residents,
- 23 minutes for dementia bed residents, and
- 62 minutes for psychogeriatric bed residents.

Therefore, only hospital bed and psychogeriatric bed residents received a median of over 44 minutes of RN direct care (the Australian minimum). Both rest home bed residents and dementia bed residents fell well below this benchmark. In terms of the median, no residents received the Australian recommended five-star 78 minutes.

The survey also found that the median amount of care provided by RNs, ENs and caregivers/kaiāwhina combined was:

- 147 minutes for rest home bed residents,
- 233 minutes for hospital bed residents,
- 196 minutes for dementia bed residents, and
- 248 minutes for psychogeriatric bed residents.

Again, only hospital bed and psychogeriatric bed residents received over 215 minutes of direct care (the Australian minimum). Both rest home bed residents and dementia bed residents fell well below the benchmark. In terms of the median, no residents received the Australian recommended five-star 258 minutes.

Looking forward

In their 2024 review of aged care funding and service for Te Whatu Ora, Sapere concluded that New Zealand could experience a shortage of almost 12,000 beds by 2032. Sapere's bed demand projection was based on applying existing population utilisation rates to projected growth in the population aged 65 years and older. Their bed shortfall was based on comparing the bed demand projection with the trajectory of historical increases in bed numbers. There is a view within the ARC sector that, unless funding to the sector is increased, historical increases in bed numbers might not continue and could even fall. This would result in a greater bed shortfall than projected by Sapere.

Sapere's projected shortfall did not take into account the changing acuity of patients entering ARC. Sapere reported that the proportion of individuals entering ARC at rest home level fell from 54% in 2016/17 to 49% in 2022/23 and the proportion entering at hospital level rose from 35% in 2016/17 to 37% in 2022/23. We have also been told that there is an increasing number of younger residents entering ARC with dementia related to alcohol abuse. Younger residents tend to be stronger than older residents and therefore need more staff to manage them.

There are also currently multiple projections of bed demand. Ernst and Young (EY) produced projections in 2019 and updated them in 2022.

[53] ARC Sector Profile 2024, NZACA, https://nzaca.org.nz/advocacy-and-policy/arc-sector-profile/

- Their 'Population change' scenario was based on estimated 2020/21 per capita utilisation rates (the proportion of the population in different age groups using ARC) applied to population growth projections to 2041/42.
- Their '5 year trend' scenario applied national ARC trends over the previous 5 years to DHB and AREA utilisation rates for the coming five years. Population growth drove the scenario for the rest of the projection period.
- Their 'National Average' scenario moved DHBs and AREAs to the estimated national average 2020/21 utilisation rate by 2025/26. Population growth drove the scenario for the rest of the projection period.

Sapere's projections published in their report were the culmination of their phase 1 analysis. Sapere produced a 'Baseline' scenario, a '5-year trend' scenario and a '5-year trend + substitution' scenario. The '5-year trend + substitution' scenario involved rest home level ARC patients being substituted into HCSS. We have not been able to find out how the Sapere 'Baseline' scenario differs to the EY 'Population change' scenario, or how the Sapere '5 year trend' differs to the EY '5-year trend' scenario.

We understand that the Sapere projections were further refined as part of phase 2 of their analysis of ARC funding and service. However, we have been unable to obtain the phase 2 report from Te Whatu Ora.

We have a version of EY's projections from 2022. Under the population change scenario, bed day demand increases 35% between 2022/23 and 2030/31. Under the past 5-year trend scenario, bed days increase 28% between 2022/23 and 2030/31.

Applying these growth rates to the RN workforce sees demand for RNs growing from **4,581 FTEs** in 2023 to **6,201 FTEs** in 2031 under the population change scenario, an increase of **1,620 FTEs**. Under the past 5-year trend scenario, RN demand increases to **5,909 FTEs** by 2031, an increase of **1,328 FTEs**. These projections are crude. They don't take into account changes in patient acuity, changes to models of care within the ARC setting, or broader changes to models of care such as transitioning more care to home and community settings.

Recommendations

Much of the workforce information available on the ARC sector is based on NCNZ APC data or the NZACA survey. The following improvements could be made.

- An annual headcount of caregiver/kaiāwhina and FTE numbers across all facilities. The data would ideally be published for each individual facility.
- An annual count of vacancies and turnover for RNs, ENs and caregiver/kaiāwhina across all facilities. The data would ideally be published for each individual facility.
- An accurate record of RN, EN and caregiver/kaiāwhina pay rates across all facilities.
- An annual count of the number of patients across all facilities and their acuity. To accurately estimate the FTEs required to meet any mandated care minutes, the data would need to be published for each individual facility.
- If mandated care minutes were introduced, any system for classifying patient acuity that is used to apply care minutes needs to be consistent across the

country. In their 2024 review of ARC funding and service, Sapere noted that inconsistency of interRAI[54] assessments across the health sector mean it would be difficult to have a clear understanding of acuity of ARC patients in New Zealand.

[54] interRAI is a suite of standardized clinical assessments designed to assess a person's health, wellbeing, and needs

General practice

A general practice refers to a medical clinic where a General Practitioner (GP) provides primary healthcare services to patients of all ages, treating a wide range of common health conditions, and acting as the first point of contact for most medical needs within a community.

We have been unable to estimate vacancy rates because of a lack of data, however a survey of general practices conducted in 2024 suggests an estimated **1,347 nurses** left their practice in the last 6 months, or 21% of the general practice nursing workforce. Increasing the nursing workforce in general practices by 5.6% to cover the currently unenrolled population would require an estimated **365 additional nurses (274 nurse FTEs)**.

The size of the general practice nursing workforce

General practices are privately owned businesses and there is no central repository of workforce data about nurses working in this setting. NCNZ reports that in March 2023, a total of 9,045 nurses were employed in the primary health care /community service (non Te Whatu Ora) setting, 8,494 (94%) were RNs (6,381 FTEs), 255 (2.8%) were ENs (182 FTEs) and 296 (3.3%) were nurse practitioners. However, the primary health care /community service (non Te Whatu Ora) setting is much broader than general practices.

The General Practice Owners Association (GenPro) surveys its members annually. In its August 2024 survey it asked its members how many nurses (headcount) they usually employ. Across 244 respondents, the number averaged out at 6.65 nurses. Some 58% employed up to five nurses, 26% employed between 6 and 10 nurses and 16% employed more than 10 nurses.

Applying the 6.65 average to all 978 general practice providers in New Zealand gives us a nursing workforce **headcount of 6,501**. Based on the NCNZ data above, 1 nursing headcount in the primary health care /community service (non Te Whatu Ora) setting is equivalent to 0.75 FTEs. Applying this to the GenPro headcount gives us an FTE estimate of **4,884 nursing FTEs** in general practice.

The estimates based on the GenPro survey equate to a nurse-to-population ratio of **122** general practice nurses (headcount) per 100,000 population, and **92** general practice nurse FTEs per 100,000 population in 2024.

Alternative measures

Nursing Council workforce statistics report that as of 31 March 2023, 4,700 (headcount) and 3,258 nurse FTEs worked in the 'practice nurse' practice area, which is considerably smaller than the estimate based on the GenPro survey.[55]

[55] The New Zealand Nursing Workforce, 2022-2023, Nursing Council of New Zealand, (2024), https://nursingcouncil.org.nz/Public/NCNZ/publications-section/Workforce_statistics.aspx

A 2019 report by General Practice NZ concluded that under the standard model there is commonly a ratio of approximately 1:1 between doctors and practice nurses, although there is considerable variation around that level.[56] In 2022, the Royal New Zealand College of General Practitioners reported that there were 5,600 specialist general practitioners in New Zealand.[57] The number of general practitioners will have changed since 2022, as could the ratio of doctors and practice nurses. Based on the available data, 6,501 nurses employed in general practices seems a little high, but is realistic.

Vacancy rates are not currently captured

The GenPro survey also asked how many nurses had left their practice in the last 6 months. Across the 244 respondents, the number averaged out at 1.38. Some 41% of practices said no nurses had left their practice. For 19% of general practices, the number of nurses who had left in the last six months amounted to 50% or more of the nurses they usually employ. Applying the 1.38 average to all general practices amounts to **1,347 nurses** leaving their practice in the last 6 months or 21% of the nursing workforce. This equates to an annual turnover of 42%. The survey also found that 33% of respondents had nurse vacancies at the time of the survey.

These statistics do not give us a vacancy rate for general practices because they do not count the number of vacancies at a point in time. However, vacancies over the past 6 months give us a sense of the turnover of nurses in general practices. The figure from the 2023 survey was higher at 1.61 vacancies, on average, in the past 6 months.

As an alternative measure of vacancies, we counted the number of advertised vacancies on Seek's website[58] with the keyword 'general practice nurse'. As of 6 March 2025, there were 248 jobs being advertised that were listed in the past 30 days. As a proportion of the estimated 6,501 nurse headcount, this is a vacancy rate of 3.8%. We can't assume that this number captures all vacant nurse positions in general practices.

Resourcing has not kept up with demand

Resourcing for general practices in New Zealand has not kept up with demand for services over successive years. General Practice New Zealand has said that over the last 10 years a growing underlying funding shortfall has developed and that in 2024 general practices were underfunded by 14%.[59] The situation is considerably worse for practices with high-need populations. These funding shortfalls have led to resourcing shortfalls such as nurse staffing and their pay rates.

Capitation funding is tethered to the volume of patient consults, rather than the time spent with patients which varies according to individual health needs. The illnesses, injuries, and disabilities managed outside of hospital settings are increasing in complexity which means general practices are spending more time with patients. Increasing complexity is the result of the ageing population, increasing co-morbidities, new treatment options, and higher thresholds of acuity for access to secondary care.

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[56] Workforce and resources for future general practice, General Practice NZ, (2019), https://gpnz.org.nz/wp-content/uploads/Workforce-Resources-FINAL-DISCUSSION-DOC.pdf

[57] https://www.rnzcgp.org.nz/news/college/gp-future-workforce-requirements-report-highlights/#:~:text=In%20New%20Zealand%20there%20are,in%20New%20Zealand%20per%20100%2C000.

[58] https://www.seek.co.nz/practice-nurse-jobs

[59] https://www.rnz.co.nz/news/political/522547/doctors-warn-fees-will-need-to-rise-due-to-funding-shortfall

Delays in planned hospital procedures since the COVID-19 pandemic have further exacerbated the pressure on general practices.

General practice funding only covers 45 minutes of appointment time per patient per year and is biased toward GP activity at the expense of the wider practice team involved in delivering primary care services, particularly undercounting nurse activity.[60]

Nurses are stressed, exhausted and burning out

Alongside these funding shortfalls, general practice nurses have been given increasing responsibilities in the last decade such as screening, swabbing, immunisations, following up with patients, to support a dwindling GP workforce and overwhelmed hospitals.[61]

A survey of doctors in primary care by New Zealand Women in Medicine in 2022[62] found that there were long-term (up to a year) vacancies for practice nurses, and that staff at all levels and roles were stressed, exhausted, and burning out due to a rise in demand for appointments and increasing patient complexity. Small and rural practices were finding it particularly difficult to manage cover for sickness and leave.

Shortfalls have led to service restrictions and unmet needs

Funding shortfalls have led to a situation where people are increasingly unable to access the care they need when they need it. The 2022/23 New Zealand Health Survey showed 26% of adults and 19% of children were unable to access their GP because of the time taken to get an appointment, up from 12% in 2021/22 for adults and 8% for children.[63]

In the absence of sufficient funding from Government, the alternative for many practices has been to increase the fees their patients pay, which has made visiting a doctor less affordable for some.[64] The 2022/23 New Zealand Health Survey found 16% of adults were unable to access their GP because of cost, up from 11% in 2021/22.[65]

GenPro estimated that about half of general practices had closed their books to new patients in 2024,[66] which means they were not enrolling additional patients. The number of non-enrolled New Zealanders is difficult to estimate accurately, and the number varies year to year, but since 2020, the number has been around 300,000.[67]

General Practice NZ's 2023 survey of GPs[68] asked GPs about service restrictions due to nursing shortages, they included the following.

- Practices closing at the weekend.

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[60] Securing General Practice in Aotearoa, General Practice NZ, (2024), https://gpnz.org.nz/wp-content/uploads/Sustainable-general-practice-in-Aoteraroa-New-Zealand-2024-GPNZ.pdf
[61] https://businessdesk.co.nz/article/health/are-gps-really-underfunded
[62] https://www.nzwim.org.nz/work
[63] https://minhealthnz.shinyapps.io/nz-health-survey-2023-24-annual-data-explorer/_w_c6b5d98a/#!/key-indicators
[64] Securing General Practice in Aotearoa, General Practice NZ, (2024), https://gpnz.org.nz/wp-content/uploads/Sustainable-general-practice-in-Aoteraroa-New-Zealand-2024-GPNZ.pdf
[65] https://minhealthnz.shinyapps.io/nz-health-survey-2023-24-annual-data-explorer/_w_c6b5d98a/#!/key-indicators
[66] https://www.stuff.co.nz/nz-news/350342166/half-countrys-general-practices-not-taking-new-patients
[67] Access to Primary Care tables, Te Whatu Ora, https://www.tewhatuora.govt.nz/for-health-providers/primary-care-sector/primary-health-organisations/enrolment-with-a-general-practice-and-primary-health-organisation
[68] Nursing pay gap: Impact on services and the community, General Practice NZ, (2023), https://gpnz.org.nz/resources/nursing-pay-gap-impact-on-services-in-the-community/

- Cuts to immunisation programmes and screening programmes such as cervical cancer screening, cardiovascular risk screening, and before school checks.
- Inability to keep on top of important patient recalls such as diabetic annual reviews.
- Delays communicating test results to patients, such as blood tests.
- Pulling nurses off the phones which curtailed telephone triage, telehealth, or health advice.
- Reduced time available for long-term condition management, care planning, work on reducing inequalities, and health promotion work.
- Community nursing and home visits to vulnerable or high needs patients has been affected.
- Exiting school nursing contracts.
- No longer able to attend multi-disciplinary community meetings.
- Cutting back fee earning services such as ear clinics, spirometry, immigration, travel, pre-employment medicals which are important to practices' financial sustainability.
- Work being transferred back to GPs such as wound dressings.
- Less minor surgery.
- Less availability for services that have been moved from the hospital setting such as infusions.

