Kaitiaki
NURSING NEW ZEALAND

NEWS

Internationally-qualified nurses behind 12,000-surge to Australia

BY MARY LONGMORE

December 20, 2024

The number of nurses leaving to work in Australia has soared to nearly 12,000 in the past year — a 53 per cent rise, figures from the Australian Health Practitioner Regulation agency (Ahpra) show.

Photo: AdobeStock

And it's mostly driven by internationally-qualified nurses (IQNs) who have given up on New Zealand, says IQN leader Saju Cherian.

> **'New Zealand used to be a dream destination for overseas nurses – but there is no chance at all anymore'**

New Zealand 'too hard' for Māori

NZNO kaiwhakahaere Kerri Nuku said she knew of Māori nurses and other health workers who were heading to Australia to escape the heightened racial pressures in Aotearoa currently.

"They say it's too hard to be Māori at the moment. If you place the cultural

"New Zealand used to be a dream destination for overseas nurses," he told *Kaitiaki*. "But there is no chance at all anymore — no-one gets jobs here, so all the IQNs . . . are applying for registration over there."

Nursing Council director of policy, research and performance Lauren Prosser confirmed most of those leaving would be IQNs.

The number of "verification of good standing" to work in Australia requests the council had received from NZ-qualified nurses had remained stable over the past 18 months, at around 10 per cent of total requests. That suggested the growth was primarily driven by IQNs who had registered in NZ, she said.

Cherian said the loss of skill would be felt for years — and showed a "complete failure" in workforce planning.

Saju Cherian

"It's a huge loss — and it's not just the IQNs, it's also the New Zealand-trained nurses and Māori," said Cherian, who is a Palmerston North nurse and NZNO board member. "We're already short of nursing numbers for Māori and Pasifika and even those nurses are moving to Australia."

Even those in work were fed up with unsafe staffing and low pay and had lost hope under the current cost-cutting Government, he said.

"The new grads cannot find a job and they're moving — and even the experienced nurses are moving."

IQN numbers have grown rapidly and now make up 46 per cent of the nursing workforce here, according to Nursing Council statistics, after being put on the immigration fast-track during the COVID-19 pandemic. They are primarily from the United Kingdom, Ireland, India and the Middle East, the council's quarterly report (https://www.nursingcouncil.org.nz/Public/NCNZ/publications-section/Workforce_statistics.aspx#Quarterly-data-reports) shows.

But this year — along with New Zealand's own nursing graduates — many have been unable to find work (https://www.stuff.co.nz/politics/350344355/hundreds-international-nurses-are-leaving-because-they-cant-find-jobs) as Te Whatu Ora's belt-tightening bites.

'Heart-breaking' loss, say students

NZNO — Tōpūtanga Tapuhi Kaitiaki o Aotearoa student co-leader Bianca Anderson said it was "heart-breaking" but not surprising so many nurses were leaving given the uncertain job market here.

> **'It's a huge loss – and it's not just the IQNs, it's also the New Zealand-trained nurses and Māori.'**

"People need money – they need to pay their rent, afford to live and feed their families."

Last month, Te Whatu Ora said it could only employ just over half the nursing graduate cohort intead of the usual 80 to 90 per cent.

burden on them as well as the pressures in the system — they just need a break from it," she told *Kaitiaki*. "They can go to Australia and be respected in the workforce without that cultural pressure — and they will be paid well."

Kerri Nuku

Along with a hostile political environment with proposals such as the ACT Party's Treaty Principles Bill, Nuku said there were often extra cultural burdens placed on nurses in the workplace.

It was somewhat bittersweet that she observed on a recent visit that there appeared to be more strategies in Queensland to support Māori nurses and patients than in New Zealand's own health workforce plan.

NZNO student leaders, including Bianca Anderson at far right, worry about the future of the New Zealand nursing workforce with so many leaving for Australia.

"It's heart-breaking for the health system here because it means we're losing key resources to other countries instead of building it up on our country," she told *Kaitiaki.*

"It's only going to continually impact our patients and the staff who stay in New Zealand. It's going to add to the patient safety and understaffing issues we face and the burnout of the current workforce."

NZNO kaiwhakahaere Kerri Nuku said such a significant exodus meant Aoteaora was losing a valuable investment which would take a long time to rebuild.

> **'The new grads cannot find a job and they're moving – and even the experienced nurses are moving.'**

But given the lack of support here, she didn't blame them.

"Given that we've seen a workforce strategy that's looking at the status quo, rather than building up an increased workforce, I think that might reflect the sentiment: Why stay in New Zealand where there isn't support for recruitment and retention of a workforce, and not look for greener pastures?"

No jobs?

Growing exodus

Over the 2023/24 year*, 11,989 nurses from New Zealand registered to practice in Australia, under the Trans-Tasman Mutual Recognition Act — which recognises a shared set of professional standards across the two countries.

That compares to 2022/23, when 7848 nurses from New Zealand registered to practice across the ditch — a rise of 53 per cent.

A breakdown of the 2024 figures show about 700 to 900 leaving each month until May, when the number leaps to 1533 and stays around there for the rest of the year.

Stories of Te Whatu Ora's financial troubles began emerging in May.

In April, Te Whatu Ora revealed it was under pressure to cut millions in spending (https://www.rnz.co.nz/news/national/515300/hospitals-asked-to-save-total-of-105-million-by-july-te-whatu-ora-confirms) to get it back on budget. Nurses and kaiāwhina said there was no cover for sick, annual and maternity leave, and that staff weren't being replaced — despite shortages on the floor. Meanwhile, hundreds of internationally-qualified nurses struggled to find work (https://www.rnz.co.nz/news/indonz/518006/hundreds-of-experienced-international-nurses-jobless-amid-nursing-shortage) after being fast-tracked into New Zealand during the COVID-19 pandemic and global nursing shortages .

By June, there was a hiring freeze on what chief executive Margie Apa said applied only to non-frontline roles.

However, reports of a pause on recruiting mid-year graduates quickly became public. While denied by Te Whatu Ora, only three in five graduates were eventually hired compared to the normal 80 to 90 per cent.

Since then, hundreds more nursing graduates have been turned away from Te Whatu Ora — many saying they would head to Australia.

Te Whatu Ora said it had hired enough nurses. However, emails released to *Kaitiaki* reveal its nursing leaders' challenges in finding enough entry-level graduate roles in an "environment of financial restraint."

Apa told Parliament's Health Select Committee this month usually it would take 80 to 90 per cent of nursing graduates.

Nurses from NZ registered to practice in Australia

2020/21		2021/22		2022/23		2023/24	
Nurses Registered	% change	Nurses Registered	% change	Nurses Registered	% change	Nurses Registered	% change
1,268	-23.5%	2,968	134.1%	7,848	164.4%	11,989	52.8%

- *Figures supplied by the Australian Health Practitioner Regulation Agency. The figures are taken over the Australian financial year, which runs from July 1 to June 30.*

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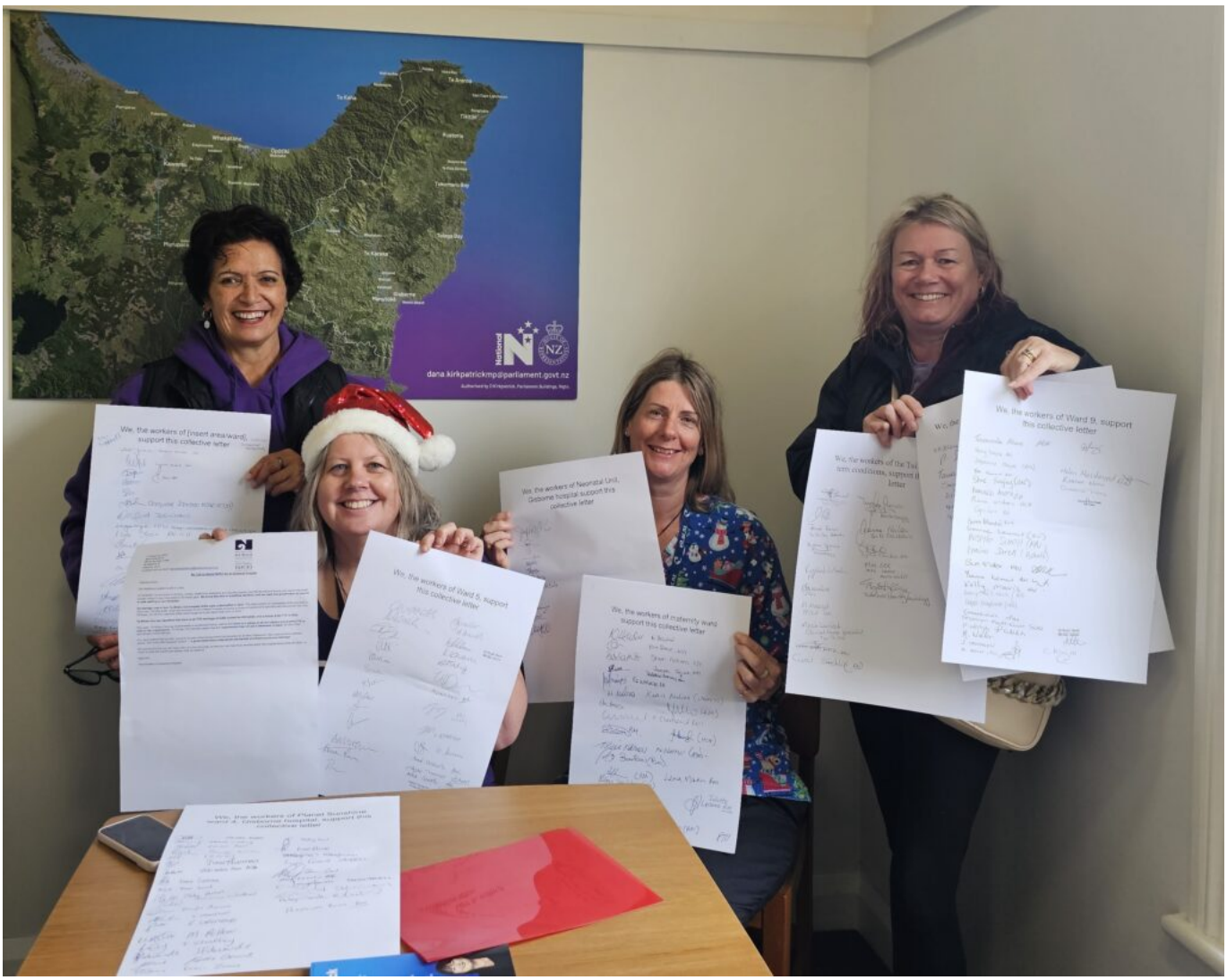
Gisborne nurses working with ‘unsafe’ out-of-date staffing levels, call on local MP to intervene

BY MARY LONGMORE

December 20, 2024

Desperate nurses in Gisborne are calling on their local MP to intervene after running on outdated staffing levels which they say are a huge risk to patient safety.



Gisborne nurses and kaiāwhina (left to right): RNs Rosina Aupouri, Michell Krawczyk and Christine Warrander, and health-care assistant Nikki Hewson with some of the signatures on their letter to local National MP Dana Kirkpatrick.

A group of Gisborne nurses has delivered a letter signed by more than 200 nurses, doctors and kaiāwhina to their local MP, National’s Dana Kirkpatrick, calling for safer staffing in hospitals.

“In Tairāwhiti, we are short of doctors, nurses, health-care assistants and security guards, and the recruitment freeze and cuts to the health budget makes it near-impossible to fill these gaps,” they wrote.

Unable to be part of this week’s rolling strikes due to unsafe weather — gale-force wind and torrential rain — the nurses and kaiāwhina instead focused on sharing their stories of a “broken health-care system” with their local MP.

“We’ve picketed in the rain before, but this was next level!” said NZNO delegate Christine Warrander.

> **‘We already know they’re trying to cut as much fat as they can and don’t really care what’s happening on the ward.’**

Meanwhile, Gisborne Hospital wards were still running on 2022 staffing allocations — despite new calculations showed more nurses were needed.

“We’re really short-staffed on our ward,” said Warrander, who last year led a health and safety strike at Gisborne Hospital despite legal action by Te Whatu Ora.

One 24-bed ward was forced to cope with just five full-time-equivalent (FTE) nurses, when 6.5 were needed to safely staff daytime shifts.