Shortfalls are having knock-on effects

General practice has been shown to reduce the need for hospitalisations and urgent care and reduce mortality. International evidence indicates that for every $1 invested in primary care, downstream savings of up to $13 are made.[69] Therefore, in all likelihood, funding shortfalls in primary care are placing additional pressure on secondary health services.

Pay disparity with Te Whatu Ora services

In October 2022, primary care nurses went on strike to demand pay parity. The nurses were asking the Government for a pay increase, not their direct employers, the general practices. The nurses wanted ring-fenced funding for their wages, with annual increases matching inflation, to be included in capitation funding.

In 2023, the New Zealand government allocated $240m to address pay disparities between community and Te Whatu Ora funded settings. General practices received a portion of this funding and were required to use it to increase pay for nurses and kaiāwhina. The funding was intended to increase the base pay rates of eligible workers to 95% of the relevant Te Whatu Agreement in Principle Pay Equity base pay rates, which did not achieve pay parity.

Despite the injection of funding to from 2022 to 2024 that closed pay disparities between general practices and Te Whatu Ora services somewhat, pay disparities were exacerbated again by the 2023 pay equity settlement for Te Whatu Ora nurses. NZNO found that there is a clear pay disparity between general practice nurses and nurses paid

[69] Securing General Practice in Aotearoa, General Practice NZ, (2024), https://gpnz.org.nz/wp-content/uploads/Sustainable-general-practice-in-Aoteraroa-New-Zealand-2024-GPNZ.pdf

by Te Whatu Ora. In a survey of general practice nurses in 2023,[70] NZNO found the following.

- On average, general practice nurses were paid 14%-21% (between $5.14 and $7.88 per hour) less than their Te Whatu Ora counterparts. The pay gap can be significantly higher when different access to penal and overtime rates is factored in.
- One-third of RNs in general practice were paid minimum rates that were between 22% and 27% ($5.77 and $9.68 per hour) less than their Te Whatu Ora counterparts.
- Only 3% of the RNs and ENs who responded to the survey were paid higher rates than their Te Whatu Ora counterparts.
- The average wages of nurse prescribers and nurse manager respondents were below the rates paid to an equivalent Te Whatu Ora nurse.

Budget 2024 saw $2.2b allocated to primary, community and public health care over the next four years. It is unclear how this money is to be split between primary and community care, public health, and increased breast screening services. None of it was ringfenced for practice nurse pay.

In March 2025, the Government committed to increasing the number of training places for nurse practitioners in primary care to 120 a year (at a cost of $21.6 million over four years) and to supporting advanced education for up to 120 primary care RNs (at a cost of $21.6 million over four years).

Pay disparity increases nurse turnover

A survey of GPs in 2023 that examined the causes and implications of the nursing pay disparity[71] found that it contributed to higher turnover of nursing staff. Nurses were leaving general practice for higher paid jobs in Te Whatu Ora roles, in private hospitals or overseas, or were leaving the nursing profession altogether.

The researchers found that many of the reasons for nurse turnover in general practice (e.g. retirement, parental leave, overseas experience, relocation, burnout) have always been true for the sector. However, turnover is higher, and recruitment is harder now because of the pay disparity with nurses employed in Te Whatu Ora services.

General practice does have benefits not offered in other settings such as hospitals. For example, general practices do not require shift work, which is attractive to many nurses.

The aging workforce is a further challenge

A further concern for general practices is the aging of their nursing workforce. In 2023, around 8,700 nurses worked in a primary health care/community services setting. Some 37% of these nurses were aged 55 years or older compared with 28% of nurses across all settings (see Chart 7).[72] The difference is particularly stark in the 30-39 years age group.

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[70] https://www.nzno.org.nz/about_us/media_releases/artmid/4731/articleid/6520/nzno-researchshows-clear-pay-disparity-for-general-practice-nurses

[71] Nursing pay gap: Impact on services and the community, General Practice NZ, (2023), https://gpnz.org.nz/resources/nursing-pay-gap-impact-on-services-in-the-community/

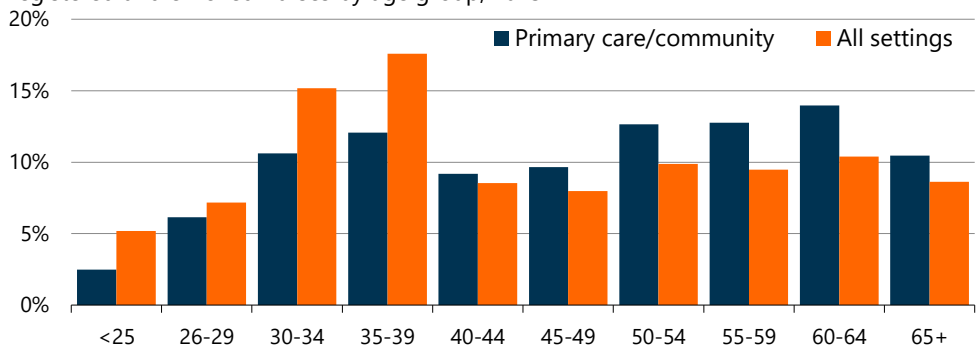
[72] The New Zealand Nursing Workforce, Nursing Council of New Zealand, (2023), https://online.flippingbook.com/view/947433727/

Some 23% of primary health care/community nurses were aged 30-39 years in 2023 compared with 33% of nurses across all settings. The loss of experienced primary care nurses either through retirement or moving to higher paid jobs elsewhere in the health sector, means that new entrants cannot be adequately trained and supported.[73] Workforce data for primary health care/community services includes general practices as well as other services.

Chart 7

Primary care nurses have an older age profile

Registered and enrolled nurses by age group, 2023



Source: Nursing Council of New Zealand

Based on the latest Whatu Ora workforce forecasts, we estimate that the headcount of primary care related nurses per 100,000 population will decline by a total of 2.9% over the next 10 years.

Primary care nurse exit rates are high

The aging workforce and pay disparities have contributed to exit rates for primary care nurses increasing recently from 11% in 2018 to 32% in 2023. This compares with an exit rate of 8.6% for all nurses in 2023.[74] Workforce data for the primary health care setting includes general practice as well as other services.

Relatively low reliance on IQNs

General practices have relatively low reliance on IQNs. In 2023, 17% of nurses in a non-Te Whatu Ora primary health care or community services setting were internationally qualified (up from 16% in 2019) compared with 33% of the overall practicing nurse workforce.[75]

[73] Nursing pay gap: Impact on services and the community, General Practice NZ, (2023), https://gpnz.org.nz/resources/nursing-pay-gap-impact-on-services-in-the-community/

[74] Te Whatu Ora calculations based on NCNZ workforce data

[75] The New Zealand Nursing Workforce, Nursing Council of New Zealand, (2023), https://online.flippingbook.com/view/947433727/

Domestically trained nurses not adequately prepared

Anecdotally, we have heard that graduate nurses are not adequately trained for the general practice setting with skill deficiencies in vaccination, wound dressing, and smear taking. Crucially, graduate nurses lack the confidence to work independently because in their training placements they are always under supervision.

Closing the gap

Earlier in this section we estimated that there were **6,501 nurses** working in general practice, which was an estimated **4,884 FTEs**. We don't know what the vacancy rate is, but we estimate that **1,347 nurses** left their position over a six-month period in 2024.

How many additional nurses would be needed to meet unmet need? We can make some crude estimates based on key measures of unmet need.

- 300,000 people (5.6% of the population) are not enrolled with a GP.
- 26% of adults and 18.5% of children were unable to access their GP because of the time taken to get an appointment.

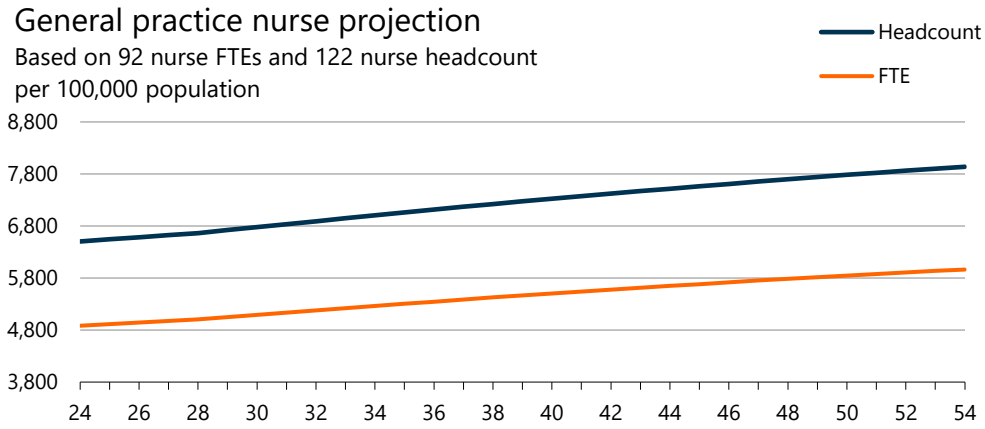
Increasing the nursing workforce in general practices by 5.6% to cover the unenrolled population would require **365 more nurses (274 nurse FTEs)**. This estimate assumes that the increase in required nurses is proportional to the number of people not enrolled. If these people tend to have different needs to the enrolled population, the actual number of additional nurses needed could be different. The number of additional nurses needed will also depend on the models of care utilised in general practices.

Estimating how many nurses are required to reduce wait times is more challenging. We don't know the relationship between nurse numbers and the proportion of people unable to access their GP because of the time taken to get an appointment. There is probably a closer relationship between wait times and the number of GPs. However, we can tentatively conclude that reducing the number of non-enrolled New Zealanders is not the only target for meeting unmet need. A large proportion of people who are enrolled also have unmet needs. The estimate of 365 additional nurses (274 FTEs) to cover unenrolled New Zealanders is therefore probably an under-estimate.

Projected needs

Based on maintaining the nurse-to-population ratio at an estimated 122 nurses (headcount) per 100,000 population and 92 nurse FTEs per 100,000 population, the general practice nursing workforce would need to grow 7.7% (an average of 0.7% per year) between 2024 and 2034, which equates to an additional **50 nurses (headcount) a year or 38 nurse FTEs a year**. Similar growth rates are required beyond 2034 (see Chart 8).

Chart 8



Source: Infometrics

This projection does not take into account the current number of vacancies in the general practice nursing workforce (we don't currently have a general practice nurse vacancy rate), current unmet needs in the population (non-enrolled people and people who can't get a GP appointment within a reasonable timeframe), and Te Whatu Ora's estimate that the aging nursing workforce will result in a reduction in the supply of primary care nurses per 100,000 population of 2.9% over the next 10 years. Combining our demand projection of 7.7% over the next ten years, with Te Whatu Ora's projection of supply, the gap between what is needed and what is available is estimated to be equivalent to 11% of the current workforce.

Recommendations

There needs to be a central repository of data about the general practice nursing workforce that encompasses nurse headcounts, FTEs, vacancy rates, turnover rates, pay rates, patient numbers and other relevant measures of the nursing workload.

Mental health and addiction

Mental health and addiction (MHA) services are delivered through several agencies: Te Whatu Ora, non-governmental organisations (NGOs), general practices and other community providers, and other government agencies such as Department of Corrections, Ministry of Social Development and Oranga Tamariki — Ministry for Children. Te Whatu Ora is the primary provider.

In 2023, 5,430 nurses reported mental health or addiction as their practice area, 344 (6%) in addiction services, 2,574 (47%) in mental health community services, and 2,512 (46%) in mental health inpatient services.

This remainder of section focuses on nurses employed in health funded MHA services for adults and children delivered through Te Whatu Ora and non-governmental organisations (NGOs). Due to a lack of data, this section excludes nurses employed as health improvement practitioners in the Access and Choice Programme for primary healthcare, and nurses employed in mental health and addiction services delivered by other government agencies. The Department of Corrections nursing workforce is examined in the Corrections chapter.

There were an estimated **458** MHA nursing vacancy FTEs in 2022. An estimated **330-340** additional nurse FTEs are required for optimal care. This estimate is based on a crude scaling up of the MHA nursing workforce to meet unmet mental health and addiction needs.

Applying current nurse exit rates to the MHA workforce, we cautiously estimate that around 32,200 nurse FTEs will be needed between 2022 and 2052 (an average of **1,074 FTEs a year**) to replace nurses who leave the sector. This compares with a projected 1,000 additional nurse FTEs (**34 FTEs a year**) needed to grow the MHA nursing workforce to maintain the current nurse-to-population ratio.

Te Whatu Ora and NGO health funded services

The following figures are estimates only. There were around **3,910 FTE** nursing positions in the health funded mental health and addiction (MHA) sector in 2022. This number includes nurses employed plus vacant positions. It excludes nurse researchers, nurse managers and clinical directors.

Most MHA nurses (81%, 3,185 FTEs) worked in Te Whatu Ora funded services for adults (18+ years) in 2022. Nurse FTEs in this part of the sector rose by an annual average 4.7% between 2014 and 2018, and by an annual average of 1.2% between 2018 and 2022. A further 10% of MHA nurses worked in Te Whatu Ora funded services for children and adolescents in 2022 (see Table 15).

Table 15

Mental health and addiction (MHA) nursing FTE positions (employed plus vacant)

				Annual average growth			2022 % of MHA nursing workforce	2022 Total MHA provider workforce	2022 Nurses % of total MHA provider workforce
	2014	2018	2022	2014-18	2018-22	2014-22			
Adult services									
Te Whatu Ora services	2,527	3,034	3,185	4.7%	1.2%	2.9%	81%	7,311	44%
NGO services	150	174	284	3.7%	13%	8.3%	7.3%	5,165	5%
Children's services									
Te Whatu Ora services	271	332	390	5.2%	4%	4.7%	10%	1,382	28%
NGO services	27	53	52	17.9%	0%	8.3%	1.3%	655	8%
Total MHA nurses	2,975	3,592	3,910	4.8%	2%	3.5%	100%	14,513	27%

Source: Te Pou

The NGO nursing workforce is relatively small. In 2022, 7.3% of MHA nurses worked in the non-governmental organisation (NGO) adult services sector and a further 1.3% of MHA nurses worked in the NGO child and adolescent services sector.

Vacancy rates highest in Te Whatu Ora child and adolescent services

The was an estimated **458** MHA nursing vacancy FTEs in 2022 (see Table 16). These figures exclude nurse researchers, nurse managers and clinical directors. The MHA nurse vacancy rate of 12% in 2022 was slightly higher than the 11% vacancy rate for the entire MHA workforce. Nurse vacancy rates were particularly high in Te Whatu Ora child and adolescent MHA services: 19% in 2022 compared with an overall MHO nurse vacancy rate of 12%.

Table 16

Mental health and addiction (MHA) nursing vacancy metrics

	Vacancy rate		FTEs vacant	
	2018	2022	2018	2022
Adult services				
Te Whatu Ora services	6%	11%	173	340
NGO services	3%	14%	5	39
Children's services				
Te Whatu Ora services	14%	19%	47	74
NGO services	5%	11%	3	6
Total MHA nurses	6%	12%	227	458

Source: Te Pou

Vacancy rates might be underestimated due to lack of information from two Te Waipounamu providers.

As regards MHA adult services, MHA nurse vacancy rates in 2022 were much higher than in 2018 in part because resignation rates were higher in 2022. In Te Whatu Ora funded adult services, the vacancy rate was 11% in 2022 compared with 5.7% in 2018 (see Table 16).

The resignation rate in Te Whatu Ora adult and child/adolescent services (of which, adult services is the largest part) was 13% in 2022 compared with 10% in 2018 (see Table 17). Recruitment and resignation rates do not tell the whole story because they do not

account for people moving across different types of services within one provider, changing their working hours, or funding increases resulting in new roles.

The vacancy rate of nurses in NGO adult services was 14% in 2022, a significant increase from just 3% in 2018. The vacancy rate for nurses in NGO services was high despite the resignation rate having fallen from 21% in 2018 to 8% in 2022. Lower resignations in 2022 might reflect the impact of COVID-19 lockdowns, as alcohol and drug and mental health services were able to maintain employment continuity.[76]

Table 17

Mental health and addiction (MHA) nursing turnover metrics

	Resignation rate		Recruitment rate	
	2018	2022	2018	2022
Te Whatu Ora (adult & children's)	10%	13%	14%	13%
NGO (adult only)	21%	8%	17%	22%
Total	11%	13%	15%	14%

Source: Te Pou

Te Whatu Ora estimates that the exit rate of nurses in the mental health (community) setting jumped to 43% in 2023 from 24% in 2022 and from 11% in 2018. The exit rate counts nurses leaving the mental health community setting to practice in another setting or leave the nursing workforce all together. The scope of the mental health (community) setting probably doesn't align exactly with the scope of the Te Pou data used in much of this section, so any comparisons should be made with caution.

Nurse vacancy rates highest in te Manawa Taki (mid-North Island) region

Within Te Whatu Ora funded adult regional services, vacancy rates and resignation rates for nurses were highest in the Te Manawa Taki (mid-North Island) region and lowest in the South Island region in 2022. Recruitment rates were highest in the Central (lower North Island) region and lowest in the South Island region in 2022 (see Table 18).

Table 18

Te Whatu Ora adult MHA regional nursing workforce turnover metrics, 2022

	Vacancy rate	Resignation rate	Recruitment rate
New Zealand	11%	13%	13%
Northern	10%	13%	15%
Mid-North Island	17%	17%	14%
Central	10%	15%	16%
South Island	9%	13%	11%

Source: Te Pou

[76] NGO workforce estimates: 2022 survey of adult alcohol and drug and mental health services, Te Pou, 2023, https://www.tepou.co.nz/resources/ngo-workforce-estimates-2022

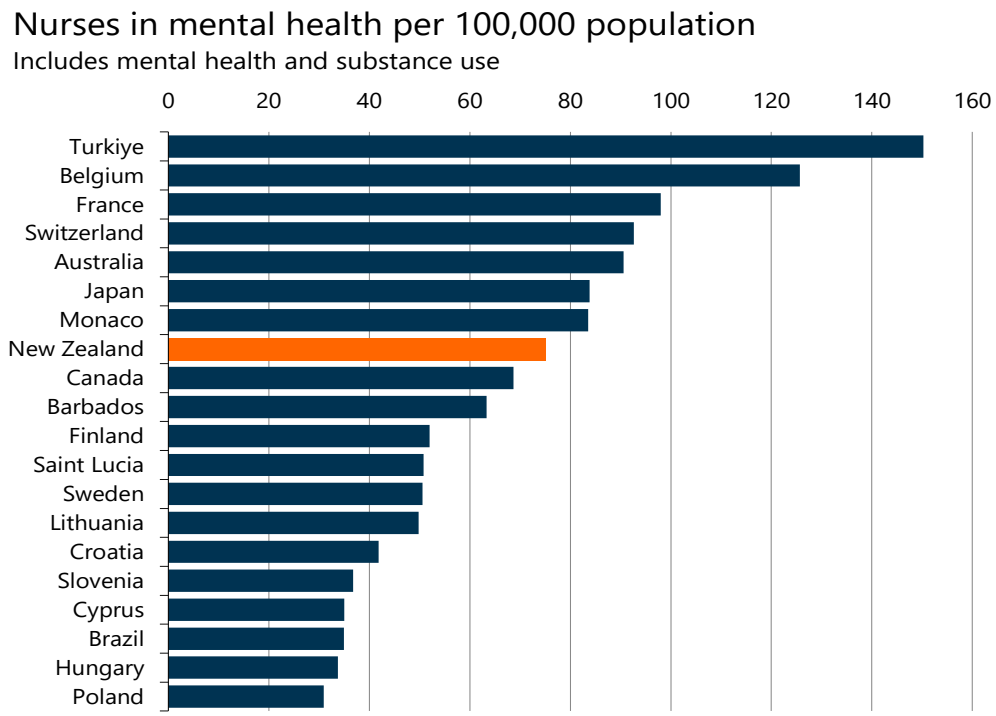
NZ compares well internationally

Infometrics has calculated nurse-to-population ratios for adult and child/adolescent MHA services funded by Te Whatu Ora and NGO services in 2022. Based on the estimate of 3,922 FTE employed and vacant nurse positions in 2022 (see Table 15), and a population estimate of 5,116,840 in 2022, this equates to a nurse-to-population ratio of 76.6.

Te Pou has previously reported nurse-to-population ratios for adult and child/adolescent MHA services funded by Te Whatu Ora based on employed nurse FTEs. The Infometrics figure is based on up-to-date Stats NZ population estimates, includes NGO services, and includes vacant positions at both NGO and services funded by Te Whatu Ora. The Infometrics estimates will therefore differ to any figures reported previously by Te Pou.

An international comparison of mental health nurse-to-population ratios places New Zealand in the top 10 of countries (see Chart 9) based on World Health Organization surveys of 158 countries carried out between 2013 and 2017.[77] Country comparisons are problematic because the structure of health systems differs across countries, as does the prevalence of mental health and substance use issues.

Chart 9



Source: World Health Organisation

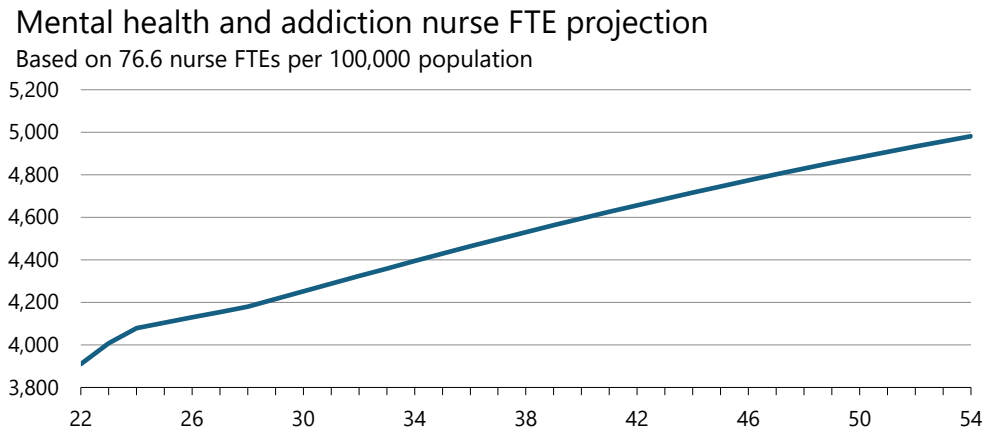
[77] https://www.who.int/data/gho/data/indicators/indicator-details/GHO/nurses-working-in-mental-health-sector-(per-100-000)

Population growth will require more MHA nurses

Based on maintaining New Zealand's nurse FTE to 100,000 population ratio in 2022 of 76.6 constant and based on Infometrics national population projections, the projected demand for nurses in MHA increases:

- from **3,910 FTEs** in 2022 to **4,393** in 2034, an average of 40 additional FTEs a year, an annual average increase of 1.0%pa,
- to **4,715 FTEs** in 2044, an average of 32 additional FTEs per year between 2034 and 2044, an annual average increase of 0.7%, and
- to **4,995 FTEs** in 2054, an average of 26 additional FTEs per year between 2044 and 2054, an annual average increase of 0.5% (see Chart 10).

Chart 10



Source: Infometrics

In addition to meeting future needs, this projection assumes that current vacancies (458 in 2022, see Table 16) can be filled. The projection also assumes the current ratio of nurse positions to population is enough to meet population needs.

This might not be the case for two reasons. Firstly, there is evidence that current population mental health needs are not being met. The New Zealand Health Survey 2023/24 found that 10.7% of adults (aged 15+) and 6.5% of children (2-14 years) had an unmet need for mental health or addiction services in the past 12 months. This amounts to 520,000 people in the population with unmet mental health or addiction needs, or 9.7% of the population.[78] Some of this unmet need will be because of vacancies in the MHA workforce. Taking this into account, a crude scaling up of the MHA nursing workforce to meet this need amounts to around **330-340** additional nurse FTEs.

Secondly, historical trends suggest the population will experience rising levels of stress in the future. In its Te Whatu Ora Mental Health & Addiction Workforce Plan, 2024 – 2027[79] Te Whatu Ora notes that the proportion of the New Zealand population

[78] https://minhealthnz.shinyapps.io/nz-health-survey-2023-24-annual-data-explorer/
[79] https://www.tewhatuora.govt.nz/publications/mental-health-and-addiction-workforce-plan-2024-2027

experiencing high or very high psychological stress has risen persistently since 2011/12. Therefore, maintaining the MHA nurse-to-population ratio at the 2022 level might not be sufficient to meet population needs in the future.

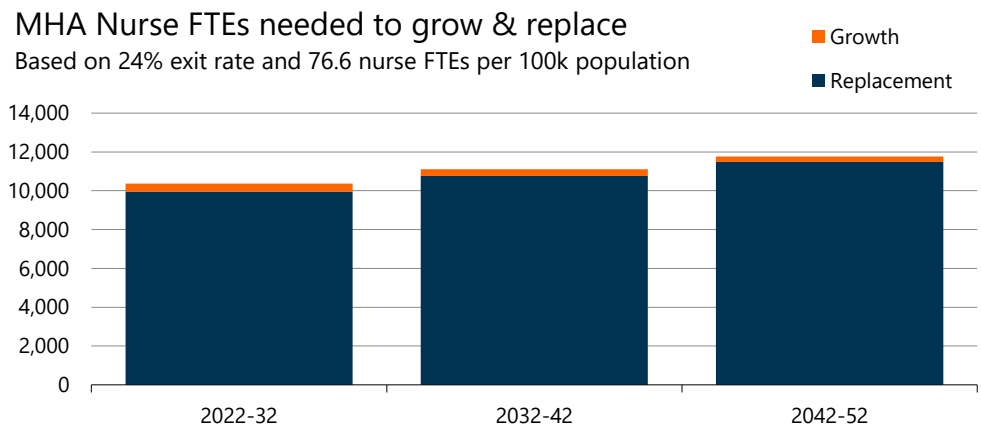
Workforce growth is small compared with replacement demand

Furthermore, the additional nurse FTEs required to grow the MHA workforce to maintain the 2022 nurse to population ratio is small compared with the FTEs required to replace the nurses that leave the MHA sector every year.