The figures had been calculated in October by safe staffing tool CCDM (care capacity demand management) which matches patient need to staff skill and numbers.

But budget for its recommended safe staffing levels had not been approved, said Warrander, who feared CCDM would be dumped altogether by Te Whatu Ora.

> **‘We were lucky and got her through that . . . but there are unsafe situations like that.’**

“Now they’re talking about doing away with CCDM completely which is going to leave us in a really dangerous place as they can just say whatever staffing they want and we’ll have nothing to back us up,” she told *Kaitiaki.* “We already know they’re trying to cut as much fat as they can and don’t really care what’s happening on the ward.”

Christine Warrander, far right, with colleagues Carmen West (left) and Carole Wallis, flanking NZNO organiser Lewis Wheatley after winning the right to strike in May 2023, despite a legal challenge.

Meanwhile, staff were run ragged, the ward was over-capacity and patient safety was compromised.

“Last week we had a patient cleared for discharge but waiting for results, so they were put in the lounge room, where there’s no oxygen, no emergency bell. She came out of there sweaty, grey and not very well at all,” Warrander said. “We were lucky and got her through that . . . but there are unsafe situations like that.”

Kirkpatrick had been invited to come and talk to them about their experiences early in the new year.

> **‘It’s going to leave us in a really precarious situation. Why can we not give our locals the jobs they’re wanting?’**

“We just want some acknowledgement and action to be taken,” Warrander said.

“We’ve had a lot of internationally-qualified nurses who have come and filled the gaps — they’re going to be leaving, so we’re going to be back to the same situation,” Warrander said.

“And all our new grads have gone elsewhere because they can’t get jobs here. It’s going to leave us in a really precarious situation. Why can we not give our locals the jobs they’re wanting?”

Dana Kirkpatrick

The letter notes that in 2023, one in four New Zealand hospital shifts on average were understaffed — yet there was a recruitment freeze in place at Te Whatu Ora, the letter said referring to figures released to NZNO (https://www.nzno.org.nz/about_us/media_releases/artmid/4731/articleid/6776/official-nurse-unsafe-staffing-figures-genuinely-alarming) under the Official Information Act this year.

> **'Health NZ is currently in negotiations with the NZ Nurses Organisation. The primary dialogue on safe staffing sits with them and discussion needs to be led by the parties involved.'**

"We know this is a political decision and we need this Government to commit to safe staffing in our hospitals," staff wrote.

Kirkpatrick told *Kaitiaki* she was happy to meet with the nurses and kaiāwhina, but could not discuss pay and conditions due to 2024/25 bargaining currently underway.

"As always, I am very aware of the skill and commitment of our Gisborne nurses in supporting the health system. . . Health NZ is currently in negotiations with the NZ Nurses Organisation. The primary dialogue on safe staffing sits with them and discussion needs to be led by the parties involved."

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2024 strikes an amazing expression of 'kotahitanga'

BY RENEE KIRIONA

December 20, 2024

The last of the health strikes for 2024 have ended with one of their negotiators encouraging nurses, midwives and healthcare workers throughout Aotearoa to keep up the "kotahitanga" leading into the new year.

ED nurse Ryan O'Donnell injecting energy into the strike in Wellington (Photographer: ROBERT KITCHIN/STUFF)

Dunedin on strike

The past three weeks have seen thousands of Te Whatu Ora workers, who are members of NZNO, take part in a nationwide strike as well as rolling strikes at various hospitals throughout the country.

Today the last rolling strikes for the year were held in West Coast, Canterbury and Hawke's Bay where the torrential rain failed to hold back nurses from hitting the picket line.

Maria Tutahi, a negotiator for the NZNO bargaining team, said members showed huge amounts of resilience, strength and unity during the strikes.

"Our voice was one and we will need to keep that kotahitanga or unity leading into 2025. There have been two mediations with Te Whatu Ora over the past three weeks, but no movement on the collective agreement yet.

"So we all need to come back next year with some more collective kaha or spirit," said Tutahi (Ngāi Tūhoe) who spoke of a proverb the late King Tāwhiao used in reference to strength in unity.


Maria Tutahi

> **'Ki te kotahi te kākaho ka whati ki te kāpuia e kore e whati – If there is but one reed it will break, but if it is bunched together it will not.'**

NZNO president Anne Daniels described the Wellington picket lines as "energetic."

"Every member I spoke to knew what the issues were and why we were striking."

The bargaining team's next date with Te Whatu Ora negotiators will be January 20 in Wellington, where two days have been set aside for that meeting.

ED nurse Ryan O'Donnell reiterated in his picket line speech to his colleagues at Wellington Hospital yesterday, that while there were many claims (https://maranga-mai.nzno.org.nz/2024_claims), the most important was achieving more safety for patients.

“We’re not in this for the money! And everyone on this picket line actually wants to be with their patients but when their safety is being compromised, we have to get out here and get noisy, stand up for them.

“And we will keep standing up together, until we get the change that’s needed.”

NZNO bargaining team

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NEWS

Papers reveal directors of nursing fighting for graduate employment

BY MARY LONGMORE

December 19, 2024

No pause? Fear, confusion and 'murky waters' as directors of nursing (DONs) say they were not permitted to hire mid-year graduates.

Photo: AdobeStock.

Correspondence released to NZNO-Tōpūtanga Tapuhi Kaitiaki o Aotearoa under the Official Information Act (OIA) reveals DONs around the country in June were being denied permission to recruit new graduates.

"We have to have our NETP/NESP numbers into ACE by Friday and at this stage with no authority to approve these at a district or regional level (using vacancy) we are at serious risk of not having NETPs and NESPs for July-Sept," one DON emailed Te Whatu Ora's newly appointed chief nurse Nadine Gray on June 18.

They are referring to supported nurse graduate entry positions, NETP (nurse entry-to-practice) and NESP (nurse specialist-entry-to-practice, for mental health nursing).

Pause or not?

The murky financial waters Te Whatu Ora was navigating first emerged in April, when a series of leaked emails to RNZ revealed it had been ordered to save $105 million (https://www.rnz.co.nz/news/national/515300/hospitals-asked-to-save-total-of-105-million-by-july-te-whatu-ora-confirms) by July 1.

In June, Te Whatu Ora's chief clinical officer Richard Sullivan instructed

Nadine Gray

On June 26, another DON said no graduate recruitment had been approved for their region. "At this point in time, we have not received regional approval or managed to progress current nursing vacancy forms to replace nursing staff with NETP/new graduate recruitment."

'The reason I ask for this clarity is that we all still seem to be in murky waters with this.'

One, on June 4, said "no [safe staffing calculator] CCDM council agreed FTE calculations are being improved for recruitment . . . so our July recruitment will be very diminished."

Another DON on June 26 says Gray's suggestion that graduates be "staggered" into NETP roles over time, rather employed as a single cohort, was "not workable".

A different DON, on June 25, asks for clarity over graduate recruitment due a "disconnect" between regional recruitment panels and the ACE [national job-matching] process.

"The reason I ask for this clarity is that we all still seem to be in murky waters with this."

A recruitment freeze (https://www.rnz.co.nz/news/national/519492/health-nz-orders-immediate-hiring-freeze-on-non-frontline-roles) for all non-frontline roles had just been put in place on June 13. Te Whatu Ora chief executive Margie Apa said it would not impact frontline services.

But a few days later on June 19, leaked news that mid-year graduate recruitment had been frozen due to budget constraints sparked an outcry.

On June 21, Gray flatly denied this, stating to *Kaitiaki*: "There is no recruitment pause" and graduates would be employed where there were vacancies.

nursing and clinical leaders on June 18 to pause mid-year graduate recruitment due to budget constraints, more leaks suggested.

Anyone who had held vacancies for the graduates would now have to fill out a "request to recruit" form but only if the role was critical, communications sighted by *Kaitiaki* stated.

The reported student freeze hit the news (https://www.rnz.co.nz/news/national/520062/graduate-nurses-not-guaranteed-jobs-under-health-nz-budget-cap-union) after an NZNO press release (https://www.rnz.co.nz/news/national/520062/graduate-nurses-not-guaranteed-jobs-under-health-nz-budget-cap-union) on June 19.

NZNO — Tōpūtanga Tapuhi Kaitiaki o Aotearoa chief executive Paul Goulter said the decision to pause graduate recruitment was "incredibly disappointing" and a blow to the nursing workforce.

NZNO student co-leader Shannyn Bristowe said Te Whatu Ora had "trampled on the mana of the future workforce".

Chief nurse Nadine Gray responded by saying there was no pause and graduates were being employed "where we have vacancies.

"It is important to remember that the health sector in New Zealand is bigger than just Health NZ. Graduates may also be employed in primary/community care, aged residential care or public health."

'MH&A [mental health and addictions] roles are priority roles and exempt from the current recruitment pause.'

"Any statements saying otherwise are incorrect."

However, along with the DON comments, in a separate batch of correspondence released to *Kaitiaki* under the OIA, Gray refers to a "current recruitment pause" on June 24.

Andrew Slater

"Applicants for the nurse entry to specialty practice (NESP) roles will be offered positions, as MH&A [mental health and addictions] roles are priority roles and exempt from the current recruitment pause," Gray, outgoing chief nurse Emma Hickson and strategic workforce manager Allison Plumridge wrote in a proposal to chief people officer Andrew Slater.

Asked about the email this month, Gray said she had been referring to a pause on non-clinical recruitment.

"The recruitment pause referred to in the email on 24 June was in reference to the organisation-wide pause on recruitment of hospital roles that were not patient-facing, public health roles that were not community-facing and on enabling services such as people and communications and finance."

> **'There is no funding available from the nursing workforce 2023/24 budget to provide any support to ensure new graduate nurses can be placed in roles.'**

Gray said recruitment for frontline clinical roles continued "in line with budget FTEs [full-time-equivalent positions]" available. Between June and October this year, 1452 offers of employment were made to nurses and accepted, she said.

'No funding' for graduates

Pause or not, the challenge of finding roles for new nurses in an "environment of financial restraint" is clear in a mid-June flurry of emails, including Gray's.

There were lengthy discussions about managing the 535 mid-year graduates who had applied for entry jobs at Te Whatu Ora through its national job-matching system, ACE (advanced choice of employment).

Shannyn Bristowe

In an undated internal memo to Slater, Gray and Hickson refer to "well-documented" nursing workforce shortages, which meant it was "imperative" to place and retain new graduates — particularly Māori and Pacific.

But: "There is no funding available from the nursing workforce 2023/24 budget to provide any support to ensure new graduate nurses can be placed in roles", they said.

Gray expressed hope there might be funds allocated from Te Whatu Ora's wider 2023/24 budget. It was not clear if this happened.

But on July 17, Te Whatu Ora confirmed it had taken three in five of the mid-year graduates. This is far lower than what Apa told the Health Select Committee this month was its normal 80 to 90 per cent hiring rate for new graduates.

Backlash fears

While much is redacted, the documents also show several emails among Te Whatu Ora managers, nursing leaders and media advisors about how to publicly communicate the lack of jobs for graduates.

They also reflect a deep concern from nursing leaders and educators across the country, many of whom were worried about a backlash and wanted to know what to say to ākonga — students — about to graduate.

Graduate nursing roles have been hard to find this year.

Minister of Health Shane Reti's office also asked Te Whatu Ora on June 20 whether all the mid-year graduating class would be employed. "Employed somewhere?"

Gray's agreed statement was that graduate nurses would be matched according to available vacancies but they may have to consider roles outside hospitals in primary and aged care due to high nurse recruitment in 2022/23.

Proposed solutions included a "staggered approach" to recruitment to keep within budget, expanding supported-entry places available in primary, community and mental health, financial incentives for non-hospital employers and prioritising Māori and Pacific graduates.

The correspondence shows Gray was also preparing for a similar message to end-of-year graduates — — hundreds of whom ended up missing out on jobs.

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Hospital-supported training for 45 Manawatū kaiāwhina brings better patient care

BY MARY LONGMORE

December 18, 2024

A group of 45 kaiāwhina at Palmerston North and Horowhenua hospitals has become the region's first cohort to graduate with a level three certificate in health and wellbeing — and patient care has hugely improved as a result.

Newly graduated kaiāwhina from Horowhenua and Palmerston North hospitals.