Aside from a spike in the exit rate of nurses practicing in the mental health (community) setting in 2023, the exit rate had remained at 24% for the preceding three years.[80] If we apply this annual exit rate of 24% for the mental health (community) nursing workforce to the MHA workforce, around 32,200 nurse FTEs will be needed between 2022 and 2052 (an average of 1,074 FTEs a year) to replace nurses who leave the sector, compared with just over 1,000 additional nurse FTEs (34 FTEs a year) needed to grow the workforce to maintain the current nurse-to-population ratio (see Chart 11). The scope of the mental health (community) data used to estimate the exit rate probably doesn't align exactly with the scope of the Te Pou data used to estimate the size of the MHA workforce, so these estimates of FTE nurse replacement demand should be used with caution.

As the workforce ages, the future resignation rate of MHA nurses could be higher than 13% as more nurses retire and younger nurses remain in their jobs for shorter tenures. It should be noted that, even as the exit rate rose above 20% in recent years, the mental health community nursing workforce attracted enough new entrants to continue growing. However, the 43% exit rate in 2023 saw the workforce diminish considerably.

Chart 11



Source: Infometrics calculations using Te Whatu Ora and Te Pou data

[80] Source: Te Whatu Ora calculation based on NCNZ workforce data

Aging workforce is the biggest concern

Feedback from Te Pou suggests that within Te Whatu Ora funded adult, child and adolescent MHA services, nurses are a long-serving workforce with an average service of around nine years. Aging is the most challenging workforce development issue for this workforce. The average age is 47 years and 45% of this nursing workforce is aged 50 or older.[81] Many of whom will want to reduce their working hours and eventually retire over the next 15 years.

Replacing nurses that retire is additional to considering how much the workforce needs to grow to keep up with population and changing demand (see Chart 10 for a projection of MHA nurse FTE demand). Anecdotally, Te Pou hear there are various other workforce development challenges including lack of time and staff roster coverage for professional development.

Vacancies and representation are also issues

In its 2022 report on the Te Whatu Ora adult mental health and addiction workforce,[82] Te Pou noted the following MHA workforce development issues.

- The workforce was dealing with staffing shortages, excess workload, and burnout.[83]
- High vacancy rates were constraining Te Whatu Ora services' capacity to grow the workforce (Te Whatu Ora MHA nurses had a vacancy rate of 11% in 2022)
- Māori and Pacific Peoples representation has been a long-standing focus for the MHA workforce. In 2022, 13% of Te Whatu Ora MHA nurses were Māori, which is high compared with other health settings but lower than the 29% of people accessing mental health services who identify as Māori.
- Since 2018, the allied health, medical, and support worker role groups had grown at twice the rate of nurses, which led to a decline in nurses' share of the total workforce.
- There are pressures on workforce supply pipelines due to a tight labour market and substantial national and international competition for qualified health workers.
- Retaining the knowledge and skills of older workers was a challenge.

In addition to addressing these workforce development issues, Te Pou advocates for growing the share of men and gender diverse peoples in the MHA workforce, offering expanded career options and flexible working hours for older nurses (such as part-time work), and supporting new graduates' entry to practice.[84]

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[81] Te Whatu Ora mental health and addiction employees: 2018 to 2023, Te Pou, (2024), https://www.tepou.co.nz/resources/te-whatu-ora-mental-health-and-addiction-employees-2018-to-2023

[82] Te Whatu Ora adult mental health and addiction workforce: 2022 adult alcohol and drug and mental health services report, Te Pou, 2023, https://www.tepou.co.nz/resources/te-whatu-ora-adult-mental-health-and-addiction-workforce-2022-adult-alcohol-and-drug-and-mental-health-services-report

[83] This finding was based on a literature review, the other findings on this list were based on Te Pou analysis of available workforce data.

[84] Te Whatu Ora mental health & addiction employee profile: 31 March 2023, Te Pou, (2024), https://www.tepou.co.nz/resources/te-whatu-ora-mental-health-and-addiction-employee-profile-31-march-2023

Working conditions are also an issue in the MHA setting. In 2024, NZNO found, through a survey of mental health nurses, that 76% had been physically threatened and over 40% assaulted within a 12-month period.[85]

Pay equity is a challenge for NGOs

Less is known about nurse workforce development challenges in the NGO MHA sector. NGO providers report that roles with a clinical focus can be hard to fill due to challenges with pay equity and parity.[86]

Te Whatu Ora focuses on training

In its Mental Health & Addiction Workforce Plan, 2024 – 2027,[87] Te Whatu Ora notes that the MHA workforce is not representative of those who use its services, pointing to an over-reliance on internationally qualified clinical workers as the reason for this. Te Whatu Ora also mentions that New Zealand has historically undertrained mental health and addiction nurses, driven in part by an expectation that nurses get some experience before specialising in mental health and addiction.

Acknowledging that there are pressures across the mental health and addiction nursing workforce, Te Whatu Ora points to some specialist areas, such as forensic intellectual disability (ID) nurses, having particularly acute shortages.

However, Te Whatu Ora are relatively upbeat, pointing to a strong supply of generalist nurses since 2023 which provides opportunities to support some of these nurses into mental health and addiction settings. Looking forward, the workforce plan has three specific actions relating to nurses.

- Improve graduate transitions — expand early career supports for mental health nurses transitioning out of NESP training.
- Expand scopes through training — from 2025 onwards, reset investment in nurse practitioner training so that 22 more nurse practitioners can be trained per year in MHA settings.
- Grow mental MHA capacity — including increasing New Entry to Specialist Practice (NESP) programme places for mental health nurses from 272 in 2024 to 475 by 2027.

Elsewhere in the workforce plan, Te Whatu Ora mentions building Māori and Pacific representation within the broader mental health and addiction workforce and growing the number of nurse practitioners trained for mental health and addiction settings.

Te Whatu Ora also launched a campaign to improve mental health, addiction and wellbeing outcomes by increasing the capacity of the nursing workforce. The campaign, entitled 'Are You Ready' aims to:

- encourage nursing graduates to choose MHA as a preferred practice area and as a professional career,
- attract former nurses back into the profession, and

[85] https://www.rnz.co.nz/news/national/518818/health-new-zealand-admits-mental-health-addiction-nurses-under-pressure

[86] Source: Te Pou, based on surveys of NGOs in 2018 and 2022.

[87] https://www.tewhatuora.govt.nz/publications/mental-health-and-addiction-workforce-plan-2024-2027

- increase the number of Māori and Pacific peoples working in this area.[88]

Increasing NESP places isn't enough

Te Whatu Ora's focus on increasing the number of NESP places will help meet the future demand for MHA nurses. However, for the 475 NESP places to be sufficient, vacancy numbers need to be reduced, and nurse exit rates need to decline. As noted earlier, there were 458 FTE vacant MHA nurse positions in 2022, and based on recent exit rates in the mental health (community) settings we cautiously estimate that an average of 1,074 nurse FTEs will need replacing each year. A further 34 FTEs will be needed to grow the workforce. Headcounts need to be even higher than FTEs because not all nurses work full-time. In Te Whatu Ora services, the ratio of nurse headcount to FTEs in 2023 was 1.11.

Reducing exit rates by increasing retention involves addressing other workforce development issues raised by Te Pou and NZNO such as excess workload and burnout caused by staffing shortages, staff being exposed to threats and assaults from patients, lack of time and staff roster coverage for professional development, a lack of career options for experienced nurses, and competition for qualified health workers in tight national and global labour markets. Representation of Māori, males, other ethnicities, and gender diverse peoples in the MHA nursing workforce also needs to be addressed.

The International Council of Nurses (ICN) proposes an even broader approach to nursing workforce development in the mental health and substance use setting. The ICN recommends improving workforce retention by:

- increasing remuneration,
- increasing staff-to-patient ratios and improving working conditions,
- increasing recognition and appreciation, and
- reducing the stigma associated with mental health nursing.

The ICN recommends improving the educational preparation of mental health nurses, such as by:

- ensuring that essential elements of mental health are covered in nursing curriculums and learning outcomes are achieved,
- ensuring that academic staff have the required competencies to teach a mental health curriculum, and
- increasing the number of clinical placement hours in mental health care settings.

The ICN also recommends the use of Advanced Practice mental health nurses and an expansion of their role, which aligns with Te Whatu Ora's plan to increase the number of Nurse Practitioners training in mental health. More broadly, the ICN suggests that prescriptive authority for mental health nurses might be an important tool in improving access to care.[89]

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[88] https://www.tewhatuora.govt.nz/for-health-professionals/health-workforce-development/nursing/nursing-recruitment

[89] The global mental health nursing workforce: time prioritize and invest in mental health and wellbeing, International Council of Nurses, (2022), https://www.icn.ch/sites/default/files/2023-04/ICN_Mental_Health_Workforce_report_EN_web.pdf

Recommendations

The workforce data used in this section was drawn from several reports that cover overlapping but sometimes different parts of the MHA system and use different data collection methods and categories. The data has been challenging to combine into a coherent picture, and we appreciate the assistance Te Pou has provided us in this endeavour.

There needs to be a central repository of annual workforce information spanning the whole MHA sector. This includes both adult and child MHA services, Te Whatu Ora services and NGO services, the Access and Choice Programme for primary healthcare, and staff working in MHA services delivered by other government agencies such as Corrections. The data collection methodologies must be consistent across the whole sector.

As far as nurses are concerned, all nursing roles must be within scope of the data collection, including nurse researchers, nurse managers and clinical directors. The data collection should include, as a minimum, nurse FTEs and headcounts, vacancy numbers and rates, recruitment rates and resignation rates, and pay rates. There should be metrics for each nursing role and each of the scopes of practice, and for the different service types. In an unpublished report, Te Pou[90] identified the following improvements needed to MHA workforce data.

- The coding of nurses' priority area of work needs to delineate between different aspects of mental health and addiction settings such as:
    - adult services separate from children's services,
    - inpatient services separate from community services, and
    - Kaupapa Māori and Pasifika services separate from others.
- The lived experience and Māori and Pacific Peoples cultural support and advisory workforces need to be clearly identified (Te Pou is engaging with StatsNZ about this).
- IT system upgrades are required in the Central region to enable the separation of mental health from the alcohol and drug and forensic workforces. More accurate coding of the alcohol and drug and forensic workforces is needed in the other three regions.
- There needs to be better completion of fields for qualifications, registrations, and mobility (where new employees came from and where employees who resign go to).

Changes to NGO workforce data collection include:

- A centralised repository of NGO workforce information that is regularly updated (currently every 2 years for Whāraurau and 4 years for Te Pou is too long), this needs to be developed with a focus on Māori data sovereignty and in collaboration with NGOs to reduce rather than increase their reporting burdens.

[90] Mental Health and Addiction Workforce Information Gaps, Te Pou, (unpublished, 2022)

- Information about socio-demographic profile is lacking for most of the workforce (for example, age, gender/sex, ethnicity) as well as for service factors (qualifications, registrations, capabilities, length of service).

Te Pou has projects underway to address some of these gaps relating to NGOs, however a central repository would require substantial investment from Te Whatu Ora.

Home and Community Support

In their 2024 review of aged care funding and service for Te Whatu Ora,[91] Sapere found that around 80,000 older people receive services in their home through Te Whatu Ora funded Home and Community Support Services (HCSS). Those services include household management services and personal care. Informal carers are also allocated respite care. Sapere found evidence that HCSS has been helping older New Zealanders to age in place. New Zealanders are delaying entry to ARC and, when they do, they enter ARC with higher acuity. However, Sapere cautioned that a failure to increase ARC prices will result in continuing facility closures, particularly within the charitable and small owner group. This will increase the burden on HCSS, which is already struggling.

The HCSS workforce has been shrinking

Sapere found the HCSS workforce has been shrinking while New Zealand's population is rapidly ageing, with HCSS employees falling by 8% in the past two years. Sapere heard that HCSS providers are struggling to attract and retain staff. The difficulties faced by providers are inextricably linked to inadequate funding, regulated prices, and funding mechanisms that limit the scope for a more regular workforce.

Pay inequity is part of the problem

Despite home and community support services receiving funding in 2023 to help address nurse pay disparities, the workforce challenges in HCSS were exacerbated again by the 2023 pay equity settlement for Te Whatu Ora nurses, which widened the pay difference between HCSS nurses and those in publicly funded hospital roles. There are also concerns that HCSS funding increases are not passed through to workers, prompting calls for a separate workforce funding mechanism.

Carers now seeing fewer clients

Sapere found the total number of HCSS clients declined 7% between 2017/18 and 2022/23. The declining volume of HCSS clients within an ageing population is indicative of a conscious decision to provide more intensive support to more complex clients.

A new funding model is needed

Sapere concluded that a new integrated model of care is needed that specifies the outcomes that the HCSS (and ARC) sectors should be looking to achieve, with sufficient flexibility for providers to tailor their services according to the best interests of older New Zealanders. [92]

[91] https://www.tewhatuora.govt.nz/for-health-professionals/clinical-guidance/specific-life-stage-health-information/health-of-older-people/aged-care-funding-and-service-models-review
[92] https://www.tewhatuora.govt.nz/for-health-professionals/clinical-guidance/specific-life-stage-health-information/health-of-older-people/aged-care-funding-and-service-models-review

Hospice and palliative care services

Hospice care is specialist palliative care that provides physical comfort and emotional, social and spiritual support for people nearing the end of life. Nationally, there are 32 hospices. Hospices provide inpatient facilities, usually in large urban centres, and community in-home services. Hospices also work with general practice teams, primary and community care providers, and ARC facilities to support people with palliative care needs. Hospices provide advice and education to a wide range of health professionals. Specialist palliative care services are also provided in hospitals. Hospital services are not covered in this section.[93]

In 2022/23, 10,880 people who died were cared for by hospice, 45% of whom died at home. In total, 18,582 patients plus their whānau were cared for by hospice. Each year hospices undertake a large number of in-person community visits, phone consultations, and bereavement care contacts.[94]

Workforce data availability will soon improve

We have been unable to access any data about the nursing workforce in hospices. NCNZ workforce data does not delineate hospices separately as an employment setting and the palliative care practice setting is broader than hospices. However, a centralised repository of data is expected to be available from Hospice NZ later this year.

Hospices face similar issues to ARC providers and general practices such as funding shortfalls and nursing pay disparities, which have led to nursing shortages in these other settings. Feedback from Hospice NZ and individual hospices is that there is not a shortage of nurses because services have been scaled to fit funding levels.

Funding shortfalls

Hospices were facing significant funding deficits in 2023, and these were expected to increase in 2024. Hospices are funded through a mix of community funding (fundraising and second-hand retail stores) and government funding via local Te Whatu Ora contracts. For most hospices, government funding covers 50-60% of their overall costs, but this varies across hospices, and the proportion is reducing for many. In some cases, it is well below 50%. Te Whatu Ora funding, expressed as a percentage of total service costs across all hospices decreased from 68.5% in 2021 to 65.8% in 2022. Because Government funding is not keeping pace with rising costs, most of these increased costs are being passed onto the communities with hospices needing to increase fundraising.

Hospice operational costs are increasing. The most significant drivers of cost increases are rising staff remuneration and the rapid rise of all day-to-day service delivery costs such as vehicle costs, clinical supplies, equipment, ICT, insurance, and building rental. Hospice operational cost increases are also due in part to there being more patients and whānau needing care and support, and to efforts to expand services to reach more

[93] Briefing to incoming Ministers, Hospice New Zealand, (2024), https://www.hospice.org.nz/bim_2023
[94] Briefing to incoming Ministers, Hospice New Zealand, (2024), https://www.hospice.org.nz/bim_2023

people. The growing demand for hospice services is being driven by an ageing population, population growth, the increasing prevalence of chronic conditions and diseases, and from the spillover of patients from primary and secondary healthcare services that are unable to cope with patient demand. [95]

Funding shortfalls causing service shortfalls

As a result of funding shortfalls, many hospices are either already making service cuts to remain financially viable or are considering cuts. Staff shortages have also had a significant impact on the delivery of services, with some hospices having to reduce inpatient beds, restrict admissions, and reduce community care as a result.

As a benchmark of the quality of palliative care, New Zealand was ranked third in the world in 2015 in the Quality of Death Index[96] (after the UK and Australia). However, in a more recent study,[97] NZ had dropped to 12th, indicating our palliative care services are not keeping pace with international developments. Inequities are also known to exist in terms of access to palliative care across regions, by care setting, by disease type, and by age and ethnicity of patient.

Pay disparity

Pay disparities between nurses employed in hospices and nurses employed in Te Whatu Ora services are a significant workforce development challenge for the hospice sector. In 2023 the sector received a total funding increase of $16.3 million. Some $11.5 million of which was allocated to help address the significant pay disparity for nurses working in the sector. However, the subsequent pay equity settlement and collective agreement for Te Whatu Ora nurses re-created the stark pay gap[98] with Hospice NZ estimating the pay gap to be up to 20% depending on the payrates individual nurses are on.

Funding shortfalls put pressure on other services

Without hospices, the inpatient admissions, community visits, phone consultations, and bereavement care contacts would all need to be met by other health services, in many cases emergency departments and hospital wards. Many of the 10,880 people who died with hospice care in 2022/23 would likely end up in other settings as death at home would be less likely.

In the report 'Investing to save',[99] KPMG found that integrated home-based palliative care saves between AU$4,544 and AU$6,109 per person from reduced emergency department and hospitalisation costs. They estimated that for each $1.00 invested in

[95] Briefing to incoming Ministers, Hospice New Zealand, (2024), https://www.hospice.org.nz/bim_2023
[96] http://www.lienfoundation.org/sites/default/files/2015%20Quality%20of%20Death%20Report.pdf
[97] https://www.duke-nus.edu.sg/lcpc/quality-of-death/
[98] Briefing to incoming Ministers, Hospice New Zealand, (2024), https://www.hospice.org.nz/bim_2023
[99] Palliative Care Australia and KPMG (2020) Investing to save: The economics of increased investment in palliative care in Australia. KPMG, Australia. (https://palliativecare.org.au/publication/ kpmg-palliativecare-economic-report)

integrated home-based palliative care there is, on average, a return of $1.00, so at the very least home-based palliative care is cost neutral.

We don't currently have this return on investment type of data for the New Zealand hospice sector. However, a rough estimate of public health system savings, using Australian figures and hospice patient numbers from 2022, could be between NZ$87.5m and NZ$117.8m. Add to that the fact that hospices currently fund over a third of the cost of delivering clinical services, and the economic benefit to the government and public health system is even greater.[100]

Demand for palliative care set to increase

As society ages, care needs are becoming more complex with more people living to older ages and with multiple comorbidities and complex social needs. The projected aging of the population has implications for the kinds of palliative care people need and where that care is delivered.

Population growth and the aging population will increase demand for palliative care services. By 2040, 17,000 people who die will need hospice care. Nearly 50,000 New Zealanders will need palliative care, and there will be a huge increase in aged care and primary care providers needing support.[101]

[100] Briefing to incoming Ministers, Hospice New Zealand, (2024), https://www.hospice.org.nz/bim_2023
[101] IBID

Corrections

Corrections nurses and other healthcare workers are responsible for the healthcare of prisoners. The focus is on primary care, but Corrections nurses work across a range of different specialities, including emergency response, women's health, mental health and addictions, and older person's health. Information about the Corrections nursing workforce has been drawn together with the assistance of the Department of Corrections: Ara Poutama Aotearoa.

The nursing workforce

Currently, the corrections system is budgeted to employ 239 RN FTEs, 17 EN FTEs and 39 healthcare assistant (HCA) FTEs. Around a quarter of the Corrections nursing workforce is male, which is high compared with the nursing workforce as a whole.

The Corrections nursing workforce is reliant on IQNs who make up around 60% of the workforce following a big influx recently. IQNs usually come into the Corrections workforce with several years' experience overseas.

Corrections recently received accreditation to recruit graduate nurses into the Nursing Entry to Practice Programme (NETP). This means graduate nurses can specify Corrections as their first, second, or third NETP choice. Previously Corrections wasn't an option for NETP, so they only got the nurses who hadn't been placed in any of their first-, second- or third-choice settings.

The corrections system can be a tough environment for nurses to work in. But it offers a diversity of care and doesn't require nurses to work night shifts.

Nurse staffing determined by prison and prisoner characteristics

There are 16 prisons in New Zealand. Corrections groups prisons together into four regions: Northern, Central, Lower North and Southern. Corrections has developed a Minimum Baseline Roster Model to determine nurse and Health Care Assistant (HCA) staffing at each prison, and to monitor attrition and vacancy numbers. Staffing requirements in the model are driven by the following factors.

- **Prison classifications** — the average length of stay of prisoners is shorter in remand prisons than in sentenced prisons. Higher turnover of remand prisoners requires higher staffing levels.
- **Prisoner numbers** — 5.4 RN/EN/HCA FTEs are required for the first 200 inmates, then 1-2 FTEs for every 60 additional inmates thereafter. Prisons are made up of blocks of 60 prisoners. Prisons get expanded one block at a time. Prison beds can also be closed or opened to increase capacity more incrementally.
- **Prisoner types** — female prisoners have higher needs and therefore receive a higher FTE weighting in the model. High security prisoners also receive a higher FTE weighting to ensure staff safety.

- **The structure of prisons** — for example, if a prison comprises two blocks several hundred meters apart, staff are required for each block to ensure they can react to emergencies in a timely fashion.

NZNO argue that staffing should also take into account the number of Māori prisoners. In the broader health system, Māori have greater health needs as well as cultural needs, which require additional resources. This reasoning should also be applied to Māori prisoners.

Staffing is currently close to recommended levels

At the moment, staffing is close to what is recommended by the Roster Model. Nationally, across the 2024-25 financial year there were, on average, 4.8 RN FTE vacancies (a vacancy rate of 2.0%), 1.03 EN FTE vacancies (a vacancy rate of 6.1%) and 2.45 HCA FTE vacancies (a vacancy rate of 6.3%). Some regions had a higher vacancy rate than others. There is a 20% RN vacancy rate and a 9.4% HCA vacancy rate in the Lower North Region. The Southern Region has a 6.8% RN vacancy rate and 7.0% EN vacancy rate.

Attrition rates are sensitive to relative pay rates and immigration

Although staffing levels are close to what is recommended by the roster model, Corrections noted that this can change in a matter of months (and has in the past) because nurse attrition rates are very sensitive to relative pay rates, particularly with nurses in Te Whatu Ora services, and to immigration flows.

Staff attrition rates peaked in 2023 following the opening of the New Zealand border which caused an outflow of staff overseas. Also, at this time there was a 10-month delay between the Te Whatu Ora nurses pay agreement and the Corrections pay agreement. This period of pay disparity contributed to higher nursing attrition rates at Corrections. Staff attrition created a large number of vacancies. However, Corrections were able to fill them because of the influx of IQNs, with individual positions attracting hundreds of applications.

Pay parity has now been achieved and attrition rates at Corrections have fallen. Health budget cuts have also played a part because they have heightened job insecurity. However, if pay disparity emerges again, and/or migration turns downward, attrition rates and vacancy numbers could quickly rise again.

Corrections needs nurses with a range of experience levels

The other workforce development issue faced by Corrections is an imbalance in the experience levels of its nursing workforce. The workforce is skewed towards nurses with five or more years' experience and to nurses with one to two years' experience. There are not enough nurses with three to five years' experience. This situation has come about because the Corrections system has several very experienced nurses who have

worked in the system for a long time. But Corrections also tends to lose junior nurses after a couple of years to other parts of the health sector. This imbalance is an issue because it places strain on the most experienced nurses to supervise, train and mentor junior nurses.

Projections dependent on prison infrastructure

The latest prison population projections from the Ministry of Justice[102] has the number of remand prisoners increasing 41% between January 2024 and January 2034, the number of sentenced prisons increasing 10% and the total prison population increasing 24%. This will undoubtably increase the demand for Corrections nurses. However, with demand tied closely to the prison infrastructure as much as the number of prisoners, we have not attempted a workforce demand projection.

[102] https://www.justice.govt.nz/justice-sector-policy/research-data/justice-sector-projections/

Plunket

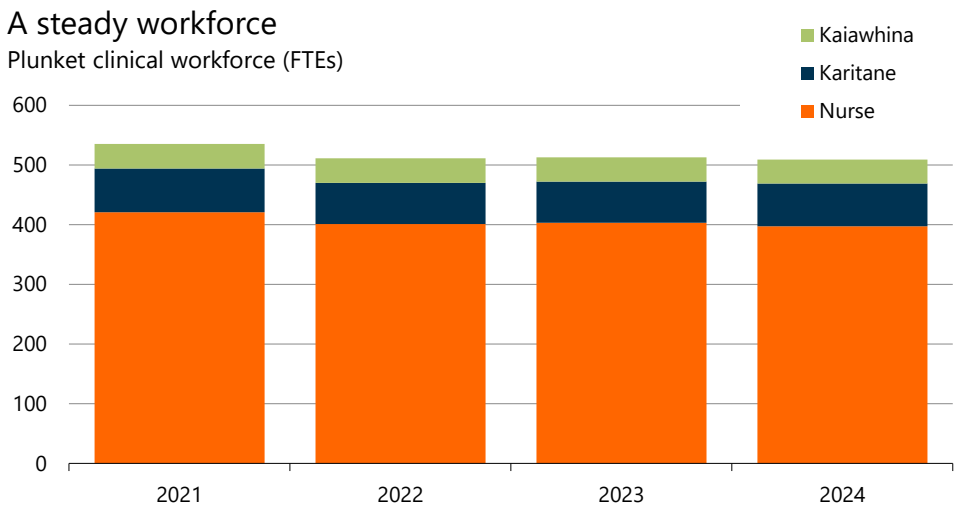
This section examines the Plunket nursing workforce. Information about the Plunket nursing workforce and its workload has been drawn together with the assistance of Plunket.