Te Whatu Ora MidCentral nurse educator Raewyn Ormsby-Lobo said it was one of the largest cohorts of hospital-based kaiāwhina to graduate in New Zealand.

"We have long recognised the value of our kaiāwhina and their outstanding contribution to patients and their whānau, as well as their support of our nursing staff."

Ormsby-Lobo said the nursing team had noticed a "huge improvement in patient care" as well as fewer pressure injuries since the training.

Others said they felt more confident to speak up for patients after the training.

The training also included safe patient handling, Māori and Pacific cultural values, and dealing with challenging behaviours, she said.

One long-time health-care assistant (HCA) David Goldstone he found it helpful to keep up with evolving practices in health care.

David Goldstone

"A few things have changed since 20 years ago, since I first started."

Training as part of a larger cohort was also good for team support, he said.

"It is worth doing and worth having."

Others said they felt more confident to speak up for patients after the training.

Many were now considering progressing with their level four certificate (https://www.careerforce.org.nz/qualifications/new-zealand-certificate-in-health-and-wellbeing-level-4-advanced-care-and-support/) in health and wellbeing, a two year course, Ormsby-Lobo said.

The COVID-19 pandemic revealed the "untapped potential we have in our kaiāwhina" and nurturing this was a priority for Te Whatu Ora MidCentral.

> **'In some instances, they may just be getting formal recognition for existing competencies.'**

Originally, 54 had enrolled, however some retired, resigned or moved hospitals over the year, Ormsby-Lobo said.

Te Whatu Ora MidCentral had partnered with work-based learning provider Careerforce — part of Te Pūkenga — to support the kaiāwhina's training.

The kaiāwhina — who worked across acute care, medical, mental health, operating theatres, outpatients and older adults — had worked hard to complete the on-the-job training over the year, she said.

Now, their skills at providing person-centred care under the direction of a nurse or other registered health professional would now be formally recognised.

"In some instances, they may just be getting formal recognition for existing competencies."

The 'mana and contribution' of kaiāwhina

Ormsby-Lobo said the term kaiāwhina encompassed a range of non-regulated roles in the health and disability sector such as health-care assistants or nurse aides and reflected the "mana and immense contribution of this large and diverse workforce".

Te Whatu Ora MidCentral planned to roll out more kaiāwhina training in the new year — including those who work with district nurses in the community. Other regions had also shown interest in picking it up, she said.

Careerforce workplace advisor Elaine Dittert said she was delighted to see Te Whatu Ora's commitment to upskilling the kaiāwhina workforce

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NEWS

Rolling nurse strikes reinforce plea for patient safety

BY SAMESH MOHANLALL AND RENEE KIRIONA

December 13, 2024

Thousands of Te Whatu Ora nurses and kaiāwhina at different locations throughout the country are taking part in rolling strikes, reinforcing their message for more patient safety.

Whanganui member (main photo) don't let the rain get in the way of their rolling strike. Photo top left by Jos Wheeler.

The strikes so far have been in Auckland, South Canterbury, Counties Manukau, Whanganui, Wairarapa, Bay of Plenty, Lakes region and the Hutt Valley.

Hutt Valley nurse Nathan Clark said NZNO members have been fighting and advocating for years for safety for their patients.

"As health professionals we know that nurses at bedsides and safe staffing provides for a better outcome, better patient care and patient experiences when receiving health care services.

"The approach Health NZ has taken to put a halt to increase staffing levels, using a tool they agreed upon, shows they really don't put patient safety and care at the forefront of what they do," Clark said.

> **'To stop the recruitment of healthcare workers because they only see a cost and not an asset or value in skilled people, is an absolute insult.'**

South Auckland members on rolling strike

Next week, rolling strikes are planned for Midcentral, Northland, Waitematā, Waikato, Tairawhiti, Taranaki, Capital, Coast and Hutt Valley, Nelson-Marlborough, Hawke's Bay, West Coast and Canterbury.

Masterton members on rolling strike

Clark said while the plight of Te Whatu Ora nurses was focused on patient safety the recent offer by their employer of one per cent, was a further "insult."

"The offer of one per cent is further insult to an already overburdened workforce that is despite recent hiring is still struggling to recruit and retain its workforce.

"The offer won't come into effect until April 2025 – six months after our current contract has expired so its 0.5 per cent on existing base rates and when factoring in inflation is an effective pay cut of three per cent.

"We need an offer that is going to retain our workforce, more so as an insult when only half of the new graduate workforce has been employed."

The rolling strikes follow last week's hugely successful national strike.

They continue this week in midcentral district, Northland, Waitematā, Waikato, Taranaki, Tairāwhiti, Hawke's Bay, Wellington, Nelson-Marlborough, Canterbury and the West Coast. All details can be found here (https://maranga-mai.nzno.org.nz/te_whatu_ora_strikes_december_2024).

Dunedin members on rolling strike

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Health workforce plan to grow-our-own 'hollow', says NZNO

BY MARY LONGMORE

December 13, 2024

Te Whatu Ora's plan to train more local health workers is a hollow promise given how few graduates it has employed, says NZNO — Tōpūtanga Tapuhi Kaitiaki o Aotearoa kaiwhakahaere Kerri Nuku.

Young woman in a medical mask holds a stethoscope with the flag of New Zealand on a light background. Concept of medicine, virus, epidemic, vaccination.

Te Whatu Ora this week released its health workforce plan (https://www.tewhatuora.govt.nz/publications/health-workforce-plan-2024) for 2024–2027.

It identifies two broad areas of focus: Modernising care through technology and new approaches; and improving workforce supply, by training more health workers locally and faster overseas recruitment.

'It is entirely drawn from operating within a constrained funding environment and repeatedly

cites workforce planning around 'living within our means.'

Kerri Nuku

But Nuku said its hope to train more local health workers "rang hollow" given how Te Whatu Ora had failed hundreds of new graduates. Nor had there been any improvement in Māori and Pacific nurse numbers over many years to better reflect their populations.

"Māori nurses are 7.5 per cent of the nursing workforce but Māori are 20 per cent of the population. Te Whatu Ora needs to properly invest in Māori-focused programmes, continue to fund effective initiatives to increase recruitment and retention of the Māori workforce and grow mātauranga Māori specialists," Nuku said.

Pacific nurses are four per cent of the nursing workforce, but people who identify as Pacific are nine per cent of the population, Nursing Council data suggests.

Nuku said the whole plan appeared to be focused on capping costs, not patient need.

"It is entirely drawn from operating within a constrained funding environment and repeatedly cites workforce planning around 'living within our means' and 'ensuring more sustainable workforce translates to a more financially sustainable system'."

Instead, she said Te Whatu Ora needed to employ enough nurses to safely care for patients. That meant removing its current pause on safe staffing calcuations, and implementing safe nurse-to-patient ratios.

Better health workforce planning, for now and the future, was needed, she said.

In the plan, Te Whatu Ora chief executive Margie Apa said an ageing population and more complex health conditions meant health system had to "work differently to remain sustainable and affordable".

Margie Apa

It outlines five priorities for the next three years:

- Getting workforce basics right like ensuring New Zealand is training the workers it needs and retaining students with financial and cultural support.
- Improving productivity through technology.
- Keeping people in the community, including with more nurse practitioners.
- Grow parts of the workforce that will help achieve the Government's five health targets such as anaesthetic technicians and mental health nurses.
- Improve diversity and inclusiveness of the health workforce, including Māori and Pacific.

The plan estimates "if nothing changes" New Zealand will need 4100 more nurses, 3450 more doctors and 4450 more allied health workers by 2033.

But nothing changing was "not tenable" and New Zealand needed to adapt its workforce to increase specialisation and "top of scope" work for nurses. A bigger "allied workforce" would also allow more affordable care.

Apa said the plan sets out the first of a three-year "journey we want to take".

Kaitiaki
NURSING NEW ZEALAND

NEWS

‘It’s cruel’ – just one in seven new enrolled nurse graduates get Te Whatu Ora jobs

BY MARY LONGMORE

December 5, 2024

A week after turning away hundreds of RN graduates, Te Whatu Ora confirms it has only offered 15 end-of-year EN graduates a job.

Photo: AdobeStock.

Just 15 out of 104 enrolled nurse graduates from the end-of-year cohort — 14 per cent — have secured jobs at Te Whatu Ora.

NZNO enrolled nurse (EN) leaders say such a low rate of employment was “cruel” and risks disillusioned ENs abandoning the workforce altogether after 18 months of training.

Te Whatu Ora chief nurse Nadine Gray told *Kaitiaki* that 51 out of 196 applicants over the year had secured ENSIPP (enrolled nurse support into practice) positions — about a quarter. But broken down, that figures includes 36 out of 92 mid-year graduates — just over a third — and just 15 out of 104 end-of-year graduates.

> **'If enrolled nurses are unable to gain employment after completing their education, they may become disillusioned with the profession and potentially leave nursing altogether.'**

That now left 145 EN graduates in the talent pool, including 15 Māori and eight Pasifika, she said.

"We highly value the skills and knowledge enrolled nurses bring to their roles," Gray said. "We encourage graduate nurses to be flexible around the location and type of work they are seeking."

Gray said a newly expanded scope of practice for ENs — coming into effect from January 20, 2025 — would give more job flexibility.

"Under the new scope, enrolled nurses can access guidance from a registered nurse or other registered health practitioner. The broadening of health professional guidance is expected to enable enrolled nurses to work in a wider variety of settings."

But NZNO enrolled nurses section (ENS) leaders Michelle Prattley and Tina Giles said many would simply give up or move overseas.

NZNO's enrolled nurse section is unhappy with a one-in-seven employment rate for EN grads. Chair Michelle Prattley, third from right in red, and Tina Giles on the far right.

"If enrolled nurses are unable to gain employment after completing their education, they may become disillusioned with the profession and potentially leave nursing altogether."

Employing so few would also "diminish the role and visibility of ENs within the broader health-care team", they said.

Prattley — who described the low intake as "cruel" and "sad" — said Te Whatu Ora's recent pause in safe staffing calculations (https://www.nzno.org.nz/about_us/media_releases/artmid/4731/articleid/6840/te-whatu-ora-nurses-to-take-

nationwide-strike-action) would likely result in even fewer EN roles.

"Without an ENSIPP programme to support their confidence and growth . . . they will end up working as health-care assistants or not knowing where to find support," she said.

> **'The broadening of health professional guidance is expected to enable enrolled nurses to work in a wider variety of settings.'**

ENSIPP offers EN graduates professional development support including clinical and pastoral in their first year.

"With this in mind, we see the potential for new grad enrolled nurses to leave New Zealand and go overseas to seek employment with support," Prattley said.

Nadine Gray

Asked for 2023 EN employment rates to compare, a Te Whatu Ora spokesperson said it would provide those next week.

Last week, *Kaitiaki* revealed just over half — 844 — of 1614 new registered nurse (RN) graduates who applied had secured entry jobs at Te Whatu Ora, leaving 770 jobless.

Nadine Gray — who has spoken of how she began her nursing career in aged care — said graduates should consider jobs in primary and community health and aged care.

> **'If enrolled nurses are unable to gain employment after completing their education, they may become disillusioned with the profession and potentially leave nursing altogether.'**

But graduates say pay scales are up to 20 per cent lower and there can be a lack of supported entry roles for new nurses. Many told *Kaitiaki* they planned to head to Australia.

NZNO student leader Bianca Anderson has accused Te Whatu Ora of failing in its most basic duty — planning future nursing workforce.