A steady workforce

Between 2021 and 2022, the Plunket clinical workforce (which is made up of nurses, kaiāwhina and karitane) fell 4.5% from 535 FTEs to 511 FTEs and stayed at around that level in 2023 and 2024. Frontline nurses, which make up over three-quarters of the Plunket workforce, fell 4.8% from 421 FTEs to 401 FTEs between 2021 and 2022 and changed very little in 2023 and 2024 (see Chart 12).

At Plunket, many frontline clinical workers work part-time so the headcount is much higher than FTEs. For example, in 2024 the clinical workforce comprised a headcount of 653 nurses, kaiāwhina and karitane, and an FTE of 509.

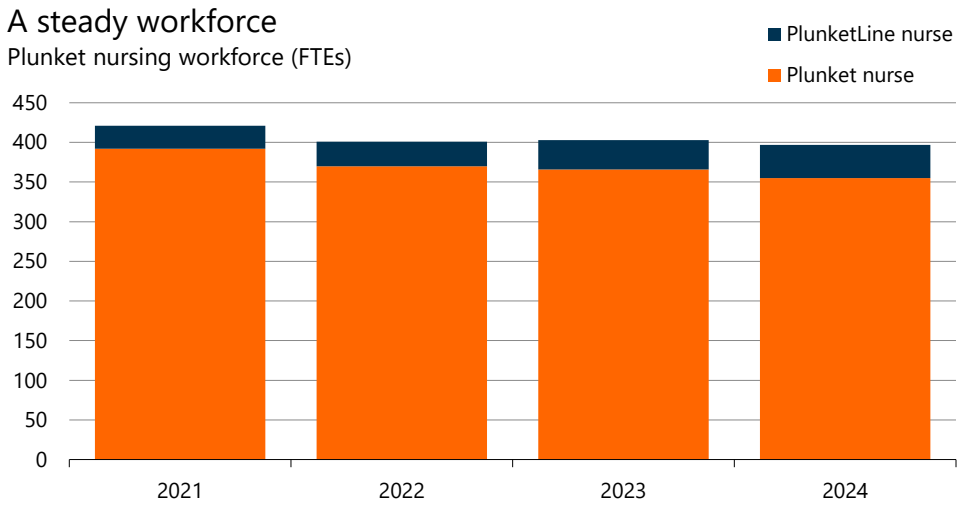
Chart 12



Source: Plunket

Plunket nurses are either PlunketLine nurses, who answer PlunketLine calls, or Plunket Nurses who practice in the community. Between 2021 and 2024, the number of PlunketLine nurse FTEs rose 45% from 29 to 42 whereas the number of Plunket Nurse FTEs fell 9.4% from 392 to 355 (see Chart 13).

Chart 13

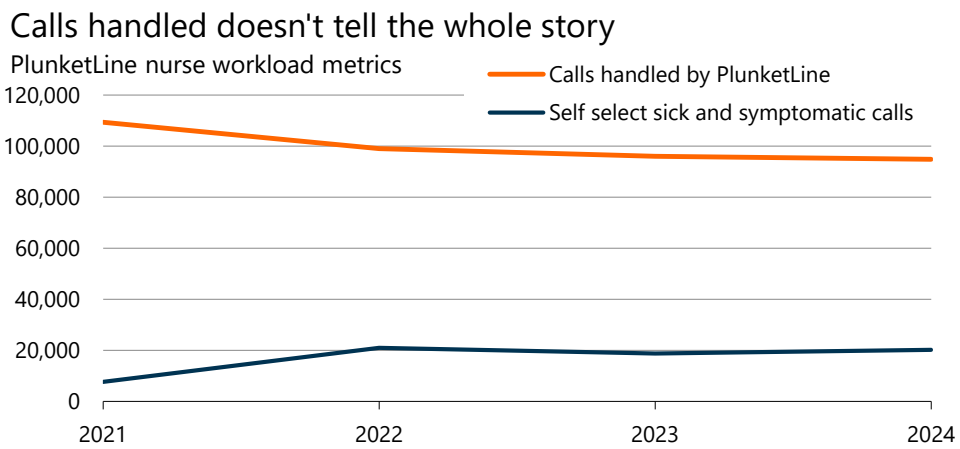


Source: Plunket

Doing more with the same

The number of calls to PlunketLine have declined in recent years. However, this does not tell the whole story. Feedback from PlunketLine nurses is that the complexity of cases has risen, which can lead to longer call times. In addition, Plunket have a contract with New Zealand Telehealth Services Whakarongorau to handle sick and symptomatic calls which PlunketLine nurses also deal with. Sick and symptomatic call numbers increased notably in 2022 (see Chart 14) and tend to take longer than traditional PlunketLine calls.

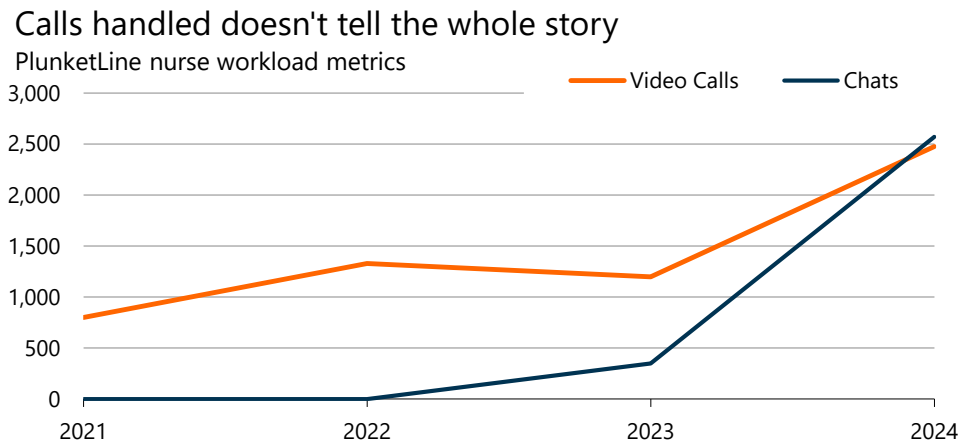
Chart 14



Source: Plunket

PlunketLine nurses also carry out video calls, for example for breastfeeding support, and respond to online chat queries both of which take longer than regular calls. Although relatively small in number, both video call and chat numbers have increased markedly in recent years (see Chart 15).

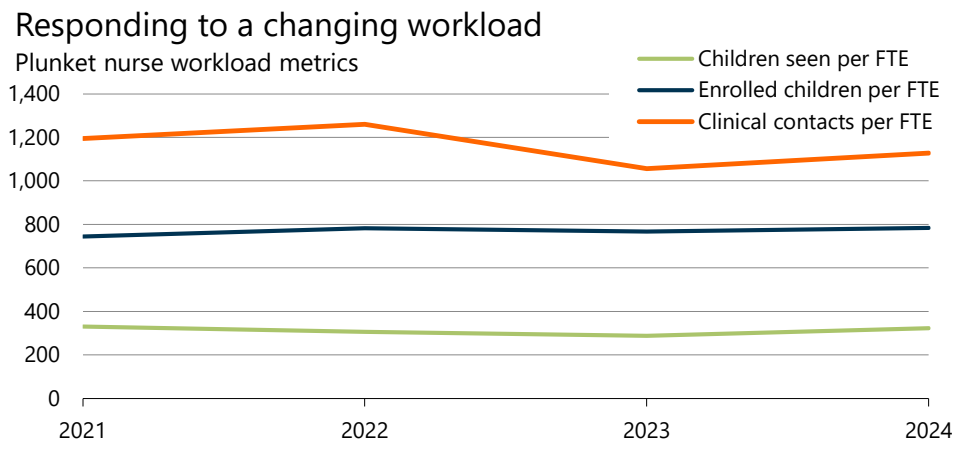
Chart 15



Source: Plunket

In Chart 16 we show Plunket Nurse workloads per Plunket Nurse FTE. Between 2021 and 2024, Plunket Nurse FTEs fell 9.4% in response to a 4.6% fall in the number of enrolled children on Plunket's books, an 11% fall in the distinct number of children seen per year and a 15% fall in clinical contacts. As a result, the number of enrolled children per FTE rose 5.3%, the number of children seen per FTE fell only 2.2%, and the number of clinical contacts per FTE fell only 5.6%.

Chart 16



Source: Plunket

Plunket have identified several priority population groups so they can respond to the unique needs of these communities. They are Māori, Pacific Peoples, people with a disability, people living in areas of high deprivation, Asian, rainbow, rural and remote communities, children in state care, and māmā aged under 20. These groups tend to be harder to reach, requiring more time and effort from Plunket's frontline workforce. However, progress is being made. For example, the proportion of babies that receive a core contact before 50 days of age has increased from 82% in 2022-23 to 86% in 2023-24 for Māori and from 86% in 2022 to 90% in 2023-24 for Pacific Peoples.

Workforce challenges

The Plunket 2024 Annual Report states that Plunket continues to have significant issues in recruiting and retaining Plunket nurses, kaiāwhina, and community Karitāne health workers due to pay disparity with their hospital counterparts.

Ahead of the September 2023 election, Plunket led a joint campaign with primary, community and telehealth care organisations calling on political parties to commit to pay parity with Health New Zealand nurses and healthcare workers for the equivalent primary care workforce. The pay gap is estimated at between 15–35%.

At the time of the pay parity campaign, Plunket had 35 nurse vacancies, potentially impacting 140 Well Child Tamariki Ora core contacts per day. Vacancy numbers are currently 20 FTEs (a vacancy rate of 5%).

For the second year in a row in 2024, Plunket had a wage surplus due to roles not being filled, which restricted Plunket's ability to deliver services. Part of the reason why staffing resources are stretched is that Plunket nurses are having to provide social support over and above what the Wellchild contract funds them to deliver.

Services are being improved and reconfigured to ensure nurses are practicing at the top of their scope and nursing time is used most efficiently. For example, administrators are handling appointment bookings, rescheduling, and diary management, which is shifting administrative tasks away from nurses.

Schools

This section looks at nurses practicing in schools. There is no centralised database containing workforce information about nurses practicing in schools. In December 2018, New Zealand School Nurses (NZSN) carried out a survey to better understand the size, characteristics, and workforce development challenges of nurses in schools. The survey found that **184** nurses were practicing in schools, over half (52%) in three regions: Counties Manukau, Auckland, and Waitemata. Over half (around 52%) were 50 or more years of age.

If we implemented NZSN recommended student to nurse ratios in all schools, as well as recommended weightings, and maximum/minimum staffing parameters, Infometrics calculates that **2,786 nurse FTEs** and a **headcount of 5,608** would be required to fully staff all New Zealand schools.

High turnover but few shortages

NZ School Nurses (NZSN) informed us that there are currently eight vacant positions. However, the number can fluctuate frequently. Annual turnover is around 20% and was as high as 40% during the pandemic. Turnover tends to vary throughout the school year, peaking in December as the year comes to a close. December vacancies tend to be filled by the time the school year begins again in February.

A range of school and student factors determine staffing

Across Ministry of Health schools that have nurses, there is a ratio of one FTE school nurse to 700 FTE students. Teen Parent Units, alternate education schools and Te Kura Kaupapa Māori (TTKM) schools funded by the Ministry of Health have a ratio of one FTE nurse to 200 FTE students. Some Ministry of Health funded schools with large numbers of students are well resourced with three to four nurses on site. Smaller schools might have drop-in clinics with a nurse visiting on a regular basis. Ratios are not implemented in Ministry of Education funded schools (see below for a more detailed explanation of funding channels).

Nurses need to be experienced to work in schools, which naturally creates an older workforce. There tends to be attrition after two years in the role, but those that stay beyond that tend to stay until the end of their career.

A fragmented setting

The employment of nurses in schools is fragmented because it has multiple funding sources and nurses are employed through a variety of agencies. About 40% of schools are funded through the Ministry of Education. Around 50% of school nurses are employed at these schools. Nurses funded in this way are employed directly by the schools.

The other 50% of school nurses are funded by the Ministry of Health. Most schools that are decile one to three[103] receive funding from Ministry of Health to employ nurses, as do Teen Parent Units, Alternative Education schools and (TKKM) schools. Te Whatu Ora either employs the nurses itself or sub-contracts employment either through Primary Health Organisations (PHOs) or schools themselves. PHOs either employ the nurses themselves, or sub-contract employment through non-governmental organisations (NGOs) or schools themselves. Private schools employ nurses directly and pay them out of their funds. Fragmentation is also reflected in the fact that there is no professional college or national association of school nurses.[104]

Fragmentation results in pay disparities

This fragmentation in funding and employment relationships results in pay disparities within the school nurse workforce. This is because some nurses are paid according to the Te Whatu Ora Multi-Employer Collective Agreement (MECA), some through the Primary Care MECA, some through the New Zealand Educational Institute (NZEI) MECA and some nurses whose employment is funded by the Ministry of Education have no pay scale at all.

Research by New Zealand School Nurses (NZSN) in 2021 found significant variation in advertised nurse pay rates across the school setting, ranging from $30 to $44.99 per hour. Anecdotally, NZSN has heard of school nurse pay rates that were only a little over the New Zealand Minimum Wage.

Furthermore, hourly pay rates don't fully reflect pay disparities within the school setting because schools that employ nurses directly tend to employ them for 40 weeks a year, not paying them during holidays. Whereas nurses that are employed by Te Whatu Ora tend to be employed for 52 weeks a year. NZSN research in 2018 found 69% of school nurses were dissatisfied with remuneration.