- *The long-fought-for new EN scope of practice removes the requirement that ENs be under the direction and delegation of RNs. Further details can be found here (https://nursingcouncil.org.nz/MyNC/NCNZ/News-section/news-item/2024/11/Enrolled-and-registered-nurse-scopes-of-practice-and-standards-of-competence.aspx).*

Kaitiaki
NURSING NEW ZEALAND

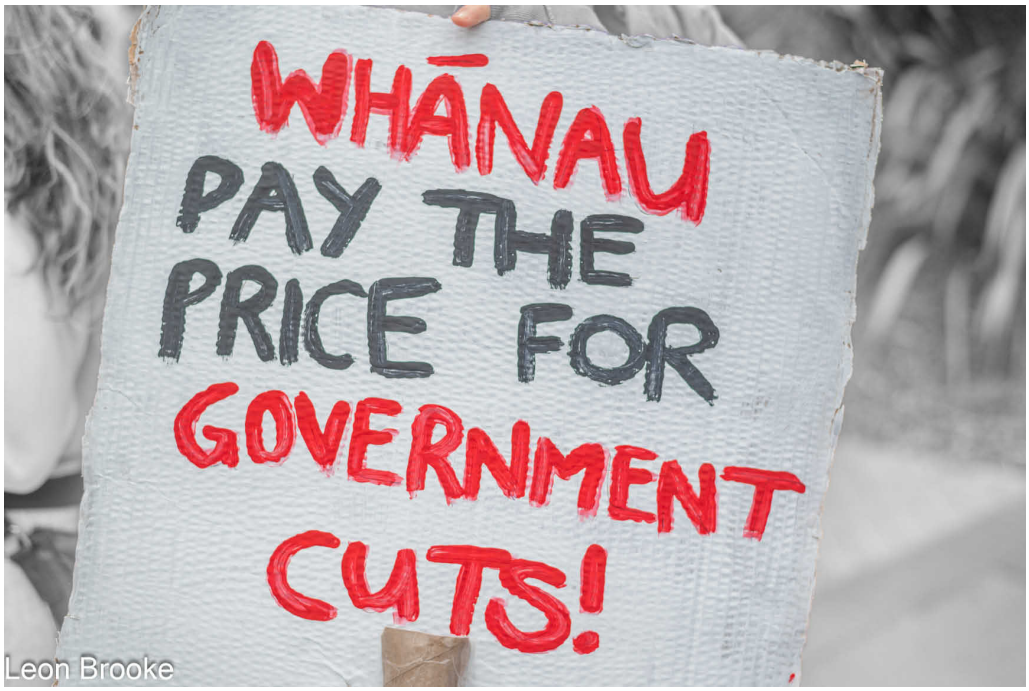
NEWS

Nationwide strike: 'It's not right' – patients speak up

BY RENEE KIRIONA AND MARY LONGMORE

December 4, 2024

"Our hospitals aren't safe – I've seen it. We need more nurses and they need to treated better and paid properly."



John Takamore stood at the picket line outside Wellington Hospital, just as passionate as hundreds of nurses and midwives who went on strike yesterday.

For the past five years, he has been in and out of hospital for prostate cancer.

"Nurses are expected to cover a lot of ground for mediocre pay," he said.

"Government wants cheap labour so it is gambling with our lives.

"Our hospitals aren't safe – I've seen it. We need more nurses and they need to treated better and paid properly."

John Takamore

Up to 30,000 nurses, midwives and health-care workers throughout the country went on strike yesterday. Their main concern is staffing levels not being safe for their patients and themselves. They are all members of NZNO.

An outpatient from Porirua, who wanted to be known as Christina, said she wanted the Government to invest more in New Zealand nurses.

Christina

"The international nurses are just as good, but we need to focus on our nurses from our own backyards," she said.

"It's not fair that they study for years and so many of them miss out on jobs and end up going overseas.

"The nurses don't have the time to look after people like they should. They are overworked and undervalued and have been for too long. It is time for this Government to invest in all those nursing graduates in this country who are waiting for a job."

George

> **'It is time for this Government to invest in all those nursing graduates in this country who are waiting for a job.'**

George, from Tauranga, said nurses are the "backbone of the health system."

"I'm sick of seeing nurses striking. Governments needs to stop resisting, and really listen to nurses."

Wellington

The strike picket outside Wellington Hospital saw about 300 nurses and midwives turn out.

Green Party co-leader Chlöe Swarbrick showed her support to the NZNO members there.

"We currently have a tax system that sees 311 of the country's wealthiest households pay an effective rate of less than half that of the average New Zealander," she said.

> **'If we can fix the tax system, we will be able to fix many others systems including health.'**

Chlöe Swarbrick

"If we can fix the tax system, we will be able to fix many others systems including health."

Auckland

Nurses in Auckland got creative during their strike, joining hands and arms and legs to form the letters WTF. And no – it does not stand for what many of you might be thinking.

Auckland on strike – hundreds of nurses join to form the WTF message

The acronym actually poses a very important question – where is the funding?

Hutt Valley

District nurse Leiani Blair with daughter Millie

Outside Hutt Hospital, up to 200 nurses and kaiāwhina – supported by doctors – were on a very noisy High Street, calling for safer staffing.

"Hutt people love to toot!" laughed one of the nurses, as more deafening horns rolled past.

What's causing the safety issues?

NZNO delegate, and enrolled district nurse, Leiani Blair told *Kaitiaki* lack of staffing meant district nurses could not pair up to do risk assessments. "There is not enough of us to go in pairs, most of the time," said Blair, who had personally felt unsafe several times.

Nurse practitioner Sue Anderson said safe staffing tool CCDM (care capacity demand management) "held them accountable to have proper staffing – of course they're going to want to get rid of it."

> **She said already staff who left or went on maternity leave were not being replaced and she only feared things would get worse.**

She said already staff who left or went on maternity leave were not being replaced and she only feared things would get worse.

"The future's looking really crap – no-one's going to want to do these jobs."

Nurse educator Jaydeen Thistoll said it would be very hard to safely staff the hospital without CCDM, which had made a huge difference. "How are we going to manage safe staffing without it?"

Delegate Eden Baker said CCDM had made a huge difference.

"For me, it's not just about the pay – although that's insulting – but having safe staffing just creates a more healthy environment for everybody – patients and nurses."

Nurse Reshmi Lata said the medical wards were regularly at orange or yellow status (understaffed).

NZNO delegate Nathan Clark – who was wearing his Christmas Grinch scrubs in a message to Te Whatu Ora — said nursing seemed hugely undervalued by Te Whatu Ora currently.

Nathan Clark

Naomi Waipouri and Sue Anderson

"We are going to see our youngest and brightest go overseas, while we have an ageing workforce."

But Te Whatu Ora had a fight on its hands, he added. "The gloves are off – I'm from the Hutt."

Support from doctors

Doctors also joined nurses on the picket lines.

Hutt doctors Tania Wilton Lydia Dunford and Aniruddh Kirtikar came out in support of nurses

Tania Wilton said nurses were "the backbone of the system", while Lydia Dunford said it was about being a team.

"We all work together for the patients, so what affects nurses, affects us and patients."

Kaitiaki
NURSING NEW ZEALAND

COLLEGES & SECTIONS

‘It can be lonely’ – NZNO nursing leadership section wants to support all senior nurses

BY THE NZNO NURSING LEADERSHIP SECTION COMMITTEE

December 4, 2024

In the first of a new monthly viewpoint from NZNO colleges and sections, Kaitiaki talks to the nursing leadership section.

COLLEGES & SECTIONS

Photo: AdobeStock.

With a complete change of committee members this quarter and an impressive growth in members, NZNO's nursing leadership section (https://www.nzno.org.nz/groups/colleges_sections/sections/nzno_nursing_leadership_section) wants to connect and support senior nurses, wherever their role.

We are open to any nurse in a leadership role joining the section. That's really important as there are as many ways to nurse as there are nurses – and there are a lot of senior registered nurses (RNs) around, they just might not have ACNM (associate charge nurse manger) for example, as part of their title.

The nursing leadership section has surpassed its own five per cent growth target this year, with 805 members – about 160 up on 2023. This is heartening and we feel it is due to our continued efforts to be relevant and supportive.

It can feel lonely in a nurse leader position – or any leadership position, without the right support.

Through surveys, coaching and mentoring workshops and monthly leadership blogs (https://www.nzno.org.nz/groups/colleges_sections/sections/nzno_nursing_leadership_section/blog), the section aims to connect with all types of senior nurses, across all areas of nursing.

The section's logo — te wheke (octopus) – is an acknowledgement of this, reflecting the many arms of senior nursing, across all aspects of the profession. As part of the professional arm of NZNO, we represent nurses across the board, including nurse practitioners, clinical nurse managers, associate nurse managers and educators — so we really want to try and meet all that need.

This year, our survey found feeling isolated was one of the challenges for senior nurses or nurses in leadership roles. Our members told us it can feel lonely in a nurse leader position – or any leadership position — without the right support.

Our feeling is that we're all nurses and we need to retain the wisdom in the workforce.

The section's senior nurse coaching and mentoring workshops (https://www.nzno.org.nz/groups/colleges_sections/sections/nzno_nursing_leadership_section/mentorship_coaching) have been well taken up. The committee wants to build on that success by finding more ways to support senior nurses/leaders around the motu, regardless of which part of the health sector they work in.

We want to retain people in nursing and if we can support any of those senior nurses, no matter what their job title is — we're all about that. Our feeling is that we're all nurses and we need to retain the wisdom in the workforce.

Challenging time for nursing

It is a challenging time currently for anyone working in the health system, whether it's in hospitals, community or aged care — and with budget pressures, there is more pressure on nursing leadership.

Te Whatu Ora is under well-publicised pressure to cut $100 million (https://www.rnz.co.nz/news/national/534775/public-sector-job-cuts-te-whatu-ora-considers-more-redundancies) from its budgeted spending this year – right down to whether staff can drink Milo (https://www.rnz.co.nz/news/national/533755/health-nz-commissioner-steps-in-to-stop-staff-losing-milo) or provide toast for new mums (https://www.rnz.co.nz/news/national/526706/outcry-after-hospitals-denies-new-mums-toast-and-tea-after-labour).

A proposal to cut four directors of nursing this year has been criticised by NZNO as another blow to nursing leadership.

> **We need to accurately represent what senior nurses and nurse leaders think about pay, funding cuts or the Treaty Principles Bill – all those sorts of things.**

Senior nurses are waiting for better pay relativity — the boost to the RN scale last year means it nearly surpasses the senior nurses' own lower steps.

Nurses are looking forward to 2024/2025 bargaining between NZNO and Te Whatu Ora, which must surely see senior nurses better recognised for their responsibilities. The recent announcement of about $10 million of funding for 75 senior/specialist nurses in areas with shortages such as mental health/critical care/rural health is a positive step.

Professional voice

It is important for college and section members, as experienced professionals, to have a say at NZNO – Tōpūtanga Tapuhi Kaitiaki o Aotearoa board level, and have input to these conversations happening within and around the organisation and profession.

For us, it is about emphasising the fact that we are part of the professional arm of NZNO. We need to accurately represent what senior nurses and nurse leaders think about pay, funding cuts or the Treaty Principles Bill – all those sorts of things.

> **We're all senior nurses, we know how it is and we want to help our fellows.**

That's the motivation of the committee. We're all senior nurses, we know how it is and we want to help our fellows, help our colleagues and build and retain our nursing mana. We'd like to leave nursing in a better state for the next generation of nurses while making a difference now. That's kaitiaki.

Joining details, as well as links to our coaching and mentoring services, blogs and events, can be found on our NLS website (https://www.nzno.org.nz/groups/colleges_sections/sections/nzno_nursing_leadership_section) and Facebook page (https://www.facebook.com/groups/dcnmsection).

Kaitiaki
NURSING NEW ZEALAND

OPINION

Auckland patient speaks out in support of nurses and kaiāwhina on strike

BY SAM PRICE

December 16, 2024

A dad-of-three is moved to write from his hospital bed in support of nurses and kaiāwhina as they strike this month.

Sam Price with nurse JR Echavez (left) and health-care assistant Elmz Belarmina.

I have never been involved in a strike, and usually take boring apolitical positions on things like health-care workers' industrial action.

And while I was not well enough to get to the picket lines outside North Shore Hospital this week, I was there in spirit, and this is why:

Last Monday, December 5, was day five for me. Day zero was the previous Thursday at roughly 2pm, when I was woken up attached to a machine that had been giving me life support for 10 days.

> **I had hoped to join the picket lines this week when the Auckland nurses and kaiāwhina went on strike, but I was still in the HDU with an IV line in.**

About a week earlier, I had spent a day in bed feeling sorry for myself thinking I had man flu.

I called Healthline and spoke to a lovely nurse, who asked me about my symptoms and then told me I needed to see a doctor within two hours.

She told me the location of the nearest after-hours and checked that I had someone who could take me there. When I got to the after-hours, a kind and professional nurse screened me and found that my blood pressure was dangerously low.

She immediately got the doctor who put in an intravenous (IV) line, spoke to the medics at Waitakere Hospital emergency department (ED), then put me in an ambulance and sent me off — I think I was only at the after-hours for 10 minutes!

I arrived at Waitakere ED to find a well-running system, with nurses and doctors working well together.

> **At the ICU I had a critical care nurse allocated to me full-time, 24/7. Every one of them was technically highly trained but also a compassionate and humane caregiver.**

Before I even arrived, they were preparing a range of antibiotics to give me.

They very quickly determined that I needed intensive care, which was at North Shore Hospital. I was accompanied in the ambulance by the doctor and nurse, and had the quickest trip down Lincoln Road on a Sunday afternoon that is humanly possible!

I arrived at North Shore to find the intensive care doctors and nurses ready and waiting. They had already reviewed my bloods from Waitakere ED, taken less than two hours earlier.

Nurses, kaiāwhina and supporters in Auckland on strike for safer staffing this week.

They told me in a kind but clear way that I had severe sepsis, which was my body over-reacting to an infection they believed was in my blood. My kidneys and metabolism had already shut down, and my circulatory system wasn't far behind.

Being a youthful and fit father of three young kids and husband of one equally-fit and even-more-active wife, what I heard was: "You're really sick, but we are pumping you full of antibiotics and once those kick in you'll be right."

> **Around now, my story falls into a long blank. I was unconscious, with various kidney and breathing machines keeping me alive.**

This aligned with my life experience of health so far, which was: Be fit and healthy, and if you get sick, go to the doctor to get some medicine and you'll be right.

At the ICU I had a critical care nurse allocated to me full-time, 24/7. Every one of them was technically highly trained but also a compassionate and humane caregiver.

Over the first night staying at ICU, my body decided to "cut off" my extremities — leaving my fingers freezing and abandoning my feet altogether.

Around now, my story falls into a long blank. I was unconscious, with various kidney and breathing machines keeping me alive.

At the same time my wife and parents were being supported by an array of registrars, senior specialists, and professional nurses — all while trying to also "keep things normal" for the kids.

> **Then my day zero arrives, with Metallica's 'Enter Sandman' blasting full noise, pulling me back into the conscious world.**

It was at this point my family experienced the strength in our Te Atatu Peninsula community.

Some of the doctors and nurses went beyond simple care, and took a personal interest and responsibility — even calling my wife with updates and good news.

Te Whatu Ora nurses and kaiāwhina on strike in Auckland have enjoyed huge public support.

Then my day zero arrives, with Metallica's *Enter Sandman* blasting full noise, pulling me back into the conscious world. (Best song choice for this occasion, in my opinion!)

My days zero to three were a challenging journey for me to reflect on and share.

> **The best care was from the nurses who knew you needed someone to hold your hand.**

Having been on a respirator, I needed to learn to breathe again, which I found a dark and scary process. The best care was from the nurses who knew you needed someone to hold your hand. Or the nurses who knew how important it was for my family to be by my side. I was bed-ridden, with feet that couldn't take any weight, and looked like they were from a failed Everest expedition.

My day four started in the high-dependency unit (HDU) after I was moved over to free up an ICU room. I started the day by convincing the doctor to take out the tubes into my stomach that had been feeding me, as well as a number of of other tubes and lines connecting me to various machines.

I also had a visit from a physiotherapist and while this was successful, it crushed me at the same time. I sat up using my own power (with their support) but I had no balance, with the entire room spinning around me.

I felt fed up with my situation and the extent of the rehabilitation I needed was really sinking in.

A while later, after some rest, two of the nurses took me (on my bed) for a tiki tour of the hospital, including going outside and sitting by the lake. This was the first time I had been outside in two weeks.

Then again today, two nurses arranged for my bed to be taken outside for an hour so that I could see my children for the first time since being admitted — they are too young for ICU/HDU age limits.

> **'There is no one caregiver, nurse or doctor who saved me. The North Shore and Waitakere hospitals operated as a perfect system of care, medicine and compassion.'**

So safe care is not just staffing ratios and efficient teams. We need to recognise that it is about meeting the cultural, emotional, and spiritual needs of patients and whānau. It's about knowing that healing isn't just a physical process, but a holistic process — and that sometimes the best thing a patient can experience is someone simply rolling their bed out into the sunshine for 15 minutes.

There is no one caregiver, nurse or doctor who saved me. The North Shore and Waitakere hospitals operated as a perfect system of care, medicine and compassion.

I had hoped to join the picket lines this week when the Auckland nurses and kaiāwhina went on strike, but I was still in the HDU with an IV line in.

But I want to publicly support the striking nurses, to acknowledge their hard work, challenging work environments and constant erosion of their ability to provide holistic care.

Auckland strike frontlines.

Kaitiaki
NURSING NEW ZEALAND

OPINION

Primary health ‘ready to tip like jenga’, says nurse vaccinator

BY DAANA WATSON

December 3, 2024

An experienced Christchurch practice nurse warns primary health is in a precarious state.

Photo: AdobeStock

Practice nurses, like GPs, are getting older and closer to retiring.

But it’s becoming ever more difficult to recruit younger nurses, with student loans and mortgages, at a time where the cost of living is so high. Primary health care’s base pay rate is so much lower than that of secondary care.

> I dread to think what it will be like for me as a retired, elderly person in 20 years.

The only thing we can offer is better working hours, with no weekends or evenings (usually!). But with a lower base rate, that’s often too much of a pay reduction to make it worth coming into primary care.

Daana Watson

So, we are fast losing staff to Te Whatu Ora or overseas, where they can get paid so much more.

Safe workloads, too, are starting to erode. Fewer nurses mean fewer job shares or locum nurses to cover illness or annual leave. The resulting burnout and increased stress from covering more appointments can make the work less enjoyable.

Our employers — with whom we are bargaining currently — seem reluctant to offer us a competitive pay rate, under a funding model that, over decades and many governments, has become far out-of-synch with patient demand.

Yet, well-funded primary health keeps people out of hospital. Meanwhile, people end up in emergency departments for non-urgent care because they can't afford their GP fee or can't even get enrolled or an appointment.

As New Zealand's population surpasses 5 million, there is a lack of future-proofing across all areas of health. There is not enough financial support in training to allow the next generation of doctors, nurses, dentists, radiographers, occupational therapists, physiotherapists and lab technicians — everybody who is part of a professional team — to flourish.

I dread to think what it will be like for me as a retired, elderly person in 20 years!

> **It feels like a Jenga puzzle – all these little blocks of wood balancing precariously and ready to tip over at any moment**

If this is where our current workforce is heading, then it's no wonder we can't keep on top of the basics.

Immunisation is a public health issue, it's not just about personal protection. I'm from the United Kingdom and can remember getting polio drops in the mid-60s, when they became available. I had smallpox and tuberculosis vaccines in my childhood as these illnesses were still prevalent and potentially life-threatening.

It's not lucky that diseases such as these are not seen nowadays — it's only because of immunisation programmes.

Look at Auckland in 2019, during the global measles outbreak. We had whole high schools closed down because there were more unvaccinated than vaccinated kids. That meant there was not enough herd immunity to be able to safely come to school. And repeat, two years later, with COVID-19.

What are the consequences of such interruptions to the education process?

Closed borders during the COVID pandemic, too, diminished our ability to supplement the primary health workforce gaps, undermining the role of the GP and practice nurse in providing holistic care for the whole family.

Dunedin primary health care nurses were among those attending nationwide NZNO paid union meetings to discuss the latest PHC multi-employer collective agreement offer in September.

Meanwhile, pharmacies are stepping into adult vaccinating, accessing subsidies that would previously have gone to primary health.

This is especially annoying when pharmacies give unnecessary vaccines then claim for them – vaccines that have already been given in general practice but are not recorded on the new Aotearoa immunisation register (which replaced the national immunisation register NIR in December 2023). Anyone born before 2004, when NIR started, won't have their MMR (measles/mumps/rubella) vaccines, nor their early vaccines such as pertussis, tetanus and diphtheria, recorded except at their general practice.

I am aware of several cases where unnecessary vaccinations have been given – and a couple of pharmacies in Christchurch that have lost their vaccination licences (https://www.pharmacytoday.co.nz/article/news/medsafe-investigates-three-pharmacies-over-vaccinations) as a result.

> **We in primary health are in a perfect storm, as a consequence of years of taking our nurses' ethos of caring and going the extra mile for granted.**

Each injection takes time — to get consent, to administer and to document — but an adult can be vaccinated so much faster than a six-week-old baby.

And now, Whānau Āwhina Plunket nurses (https://www.beehive.govt.nz/release/plunket-help-increase-childhood-vaccination-rates) have been tasked with giving childhood vaccinations in areas with low uptake. Why is the Government prepared to pay yet another provider to do this important service, instead of properly funding primary health care to do what they have been doing for decades?

Such moves undermine the role of the GP and practice nurse in providing holistic care for the whole family — and the effect is evident in the latest health target figures which show childhood immunisation rates are dropping.

This all comes amid a whooping cough epidemic. We do our best to keep on top of pregnancy and early childhood vaccinations but the chance of outbreaks — which are cyclical in nature — are always sitting there in the background. Being able to get a prompt GP or practice nurse appointment — very challenging these days — to diagnose the ailment would reduce the spread of this highly contagious disease.

We in primary health are in a perfect storm, as a consequence of years of taking our nurses' ethos of caring and going the extra mile for granted. Meanwhile, underfunding across health and training continues, and a growing pay gap with our colleagues in secondary care plays havoc with our ability to recruit and retain nurses.

It feels like a Jenga puzzle — all these little blocks of wood balancing precariously and ready to tip over at any moment.

- *Daana Watson is a member of the NZNO college of primary health care nurses.*

Kaitiaki
NURSING NEW ZEALAND

FEATURES

‘It is gaslighting’ – nurses refute Levy’s claims hospitals are fully staffed

BY MARY LONGMORE

December 11, 2024

Te Whatu Ora says it’s fully staffed with nurses and kaiāwhina — yet it won’t reveal how many shifts were below safe staffing targets in 2024.

Thousands of nurses walked off the job this month seeking safer staffing levels. Photo: Leon Brooke.

Patients might go for a week without a shower or hair-washing. Or someone with spinal injuries can’t get help to operate the technology they need to communicate. Or a nurse doesn’t have the time to sit with someone and do a full assessment.

These are some of the effects of care rationing in an understaffed hospital — but not the worst, warns Christchurch enrolled nurse Debbie Handisides.

At a glance: The battle for safe staffing

Established in 2009, CCDM emerged from a 2006 safe staffing inquiry promised during 2005 NZNO-district health board bargaining.

It is overseen by the safe staffing health workplace unit, a joint NZNO-DHB initiative.

"What's it going to take? That's what we're worried about — is it going to take a death? Is it going to take somebody's practising certificate being taken off them?"

> **'That equates to intentional unsafe staffing by Health New Zealand.'**

And someone has died — in August, a woman collapsed and died at Rotorua Hospital after waiting three hours in its emergency department (ED), which nurses say had been chronically understaffed.

Handisides is on the NZNO-Te Whatu Ora bargaining team currently embroiled in contentious negotiations for the 2024/25 collective agreement.

The differences led to a nationwide eight-hour strike this month– with rolling regional strikes (https://maranga-mai.nzno.org.nz/te_whatu_ora_strikes_december_2024) also underway in the lead up to Christmas.

An NZNO member on strike in Hawke's Bay.

Not only is Te Whatu Ora talking about a mere one per cent pay rise — which won't kick in till halfway through next year — but it has paused its safe staffing calculations till February, saying it needs to fix regional inconsistencies in how it gathers figures.

But NZNO safe staffing coordinator Maree Jones describes it as "intentional short-staffing" by Te Whatu Ora on top of an eight-month hiring freeze.

"Since May, they haven't been releasing budget for any new FTE [full-time-equivalent staff] as a result of the CCDM calculations," she says.

"That equates to intentional unsafe staffing by Health New Zealand."

In 2010, the unit agreed to progressively implement it across all DHBs.

But progress was slow. By 2015, it was only partially running in 13 regions and NZNO pushed for more commitment during bargaining.

Following a nurses' strike in 2018, then-minister of health Andrew Little agreed in a safe staffing accord to have it running in all public hospitals by June 30, 2021.

But in 2020, COVID-19 disrupts the New Zealand health system and existing staff shortages worsen due to border closures and the diversion of nurses and kaiāwhina to deal with the pandemic.