In 2023, NZSN published a unified draft pay scale for all school nurses. The draft pay scale has yet to be ratified by all relevant agencies. However anecdotally, NZSN has heard school nurses are already using the draft pay scale to demand higher rates of pay from their employers.

There is also a pay disparity between school nurses and nurses employed in other Te Whatu Ora services. In addition to different pay rates, disparity between school nurses and nurses in other Te Whatu Ora services is also caused by school nurses working less than eight-hour shifts (aligning with the school day). In contrast, eight-hour shifts are the standard in hospitals and other Te Whatu Ora services.

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[103] From 2023, Ministry of Education now classifies school according to an Equity Index number rather than deciles. Neither the Ministry of Education or the Ministry of Health currently has no publicly published policy on the Equity Index scores that make a school eligible for a school nurse.

[104] 'What will the new National Health System mean for School Nursing?', Cammell, C, (2021), LOGIC, The Official Journal of the New Zealand College of Primary Health Care nurses, Winter 2021 edition, https://www.nzno.org.nz/Portals/0/Files/Documents/Groups/Primary%20Healthcare%20Nurses/LOGIC/2021-09-17%20Winter%20LOGIC%202021.pdf?ver=UMrQ6-3ZtGtf8RJosZocQg%3D%3D

Scope creep

There has never been a documented standard scope of what a school nurse does and no national policies or guidelines to guide practice. Consequently, there has been scope creep in recent years as young people are increasingly dealing with health-related challenges such as mental health issues and economic deprivation.

The role of the school nurse is broad. It can encompass primary care delivery, mental health, sexual health, health promotion and education, and onward referrals. The role is broad because school nurses are first responders to health issues that arise with young people when they are at school. The role tends to be determined by the individual in the role and their nursing experience. Nurses in larger, better-funded schools can have multidisciplinary teams of education and health professionals such as counsellors and general practitioners to support them. In smaller, or less well-funded schools, the role of the school nurse can be largely autonomous. The funding model provided through Te Whatu Ora includes the provision of Nurse Educators and Programme Managers to oversee the nurses within the geographic catchment, but for nurses funded through Ministry of Education, this support is lacking.[105]

A fully funded sector

Vacancies do not tell the whole story. Considerably more school nurses would be needed if the (then) Labour Government's 2017 promise to place a school nurse in every school were enacted today. There are over 2,500 schools in New Zealand. Even placing one nurse in every school would require the current workforce of a few hundred to be considerably expanded.

NZSN also believes that the ratio of nurses to students should be 1:500 rather than the 1:700 benchmark applied to most schools. The current benchmark was based on a similar benchmark in schools in the USA and is not necessarily applicable to New Zealand.

Feedback from the school nurse workforce suggests the current ratio of 1:700 is inadequate. In NZSN's 2019 survey, 40% of respondents said they worked by themselves, only 19% said they got a regular meal break during the day, 41% felt that the level of staffing to meet student needs was inadequate, and 41% reported feeling emotionally drained from their work on a weekly basis. Additional school nurse FTEs are also needed for clinical supervision and to give nurses time away from their schools for professional development.

Infometrics has calculated how many school nurses would be required based on the following ratios of nurse FTEs to students and rating.

- Schools with an equity index rating in the 'fewer' range 1:500

All other schools:

- Māori and Pacific students 1:130
- Non-Māori and non-Pacific students 1:700

[105] 'What will the new National Health System mean for School Nursing?', Cammell, C, (2021), LOGIC, The Official Journal of the New Zealand College of Primary Health Care nurses, Winter 2021 edition, https://www.nzno.org.nz/Portals/0/Files/Documents/Groups/Primary%20Healthcare%20Nurses/LOGIC/2021-09-17%20Winter%20LOGIC%202021.pdf?ver=UMrQ6-3ZtGtf8RJosZocQg%3D%3D

- Specialist schools and Teen Parent Units 1:130
- Ngā Kura ā Iwi o Aotearoa Inc and Te Rūnanga Nui o Ngā Kura Kaupapa Māori o Aotearoa schools 1:300

Additional weightings:

- Single-sex girls' schools and Primary co-educational, secondary girls schools **5%**
- Schools in remote or very remote areas (based on Stats NZ's Urban Accessibility Indicator) **20%**

Minimum and maximum staffing:

- A minimum headcount of 2 nurses per school and a maximum of headcount and FTE of 5.

Based on these ratios, weightings, and maximum/minimum staffing parameters, Infometrics calculates that **2,786 nurse FTEs** and a **headcount of 5,608** would be required to fully staff all New Zealand schools. Even if these ratios were applied, but only schools with a 'fewer' equity index rating were staffed by nurses, this would require 593 nurse FTEs and a head count of 1,430. These estimates are significantly higher than the estimated 184 nurses currently practicing in schools.

Other workforce development issues

In 2023, Te Whatu Ora contracted the Society of Youth Health Professionals Aotearoa New Zealand (SYHPANZ) to undertake a workforce development project for the school-based health services (SBHS) workforce. SYHPANZ published a report on the desired state of the SBHS workforce in August 2023.[106] Based on feedback from SBHS staff and rangatahi in schools, the report proposed several areas for action that highlight both the workforce development challenges that nurses in schools face, and potential solutions.

- Establish a national body that can bring leadership and consistency to the SBHS workforce.
- Fund SBHS based on need and not on roll numbers.
- Increase the resources of SBHS to enable more FTEs to be employed, improve staffing ratios, and extend SBHS across all schools.
- Implement pay parity with nurses in other settings who have the same level of training and experience to enable SBHS to compete on a level playing field to attract and retain staff.
- Establish consistent standards of practice with core components of knowledge and skills that are funded, delivered, and coordinated nationally.
- Enhance access to high quality, nationally delivered training, supervision, and professional development.
- Establish a clear supported nurse prescribing pathway.
- Establish a defined and promoted youth health nursing career pathway with clear pathways for career progression.
- Promote purposeful recruitment of a diverse workforce.
- Invest in the physical spaces that SBHS staff practice in.

[106] https://www.tewhatuora.govt.nz/assets/For-the-health-sector/Specific-life-stage/Youth/SBHS/Report-on-Desired-State-of-SBHS-Workforce-August-2023.pdf

NZSN also spoke about the challenges of training nurses to practice in schools. No nurse training school currently specialises in curriculum that prepares nurses for working in schools. Part of the challenge is demand, with school nurses making up a small share of the total nursing workforce.

Recommendations

There needs to be a central repository of data about nurses practicing in schools. This should include, for each school, nurse headcount, FTEs, vacancy numbers, turnover and pay rates. This data can be complemented with data on school rolls and other school/student information from which actual nurse-to-student ratios can be calculated and compared with recommended nurse-to-student ratios.

Māori health providers

Māori health providers are providers that are owned and governed by Māori and are providing health and disability services primarily but not exclusively for Māori. Their kaupapa and the delivery frameworks are distinctively Māori, emphasising tikanga.

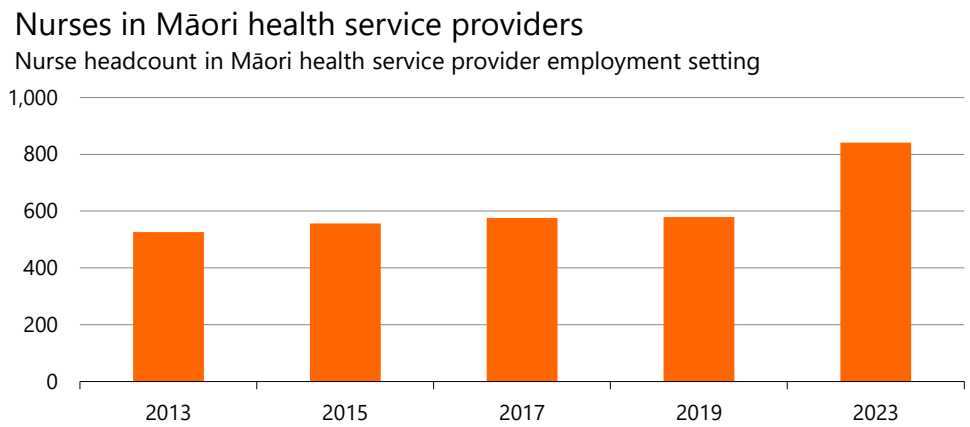
The number of Māori health providers is difficult to determine because of acquisitions, mergers, closures and the use of subsidiaries and trading names. The Ministry of Health reports that in 2022/23 there were around 310 Māori health providers (265 excluding subsidiaries), 70 more than reported in the 2019/20 year.

The types of health services delivered by Māori providers include child health, oral health, maternity, community health, specialist medicine, mental health, health of older people, and public health. Contracts delivered by Māori health providers are services targeted towards Māori, Pacific Peoples, and high-needs communities.[107]

The nursing workforce

Based on data from the Nursing Council of New Zealand, The number of nurses in the Māori health service provider employment setting grew from **526** in 2013 to **841** in 2023 (see Chart 17).

Chart 17

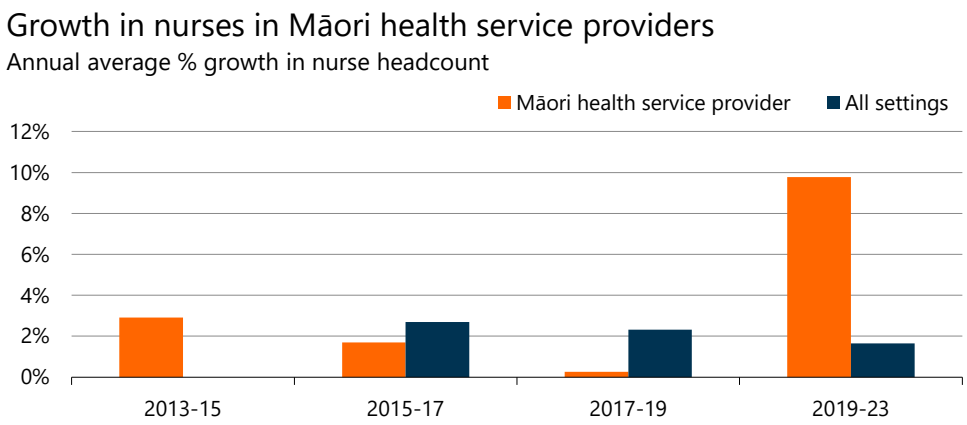


Source: Nursing Council of New Zealand

Growth in the number of nurses in the Māori health service provider employment setting has been low until recently. However, the period 2019 to 2023 saw the average annual growth rate spike at 9.8% (see Chart 18).

[107] Funding to Māori Health Providers 2018/19 to 2022/23, Ministry of Health, (2024), https://www.health.govt.nz/publications/funding-to-maori-health-providers-201819-to-202223

Chart 18



Source: Nursing Council of New Zealand

The acceleration in growth between 2019 and 2023 was due partly to a spike in the number of IQNs gaining employment in New Zealand. In 2019, IQNs made up 7.9% of the Māori health service provider workforce. By 2023, the proportion had risen to 10.1%. Across all settings, the proportion rose from 27% in 2019 to 33% in 2023.

In 2023, a total of **778** RNs, **35** ENs and **28** nurse practitioners worked in the Māori health service provider employment setting. That's a staffing mix of **94%** RNs, 4.2% ENs and 3.3% nurse practitioners. The headcounts equate to **523** RN FTEs and **28** EN FTEs.[108]

Similar issues to other types of providers

The Māori health provider nursing workforce faces many of the same issues that nurses in other community health providers face such as fragmented funding channels, funding not meeting patient needs, and funding not keeping pace with increasing patient needs. Māori health providers generally deliver care to high-needs populations. In addition to high patient acuity and co-morbidity, the work involved in delivering care to people who might be living transient lifestyles or perhaps have a low level of trust in health providers is not recognised in funding levels. Providers are also constrained in their ability to increase patient fees, particularly to low-income groups, because for many patients, fees are a barrier to access.

Funding shortfalls result in pay disparities between nurses in Māori health providers and nurses paid under the Te Whatu Ora collective agreement, such as nurses in public hospitals. In recent years, many Māori providers have missed out on parity funding for community health providers because they are technically general practices. Pay disparity has led to higher attrition rates in recent years among nurses in Māori health providers because they have left their jobs to get higher paid jobs in public hospitals.

Pay disparity also makes it even more challenging to attract nurses to work in Māori health providers. For example, one manager of a Māori health service we spoke to had had two nurse positions vacant for over 8 months.

[108] All the data in this workforce section is sourced from the Nursing Council of New Zealand workforce statistics reports, https://nursingcouncil.org.nz/Public/NCNZ/publications-section/Workforce_statistics.aspx

Nurses working in Māori health providers work long hours because they are the person that people in their community go to when they have health concerns, sometimes outside usual business hours. These longer hours are not recognised in pay rates, leading to stress and burnout. Much of the work is autonomous with very little supervision or time for professional development.