By 2021, CCDM is implemented in all 20 DHBs to some degree — but none fully.

A 2022 review (https://www.health.govt.nz/publications/nursing-safe-staffing-review-and-report-on-the-review-of-the-care-capacity-demand-management-ccdm) of CCDM by the nursing advisory group concluded that after 20 years, hopes for safe patient care with enough staff had been "lost in a myriad of variables and complexities".

2024 progress reports suggest "negative progress" for CCDM in five regions.

This year, NZNO has added culturally safe staff-to-patient ratios to its safe staffing claims alongside fully implementing CCDM.

— Sources: Nursing safe staffing review, NZNO library and NZNO CCDM coordinator Maree Jones.

CCDM — care capacity demand management — is a safe staffing programme which matches patient need to staff numbers and skill. Despite 15 torturous years of trying by NZNO, it is not yet fully up and running in any of Te Whatu Ora's regions.

"None of them have fully implemented it after all these years," Jones says.

Debbie Handisides, centre back, on strike in Christchurch this month.

Handisides fears that pausing its calculations is part of a plan to ditch it altogether. And while it's not perfect, CCDM is "all we have" to hold Te Whatu Ora accountable for staffing hospitals safely, she says.

"They don't want to know – and it's a tool that we don't want to lose, that's why we have it in our bargaining. We have our safe staffing claim, because we know where it's worked it's worked well — it's proven."

After identifying it was short 4800 nurses in 2023, Te Whatu Ora has since claimed it blew its budget (https://newsroom.co.nz/2024/07/24/unexpected-success-in-hiring-nurses-drives-health-nz-deficit/) recruiting 2900 — many from overseas — over the following 12 months and was staffed up. So when New Zealand's graduates hit the job market this year, hundreds were turned away from entry-level hospital jobs.

> **'We've just had four staff resign and none of them have been replaced – they haven't even been advertised.'**

Reports of a hiring freeze on graduates first emerged in June — but Te Whatu Ora repeatedly denied this, chief nurse Nadine Gray stating in July "there is no pause on the recruitment of graduate nurses".

Freeze or no freeze?

But Handisides says there is "definitely" a recruitment freeze.

"We've just had four staff resign and none of them have been replaced — they haven't even been advertised."

NZNO-Te Whatu Ora bargaining team members. Noreen McCallan is second from left and Debbie Handisides on far right.

As well as failing to recruit to the unsafe gaps identified by CCDM — they are not even replacing current nursing staff on maternity, sick or annual leave, says Handisides, who regularly talks to delegates around the country.

"The reality on the floor is that the majority of shifts are under [staffed]. If they do replace somebody who is sick, they'll replace them with the wrong skill mix — so they'll send an HCA [health-care assistant] who can't do the work of an RN."

Handisides suspects the true nursing shortfall runs into the "thousands" — and that's just in her region, Canterbury.

Te Whatu Ora has so far refused to release its 2024 safe staffing figures. This is despite promising in the 2023/24 collective agreement that it would work with NZNO to ensure it was safely staffed.

But in 2023 — when NZNO forced Te Whatu Ora to release its figures under the Official Information Act — they showed a quarter of nursing shifts were understaffed (https://www.nzno.org.nz/about_us/media_releases/artmid/4731/articleid/6776/official-nurse-unsafe-staffing-figures-genuinely-alarming). Some — such as mental health wards — were understaffed nearly all the time.

> **'It's gaslighting. What do you do with a Government which is basically telling itself a story? When someone denies your reality?'**

The impact on nurses and patients is profound, says Handisides. "People are worried about their practising certificate, because really unwell people are arriving, then not getting their full care on time and becoming more unwell. It's so difficult for nurses, especially when we care so much."

Hawke's Bay nurse Noreen McCallan, also on the bargaining team, is blunt.

"It's gaslighting. What do you do with a Government which is basically telling itself a story? When someone denies your reality? That's totally what it is," she told *Kaitiaki.*

Even though Te Whatu Ora kept saying there's no recruitment pause, there were long delays of up to several months.

"What I'm told by fellow delegates on a regular basis is there aren't enough people on the relief team, on the medical ward . . . sick leave isn't being replaced — and they're just moving patient numbers around if they can get away with it," McCallan said.

"Any delay in replacing a long-established position, which there is currently, is effectively a cut — even if it's only temporary."

The latest freeze (https://www.rnz.co.nz/news/national/530330/health-nz-looking-to-save-100m-in-data-and-digital-work-say-unions) on upgrading the health sector's ageing data systems would also increase the workload for nurses, she said.

A strike supporter in Dargaville. Photo: Jos Wheeler.

"Everybody laughed when Lester Levy said he's not making cuts," said McCallan, referring to last week's six-hour health select committee grilling (https://www.stuff.co.nz/politics/360509801/mps-verging-being-disorderly-health-nz-scrutiny-hearing) of the Te Whatu Ora's commissioner. Lester stated: "There are no cuts — I think there's a line being drawn between reducing staff and a cut."

"Tell the nurses that, tell the communities that, tell the national public service that," Labour MP Ingrid Leary replied, as Te Pāti Māori Debbie Ngārewa-Packer face-palmed and Labour's health spokesperson Ayesha Verrall said "keep digging", The Post reported (https://www.thepost.co.nz/nz-news/360509659/health-nz-commissioner-promises-reset-plans-shorter-wait-times-soon).

Levy said Te Whatu Ora was not cutting but "right-sizing" after over-recruiting mainly in management and administration which had grown "by the thousands".

McCallan believed the health system was heading into steep decline "like I've never seen before".

Pausing CCDM calculations — on top of a hiring freeze — would only speed an overseas exodus of nurses and impact the health system for years to come, she warned.

"If we don't get the CCDM FTE calculations that are contractually obliged to happen — that are in our contract — then people will keep resigning because they'll go to Australia."

> **'We are going to see our youngest and brightest go – and we've got an ageing workforce.'**

Lower Hutt nurse and delegate Nathan Clark said staff were deeply worried about the long-term impact of the current recruitment lag and CCDM pause.

"We are going to see our youngest and brightest go — and we've got an ageing workforce," he said from the Hutt Hospital picket line this month.

Maree Jones said it was hugely disappointing that CCDM was not fully implemented in any hospital or region after so many years.

And now, even these painfully slow gains are being ripped away.

"Some were just about there, but now there's little priority for the programme and hardly any resource."

Even where CCDM is working, there aren't enough nurses to fill the gaps it identifies, striking Lower Hutt nurses and kaiāwhina told *Kaitiaki*. Medical wards especially were often below the target FTE, they said.

Hutt Valley nurse Nathan Clarke on strike this month.

'We value you' – Te Whatu Ora

Te Whatu Ora deputy chief executive northern region Mark Shepherd says the pause is simply to review how it does CCDM staffing calculations after regional inconsistencies — but acknowledges they will be limited by budget.

"FTE [full-time equivalent] calculations will resume in the new year and be aligned to ongoing budget and planning cycles," he said in a statement.

And while Te Whatu Ora greatly valued nurses' contribution, any settlement needed to reflect the "ongoing reset of Health NZ as we work to get back to budget".

The pressure on Te Whatu Ora to save $2 billion in this financial year is no secret — yet Levy has (begrudgingly) staked his job (https://www.thepost.co.nz/nz-news/350448033/health-commissioner-stakes-job-maintaining-front-line-budget) on not cutting frontline health workers.

Te Whatu Ora chief executive Margie Apa has blamed the hiring of 2900 nurses for its budget blowout. Photo: Jonathan Milne, Newsroom.

That his comment was swiftly followed by a proposal to cut four directors of nursing, means Te Whatu Ora nurses may feel increasingly confused and gaslit.

Shepherd also said nurses' salaries had risen higher than most in recent years, growing 45 per cent for those on the top RN step, with another 25 per cent from last year's pay equity settlement.

But NZNO chief executive Paul Goulter said it was "misleading" and "insulting" to include a long-overdue pay equity settlement over gender inequities in wage bargaining.

He said nurses and kaiāwhina were "fiercely committed" to caring for their patients.

“They don’t want to see patients’ safety at risk because there are not enough nurses on duty to give them the care they need.”

Details of NZNO’s claims for 2024 NZNO/Te Whatu Ora bargaining can be found here (https://maranga-mai.nzno.org.nz/2024_claims).

- *Te Whatu Ora — NZNO mediation is scheduled for this week.*

Kaitiaki
NURSING NEW ZEALAND

FEATURES

Safe staffing and stronger community health care – returning president and vice-president share their aims

BY MARY LONGMORE

December 9, 2024

In the first of two leadership profiles, *Kaitiaki* talks to returning NZNO president Anne Daniels and vice-president Nano Tunnicliff about their priorities.

Nano Tunnicliff, left, and Anne Daniels.

Safe staffing and stronger community health care are top of the list for returning NZNO-Tōpūtanga Tapuhi Kaitiaki o Aotearoa leaders, president Anne Daniels and vice-president Nano Tunnicliff.

"For the next three years, safe staffing is absolutely my priority," Daniels said. She believed this could be achieved with legally-binding nurse-patient ratios underpinned by safe staffing tool care capacity demand management CCDM — fully embedded not only in hospitals but primary health and aged care.

At a glance: NZNO's bicultural elections

In NZNO's bicultural leadership model, the president and vice-president govern alongside the kaiwhakahaere and tumu whakarae, who are elected by members of NZNO's Māori member body, Te Rūnanga, every three years.

Daniels, a long-time emergency nurse based in Ōpotiki (Dunedin), retained the presidency in September's election despite a challenge from college of primary health care nurses' chair Tracey Morgan.

Tunnicliff — who was re-elected unopposed — said a well-funded primary health system was also crucial.

"Primary health care is normally your 'in' to the system. If that's well funded and resourced, which it's not, you will have less pressure on the hospital as people are picked up much earlier in their journeys."

> **'We expect nurses to be able to go to work and do their job safely in a way that is expected by themselves and by the public.'**

The president and vice-president can serve no more than two three-year terms, while the kaiwhakahaere and tumu whakarae may serve more than two consecutive terms.

At the NZNO hui-a-tau in August, Kerri Nuku was elected unopposed as kaiwhakahaere for a 11th year while Whakatāne nurse Tracy Black was also unopposed to replace Titihuia Pakeho as tumu whakarae, after Pakeho stepped down.

Their profiles will run next week.

Daniels said NZNO had been trying to get a safe level of nurses in workplaces for 23 years — since 2001. Even with CCDM data now able to show exactly how many nurses were needed in many hospitals — and a 2018 safe staffing accord — nurses and kaiāwhina were still stuck in unsafe environments.

"How many times do we have to say this?" Daniels says, with evident frustration. "We expect nurses to be able to go to work and do their job safely in a way that is expected by themselves and by the public."

Nurses and kaiāwhina striking for safe staffing in Wellington this month. Photo: Leon Brooke.

The focus had now shifted to getting legally-enforceable safe nurse-to-patient ratios as there was so little trust in Te Whatu Ora or the Government to keep their word.

CCDM was still not fully implemented anywhere — and even where it was, Te Whatu Ora was keeping its calculations secret, Daniels said.

"If they are actually being transparent and accountable, why will they not release the actual CCDM FTE [full-time equivalent staffing shortfall]?"

Last year, it revealed that a quarter of nursing shifts were understaffed (https://www.nzno.org.nz/about_us/media_releases/artmid/4731/articleid/6776/official-nurse-unsafe-staffing-figures-genuinely-alarming) — but only after it was forced to release them to NZNO through the Official Information Act.

Te Whatu Ora has so far declined to release 2024 figures.

> **'In my long nursing career, this is the worse I've ever encountered in terms of hammering the frontline.'**

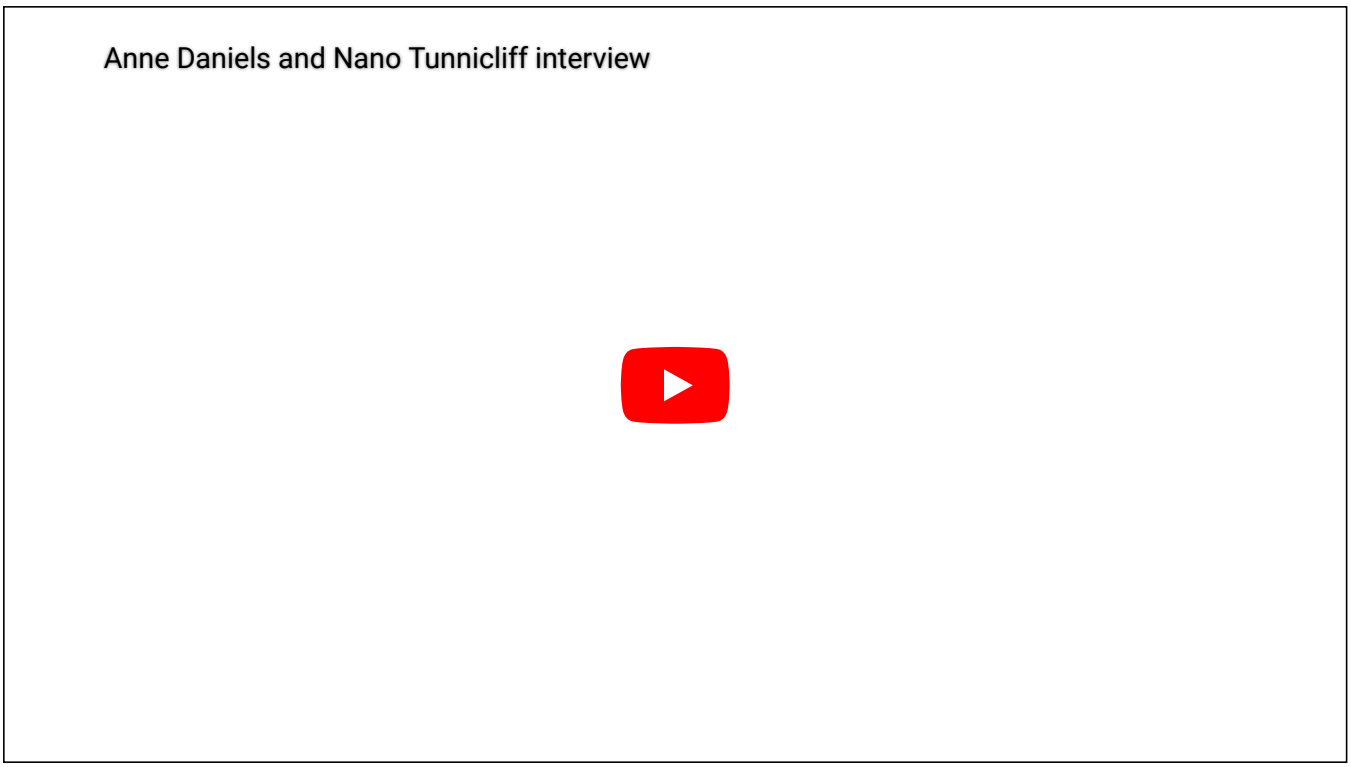
Another focus for Daniels — and NZNO's Maranga Mai! (https://maranga-mai.nzno.org.nz/why_we_support_maranga_mai) strategy — was embedding te Tiriti o Waitangi in "everything we do so it's normalised in who we are as a union and profession".

Workload 'double' while vacancies grow

Tunnicliff, who works on a medical ward in the Wellington region, agreed nurse understaffing was NZNO's biggest challenge.

Workload had doubled in the past couple of years, yet nurse numbers were not keeping up.

"It's getting quite stressful, the environment, and noticeably the sick leave has escalated."



A lack of workforce planning was evident — for example the Government had funded new cancer drugs but no workforce to administer them.

"It means we have to now pick up some of the slack around patient education – it takes a lot longer. Then you're going from a load of four to six, seven, eight [patients] in a day but still within the same opening hours."

Nurses needed to be employed according to need — which CCDM could now identify — rather than budget, she said. However, Te Whatu Ora would not release their staffing figures and appeared to be taking a budget-driven approach amid a drive to save $1.4 billion (https://www.rnz.co.nz/news/national/524282/health-nz-finances-worse-than-thought-commissioner-lester-levy), she said.

> **'So it doesn't matter if they've got 10 vacancies, they can only approve two that will then possibly be advertised.'**

"We now have a tool that can at least build in manageable workload and reflects the FTE you actually require. But then you have to get that all approved before management can then advertise and fill those vacancies," she said.

Nurses seeing 'worsening outcomes'

And what nurse managers were successfully getting approved, fell far short of what was needed.

"So it doesn't matter if they've got 10 vacancies, they can only approve two that will then possibly be advertised – and then that recruitment process that doesn't happen overnight."

She said "basic maths" suggested even though Te Whatu Ora had hired 2900 FTE nurses over the past year, its own figures identifying a 4800 nursing shortfall last year, meant New Zealand was still at least 1900 nurses short.

Nurses were seeing "worsening outcomes" as a result of the hiring constraints, said Tunnicliff, who has worked as a nurse for 36 years.

"Patients will die. . . In my long nursing career, this is the worse I've ever encountered in terms of hammering the frontline."

Dunedin's Te Whatu Ora nurses and kaiāwhina on strike this month.

Both said more resourcing for nurses in communities — primary health and aged care — would also take pressure off hospitals.

"Not just in GP practices, but in people's homes, their communities, on the marae, in schools and universities — everywhere, outside of those hospital buildings. If that happened, we would not have the pressure that is occurring today," Daniels said.

NZNO's guiding strategy Maranga Mai! identified the problems and solutions, she said. They were: A te Tiriti-led approach that worked for Māori, safe staffing, paying all nurses the same, more Māori and Pacific nurses and more affordable and accessible training.

- *Since this interview, Te Whatu Ora has paused its CCDM FTE calculations citing regional inconsistencies.*

Dunedin members on strike.

Kaitiaki
NURSING NEW ZEALAND

FEATURES

A report from the nursing frontline in Rwanda and Ukraine

BY ANDREW CAMERON

December 2, 2024

Nursing has taken Andrew Cameron all over the world on humanitarian missions. He reports here on his latest work in Rwanda and Ukraine.

Andrew Cameron with a group of elderly women in rural Georgia in 2011, where he was part of a mission improving access to health care for the vulnerable elderly. This also involved delivering food aid, due to food-growing fields being land-mined.

I often wondered — while training as a general and obstetric nurse at Hutt Hospital in the 1970s — whether I would spend my whole career nursing in New Zealand hospitals.

Fortunately for me at least, I am so far managing to have a somewhat varied career, though I know that life is not for everyone.

I write from Rwanda, where in November 2024, I am volunteering as an intensive care nurse (ICU) specialist, recruited by a British non-government organisation (NGO), to assist with a response to an outbreak of Marburg virus disease. This virulent illness has claimed the lives of several dozen Rwandan ICU nurses and doctors.

I have been here in Kigali, the Rwandan capital, for a month so far, and the local medical response teams are getting on top of the outbreak. Rwanda has a first-rate health system with highly-educated medical and nursing personnel. Case numbers are falling dramatically. That is great news for all.

Suited up in personal protective equipment (PPE) during on-site training in Kigale.

Marburg virus is a rare but severe haemorrhagic disease, and like Ebola, can cause serious illness and death from profound blood loss. It has a fatality rate ranging from 20 to 90 percent, and there is no approved vaccine, so it is not a

disease to be trifled with.

Fortunately I have some experience with Ebola, having been deployed to Sierra Leone a decade ago, where I was assigned to manage "dignified burials of the deceased, and discharge home of the survivors". Performing these burials was an emotionally taxing nursing duty.

Marburg virus disease has claimed the lives of several dozen Rwandan ICU nurses and doctors.

My first experience in the humanitarian nursing sector, in 2006, was a six-month deployment to a 600-bed field hospital in northern Kenya, where we cared for sick and wounded victims of the civil war in Sudan. I learnt a lot there.

'In Sierra Leone, I was assigned to manage the dignified burial of Ebola victims.'

For the following 18 months, I was assigned as head nurse at the 450-bed Juba Teaching Hospital in Sudan; our team assisted the Sudanese national staff to improve nursing practices and lift standards with the resources available in that hospital.

In 2008, I started my first of four years in Afghanistan, where I was a project manager at the main teaching hospital in the city of Jalalabad. I later spent a year each in Kandahar, Lashkar Gah, and Kabul, with differing duties in each location, from prisoner health, to vaccination programmes, to first-aid training.

Establishing contact and building trust is very important to the Afghan people. Many cups of tea are consumed.

Following that, I had long assignments in Yemen, and Iraq.

Then in 2011, in a mountainous region of northern Georgia, I had a mission assisting vulnerable elderly to access health care. The country was still recovering from its 2008 war with Russia.

Due to their agricultural lands being land-mined, we set up a programme to provide essential food (and even firewood, because the forests were mined as well) and also improved their access to vital nursing and medical services.

Other duties in this region of Georgia included helping village nurses with training and refurbishing a few of their little clinics. I was also involved in the care of detained people, and helped the nursing school upgrade its curriculum.

> **For me, humanitarian nursing is enriching, emotionally rewarding and memorable.**

For six months of 2023, I gained a deployment with a UK-based NGO to Ukraine, where I was an operating theatre/emergency nurse in Dnipro. Many of my friends warned me, "Don't go there Andrew, it is too dangerous," which only hardened my resolve.

I was warmly received in Ukraine wherever I went. The medical and nursing staff in the hospital in which I worked made me feel exceptionally welcome; and I worked hard to assist the war-wounded patients in those operating theatres, and post-operatively with their dressings and psychosocial welfare.

A Kiwi gift to my Ukrainian surgical counterpart was well-appreciated.

For me, humanitarian nursing is enriching, emotionally rewarding and memorable. I try my best to remain physically fit, multi-skilled and continue with life-long education and so that I may continue with such work for as many years as I am able.

Andrew Cameron, *who has qualifications in general and obstetric nursing, midwifery, intensive care, health economics and public health, received the prestigious Florence Nightingale Medal in 2011 for his services to humanitarian nursing. His 2017 memoir,* A Nurse on the Edge of the Desert*, is available at NZNO's library for members to borrow, as well as at public libraries.*

Kaitiaki
NURSING NEW ZEALAND

PRACTICE

Youth with type 2 diabetes: Screening, complications and management

CPD one hour

BY ELISA WONG, PRIYA JOSEPH, CATHERINE BACON AND BARBARA M DALY

December 12, 2024

Type 2 diabetes is getting more and more common among young people, but the condition is challenging for them to manage, and for whānau and health professionals supporting them.

**** Reading this article is the equivalent to one hour of CPD.***

Overview

Most people associate type 2 diabetes with older adults. However increasing numbers of children and young people are developing it. High rates of child- and youth-onset type 2 diabetes in New Zealand present major challenges for affected individuals, their whānau and health professionals.

Young people with type 2 diabetes often struggle to manage glycaemic levels and are typically under-treated for hypertension, dyslipidaemia and smoking cessation. Youth with type 2 develop complications (particularly renal,

retinopathy and cardiovascular disease) more quickly than adults with type 2 diabetes: half of them having significant complications within 10 to 15 years after diagnosis.

There is a lack of research for this young population and their management is often based on studies from adults with type 2 diabetes. Evidence on the effectiveness of lifestyle and pharmaceutical interventions and the rate of complications have largely come from two North American youth cohort studies: SEARCH (https://www.searchfordiabetes.org/dspHome.cfm) and TODAY (https://today.bsc.gwu.edu/home). (Research based on these two studies is referenced throughout this article.)

There is a lack of research for this young population and their management is often based on studies from adults with type 2 diabetes.

Both study groups have followed several hundred children and youth with type 2 diabetes from 2002 and 2004, respectively. Additionally, several randomised controlled trials have been undertaken to test interventions among these two study groups, to improve hyperglycaemia, hypertension and lipid levels, and to compare their effectiveness with adult trials in reducing diabetes-related complications.

This article describes:

- how obesity drives the development of type 2 diabetes in this age group,
- risk factors for screening,
- diabetes-related complications and comorbidities, and
- best management practices.

Challenges associated with managing glucose levels, and cardiovascular and renal risk factors in this age group are addressed, along with recommended lifestyle and pharmaceutical interventions.

Authors (from left) Elisa Wong, Priya Joseph, Catherine Bacon and Barbara Daly.