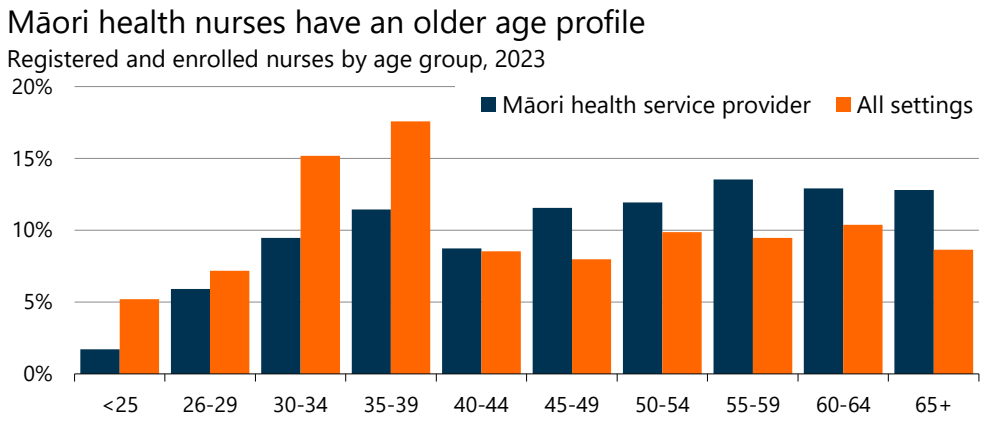
Funding mechanisms bring unique challenges

Issues specific to Māori health providers involve the nature of funding, with one-year contracts and fee-for-service contracts commonly used by funding providers such as Ministry of Health, Primary Health Organisations (PHOs) and Te Whatu Ora. Short-term contracts make it difficult for Māori health providers to provide longer-term certainty to staff whose employment is tied to contracts. Funding levels in fee-for-service contracts, such as for immunisations or smear tests, don't recognise the complexity of patient needs that need to be addressed in delivering these kinds of services.

Māori health nurses have an older age profile

NCNZ data shows that the Māori health nursing workforce is much older than the nursing workforce as a whole. In 2023, 39% of Māori health nurses were aged 55 years or older compared with 28% of nurses across all settings. The difference is most stark in the 30-39 years age bracket. In 2023, just 21% of Māori health nurses were aged 30-39 years compared with 33% of nurses across all settings (see Chart 19).

Chart 19



Source: Nursing Council of New Zealand

Projected growth dependent on funding

Infometrics projects the Māori population to grow 23% between 2023 and 2034. If we use this growth rate to project the growth of the Māori health provider nursing workforce, the number of RNs and ENs needed rises from **551** FTEs in 2023 to **679** in 2034, a rise of 128 FTEs. Most of these are RNs, whose numbers will need to rise from 523 FTEs to 645, a rise of 122.

This projection doesn't take into account that Māori health providers also serve non-Māori, so growth in the non-Māori population will also be a factor in the demand for

nurses. The projection also doesn't take into account any current unmet needs in the populations that Māori health providers serve or any future increases in patient acuity which might increase the demand for nurses over and above population growth. In terms of the number of nurses available to serve local populations, this will be determined by funding levels, pay rates and their ability to recruit the staff they need.

New Zealand Blood Service

This section looks at the nursing workforce at the New Zealand Blood Service (NZBS).

The NZBS nursing workforce

Nurses and donor technicians make up around one-third of the total staff of 908 at NZBS. Total annual employee turnover was 17% in 2023/24 and 19% in 2022/23.[109]

The clinical team at NZBS also comprises Organ Donation New Zealand (ODNZ) and the New Zealand Bone Marrow Donor Registry (NZBMDR).[110] RNs use health assessment skills and focused questioning, listening and customer service skills to determine a donor's ability to donate. RNs also undertake blood or plasma collection procedures.

Donor Technician Trainees or Qualified Donor Technicians work under the Supervision of an RN undertaking venepuncture procedures related to blood collection and a number of administrative duties.

As well as employing RNs in Collections, NZBS also employs Clinical Nurse Specialists, Nurse Educators and Transfusion Nurse Specialists. Clinical Nurse Specialists and Nurse Educators work as members of a small Training & Development team acting as role models/mentors to the Donor Services Regional teams to ensure quality service delivery. Regional Transfusion Nurses have responsibility for education, audit, and oversight of the clinical practice of transfusion within hospitals.[111]

Fostering a workforce pipeline to meet increasing demand

Demand for plasma-derived products in New Zealand is forecast to grow by more than 10%pa because it is increasingly used to treat more conditions. While the demand trend is upward, changes in clinical use and application or new innovations could cause significant upward fluctuations. A small number of clinicians ultimately control all prescribing in New Zealand and, while usage is governed by established protocols, the critical mass required to significantly increase or decrease usage is relatively small. NZBS is prioritising its ability to collect sufficient plasma to ensure surety of national supply partly by optimising use of its staff.[112] To foster a workforce pipeline NZBS is:

- planning to introduce nursing undergraduate student pilot programmes in the first half of 2025,

[109] Annual Report 2023-24, New Zealand Blood Service, (2024), https://www.nzblood.co.nz/about-nzbs/nzbs-performance/
[110] Annual Report 2023-24, New Zealand Blood Service, (2024), https://www.nzblood.co.nz/about-nzbs/nzbs-performance/
[111] https://careers.nzblood.co.nz/our-careers/nursing
[112] Statement of Intent, 1 July 2023 – 30 June 2027, New Zealand Blood Service, (2023), https://www.nzblood.co.nz/about-nzbs/nzbs-performance/

- establishing relationships with funders and external programmes to support Nursing Entry to Practice (NETP) and Enrolled Nurse Support into Practice Programmes (ENSIPP) within their Collections teams, and
- is working with NCNZ on developing competencies for IQNs now that the removal of Competency Assessment Programmes has shifted IQN education and orientation responsibilities to the employer. [113]

Pay parity

In 2024, NZNO and other unions negotiated with NZBS on matching Te Whatu Ora pay rates for NZBS nurses. There is now a New Zealand Blood and Organ Service and New Zealand Nurses Organisation Collective Employment Agreement in place for the period 12 March 2023 to 11 March 2025.[114]

Nursing and Donor Technician Strategy

In 2024, NZBS launched their inaugural Nursing and Donor Technician Strategy. The Strategy has six priorities.

1. Embodiment of an inclusive culture
2. Promoting health and wellbeing of colleagues
3. Maximising the professional contribution of nursing and donor technicians
4. Creating a workforce ready for the future
5. Recruitment and retention of nurses and donor technicians
6. Delivering safe, effective, and compassionate care[115]

[113] Annual Report 2023-24, New Zealand Blood Service, (2024), https://www.nzblood.co.nz/about-nzbs/nzbs-performance/

[114] https://www.nzno.org.nz/Portals/0/Files/Documents/Support/CA/New%20Zealand%20Blood%20And%20Organ%20Service%20%20March%202023%20to%20%20March%202025%20WEB.pdf?ver=2GopgjG_xJmJASG2if9DzQ%3D%3D

[115] Annual Report 2023-24, New Zealand Blood Service, (2024), https://www.nzblood.co.nz/about-nzbs/nzbs-performance/

Telehealth

This section examines nurses employed by organisations whose role is predominantly telehealth such as Whakarongorau Aotearoa, Ka Ora, Emergency Consult and Practice Plus.

Many nurses perform telehealth related tasks as part of their nursing role. For example, nurses in primary care might perform a telehealth triage service for their general practitioner, or a nurse in a hospice might use telehealth to support people in their homes. PlunketLine is a telehealth service for parenting issues and child health and wellbeing. These types of services are not in the scope of this section.

The nursing workforce

The telehealth nursing workforce includes nurse practitioners, RNs, nurse educators and nurse leads. Headcounts tend to be much higher than FTEs because many nurses work in telehealth part-time or on a casual basis. Often these same nurses also work in other health settings such as emergency departments or short-stay acute wards. Experience in emergency departments is valued because the triage skills used in emergency department work are transferable to telehealth. Nurse Practitioners are a key part of the telehealth nursing workforce, treating patients in the same way they do in general practices but via telehealth.

Experience needed

The feedback from the sector is that Nursing Entry to Practice graduates are not sufficiently prepared to practice in telehealth. The role is autonomous, and nurses need to be able to operate without supervision, which means some practical nursing experience is necessary. The nurses employed in telehealth tend to have five or more years' experience practicing in patient facing settings. Nonetheless, providers suggest that it would be useful to have the nursing curriculum include aspects of telehealth to ensure nursing graduates have had some exposure.

An attractive setting

Telehealth is a relatively attractive setting to work in, although the work is becoming more demanding. Vacancies are relatively scarce and easy to fill with plenty of applicants for positions. Nurses get the opportunity to work from home. It is less stressful than other settings because nurses can deal with one call at a time with no interruptions, whereas in patient facing settings such as a hospital ward, nurses are stretched across multiple patients at once. In telehealth nurses also get the satisfaction of knowing they are keeping patients out of busy emergency departments and dealing with patient needs that have not been able to be met in other settings.

However, the intensity of the work can be demanding. In times of high demand, nurses are often required to move from one call to the next without any break. A tension can also arise between wanting to remain on a call long enough to give the patient a satisfactory clinical outcome and the need to move on to other callers — although front

line staff are not expected to change their approach when demand is high. Clinical decision tools and other supports are available to help nurses deal with patients as efficiently as possible. An increasing number of calls from people with mental health issues have contributed to a more demanding working environment. Nurses are also aware of calls that are not being answered, which can put an emotional and mental strain on front-line staff.

Pay disparity

Despite telehealth services receiving funding in 2023 to help address nurse pay disparities, the 2023 pay equity settlement for Te Whatu Ora nurse widened the pay difference again between telehealth nurses and nurses in publicly funded hospital roles.

Funding mechanisms can lead to under-funding

Whakarongorau Aotearoa receives bulk funding on a 10-year contract with a 2% annual increase. Due to nurse salaries and other costs rising faster than 2%, they have had to reduce nurse FTEs. Despite an increased workload, they are expected to find efficiency savings and do more with fewer resources.

Compared with pre-COVID, call volumes have increased, and calls are taking longer, on-average, to complete. Call volumes are increasing because more people are unable to access in-person services such as GPs and mental health support. Calls are taking longer because more patients are calling in with multiple-morbidities or mental health conditions.

Underfunding is less of an issue for the services provided by Ka Ora, Emergency Consult and Practice Plus because they are either entirely or partly paid for by the patient. Contracts with other health services, such as after-hours services are also based on call volumes. These funding mechanisms mean funding is closely linked to call volumes, which means the nursing workforce can be increased or decreased according to demand. Adjustments can be made to the nursing workforce over time because (as noted earlier) telehealth is an attractive setting to work in and there are plenty of applicants for positions.

The telehealth nursing workforce is also flexible in the short-term such as over the course of a day or night. There are protocols in place to deal with instances when the number of callers increases quickly, which enable the number of nurses on duty to increase accordingly.

Scaling the service to fit funding

Unlike patient-facing services, such as emergency departments that are available 24/7, telehealth services are scaled to fit the funding they receive. In this sense, there is not a shortage of nurses in telehealth.

However, as noted earlier there is unmet need. This can take the form of calls not being answered within an appropriate timeframe, or calls being forwarded to automated messages which suggest other services that callers can try to contact.

Whakarongorau report that they monitor the number of unanswered calls. This information should be collated across all telehealth providers into a central repository and analysed to better understand the extent of unmet need in the telehealth setting, and the nurse FTEs required to meet that need.

Unlike in public hospitals, safe staffing is not defined in telehealth, which means there are no safe staffing benchmarks such as the number or duration of calls that a nurse should deal with in a shift, and benchmarks around breaks. Whakarongorau report that they have made a concerted effort to discuss adequate staffing rather than safe staffing.

Some providers have KPIs relating to the proportion of calls that are not unanswered within a set period of time There is a presumption that a certain proportion of calls being unanswered is acceptable because telehealth is not a life preserving service — patients have other alternatives if their call is not answered. However, with increasing numbers of patients calling telehealth because they are unable to access in-person services such as their GP or a mental health provider, the extent to which unanswered calls are deemed acceptable should be reviewed.

Appendix 1

Australian National Aged Care Classification (AN-ACC)

Table 19

AN-ACC resident class descriptions and mandated care minutes

AN-ACC class	Total care minutes allocation	Registered nurse minutes allocation	
Class 1	281	53	Admit for palliative care
Class 2	122	25	Independent without compounding factors
Class 3	169	35	Independent with compounding factors
Class 4	138	29	Assisted mobility, high cognition, without compoundingfactors
Class 5	185	41	Assisted mobility, high cognition, with compounding factors
Class 6	177	37	Assisted mobility, medium cognition, without compoundingfactors
Class 7	215	45	Assisted mobility, medium cognition, with compounding factors
Class 8	239	50	Assisted mobility, low cognition
Class 9	209	42	Not mobile, higher function, without compounding factors
Class 10	254	50	Not mobile, higher function, with compounding factors
Class 11	244	47	Not mobile, lower function, lower pressure sore risk
Class 12	243	46	Not mobile, lower function, higher pressure sore risk,without compounding factors
Class 13	281	53	Not mobile, lower function, higher pressure sore risk, withcompounding factors
Class 101 – Respite	163	33	Independent mobility
Class 102 – Respite	196	42	Assisted mobility
Class 103 – Respite	252	49	Not mobile

Source: The Australian National Aged Care Classification (AN-ACC) Funding Guide
https://www.health.gov.au/sites/default/files/2024-11/the-australian-national-aged-care-classification-an-acc-funding-guide_0.pdf