Introduction

Globally, the incidence of type 2 diabetes has rapidly increased over the past 20 years. Among young people (under 20 years) in the United States (US), there are 13.8 new cases diagnosed each year for every 100,000 population.1 Youth from ethnic minority groups living in Western countries are two to eight times more likely to be diagnosed with the condition than their European counterparts.1

In Australia, the occurrence of diabetes is much higher in Indigenous youth (<17 years) (4.5 to 31 per 100,000/year) than other youth (<1.4 per 100,000/year).2 Similarly, in New Zealand, Pacific and Māori youth (<15 years) have a

significantly higher annual rate of type 2 diabetes (5.9 and 4.1 per 100,000 children), respectively, than Asian and European youth (0.6 and 0.1 per 100,000).[3]

Girls have almost double the rate of boys and are most commonly diagnosed during mid-puberty, around the age of 13 years.[3]

Obesogenic environment: Growing levels of youth diabetes are occurring as modern urban life becomes increasingly obesogenic — that is an environment in which it is easier to gain weight and harder to lose it. The obesogenic environment is driven by an abundance of processed food, high in refined carbohydrates, salt and saturated fats and low in nutrients.[4]

In a largely unregulated profit-driven food industry, more unhealthy food outlets serve economically disadvantaged communities.[5] In New Zealand, approximately 58 per cent of young people consume a third of their daily food intake at school.[5] Only 17 per cent of New Zealand schools have a food-specific policy and most contract a for-profit food service with legislation loopholes allowing unhealthy food to be sold.[5]

The obesogenic environment is driven by an abundance of processed food, high in refined carbohydrates, salt and saturated fats.

A reluctance by successive governments to instigate policy changes to reduce the obesogenic environment exposes children and youth, mostly from economically disadvantaged backgrounds, to a diet that puts them at risk of obesity and developing type 2 diabetes.[6]

Risk factors for screening: Almost all youth with prediabetes and type 2 diabetes are significantly overweight or obese[1] and are less physically active than others of the same age.[7] In addition to the higher prevalence among Pacific and Māori youth, early determinants of health have the greatest impact on children and youth developing type 2 diabetes.

In New Zealand, 29 per cent of obese adolescents were from the most economically deprived households.[8] This proportion is far higher for youth with type 2 diabetes, with 70 per cent in North America being from similarly economically deprived households.[1]

At least two-yearly screening is recommended for those at risk[9] — this aligns with the American Diabetes Association (ADA) and UK-based National Institute for Health Care Excellence (NICE) guidelines.[10]

Diagnosis of youth-onset type 2 diabetes usually occurs during opportunistic routine primary care consultations, based on risk factors, signs and symptoms of diabetes, including acanthosis nigricans (dark velvety skin in body folds

and creases),[8] and is confirmed by an HbA1c >50 mmol/mol.[9] It is recommended that Māori and Pacific children are screened, if obese, with one additional major risk factor.[9]

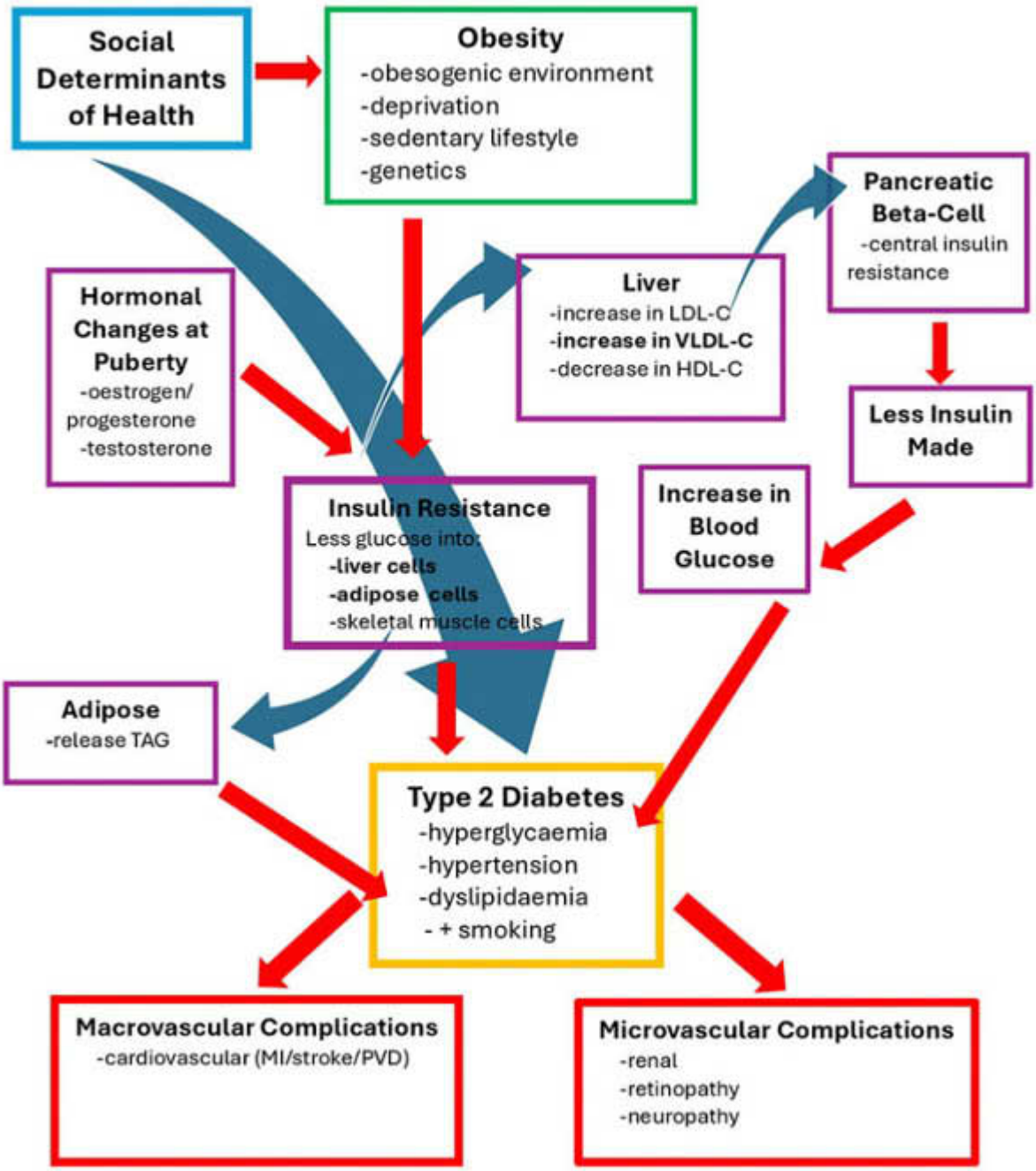
Insulin resistance (reduced insulin sensitivity), metabolic syndrome and prediabetes: Cells that require insulin for glucose entry are mostly energy storage cells (liver, adipose and skeletal muscle — outlined in Figure 1, below). In response to increased fatty tissue, these cells become insulin resistant, release inflammatory chemicals and are less able to take up glucose from the bloodstream.[11]

Liver cells respond to the reduction in intracellular glucose by breaking down stored glycogen into glucose that is secreted into the bloodstream, and altering lipid production. Synthesis of both the unhealthy lipids, low-density-lipoprotein-cholesterol (LDL-C) and very-low-density lipoprotein-cholesterol (VLDL-C), are increased, and healthy high-density-lipoprotein-cholesterol (HDL-C) synthesis is reduced.[12]

LDL-C is a major driver of atherosclerosis and VLDL-C delivers more fatty molecules to the insulin-producing beta cells in the pancreas, leading to insulin resistance in those cells and reduced secretion of insulin. Insulin resistant adipocytes (fat cells) release stored triglycerides (TAGs) into the bloodstream in response to reduced uptake of glucose.[11]

Inflammation, hypertension, and the adverse changes in lipid profiles referred to as dyslipidaemia, promote atherosclerosis and early-onset cardiovascular disease (Figure 1).

Figure 1: Progression from to insulin resistance to Type 2 Diabetes



Insulin resistance and puberty: Insulin resistance, or reduced insulin sensitivity, is largely driven by excess adiposity (body fat) and is the main risk factor for developing type 2 diabetes in young people.

Increases in growth hormone, testosterone and oestrogen during puberty cause a slight increase in insulin resistance and elevated serum glucose levels, which, in adolescents who are already insulin-resistant, can lead to a diagnosis of type 2 diabetes.[13]

Girls are more likely to be diagnosed during puberty,[13]which coincides with a decrease in physical activity[14] and wide hormonal variations associated with ovulation and menstruation.[7]

In New Zealand, less than a fifth of adolescents meet physical activity guidelines of at least one hour of moderate to vigorous activity daily,[15] increasing the risk of youth-onset type 2 diabetes. Declining fitness from childhood to adolescence is also associated with developing type 2 diabetes as adults.[16]

Youth with type 2 develop complications (particularly renal, retinopathy and cardiovascular disease) more quickly than adults.

Associated health conditions: Acanthosis nigricans (hyperpigmented skin changes), non-alcoholic fatty liver disease,[8] polycystic ovary syndrome (PCOS) and hyperandrogenism (elevated testosterone levels in females)[17] are commonly seen in youth with metabolic syndrome or type 2 diabetes.

Depression, neurodevelopmental differences, eating disorders, poor quality sleep patterns and sleep apnoea are also more common in youth with type 2, reducing their quality of life.[12] Although there are few reports on the prevalence of depression, including from New Zealand, the TODAY study reported almost 60 per cent of non-European youth had signs and symptoms of depression.[18]

Diabetes-related complications

Microvascular (capillary small vessel disease) and macro-vascular (atherosclerotic large vessel disease) lead to complications in youth with type 2, and at a significantly faster rate than adults with type 2 and youth with type 1, with 75 per cent developing at least one complication within eight years of diagnosis.[7,19]

Microvascular complications are common, with 55 per cent of the TODAY cohort developing renal disease, 51 per cent retinopathy and 32 per cent neuropathy within 14 years from diagnosis.[20]

Microvascular complications

Hyperglycaemia, hypertension and smoking are the major risk factors leading to diseased and dysfunctional capillaries and microvascular complications.[11,21] Excessive glucose binds to cell membrane proteins on the endothelial cells lining the capillaries in the kidneys, retina and around peripheral nerve cells, forming advanced-glycation end-products causing structural changes, loss of integrity and function.

Associated growth of new and fragile capillaries in the retina increases the risk of haemorrhage and loss of vision.[22]

Chronic hyperglycaemia is higher in Māori and Pacific youth with type 2 than in Europeans,[23] and is likely to explain their increased risk of renal and retinal disease,[24,25] as there are no differences in rates of hypertension or lipid profiles.[8,23]

Nephropathy (renal disease): Renal disease is the most common complication for youth with type 2 diabetes. Albuminuria is an early marker of diseased glomerular capillaries and renal disease.

A small amount of albumin detected in the urine, urinary albumin:creatinine ratio (ACR) 3-30mg/mmol, is referred to as microalbuminuria; and large amounts of albuminuria, ACR>30 mg/mmol, as macroalbuminuria.[26]

Youth with type 2 are four times more likely to develop renal disease than those with type 1 diabetes, despite similar HbA1c levels,[19,27] occurring in 55 per cent within 15 years of diagnosis.[20] Comparatively, it takes 25 years for the same proportion of adults with type 2 diabetes to develop renal disease.[20]

An audit in primary care in South Auckland showed higher prevalences for renal disease among Pacific (48 per cent) and Māori (41 per cent) young adults (18-40 years) with type 2 diabetes compared with European (34 per cent).[24] Similar prevalences (<40 years) were reported for young adults attending outpatient clinics in Auckland, with 44 per cent having albuminuria at diagnosis (including 12 per cent with macroalbuminuria) and was strongly correlated with developing retinopathy.[25]

Retinopathy: Although the risk of retinopathy is increased for youth who develop hypertension,[28] chronic hyperglycaemia is the main risk factor for retinopathy in this population, indicated by similar rates of retinopathy in both youth with type 1 and type 2 diabetes.[27]

In the TODAY and SEARCH studies, rates were similar for youth with type 1 and type 2 diabetes with 50-56 per cent having retinopathy within 12 years of diagnosis.[28] In Auckland, 56 per cent of young adults with type 2 diabetes had

evidence of retinopathy at six years following diagnosis, and the development of retinopathy was associated with duration and glycaemic control.[25]

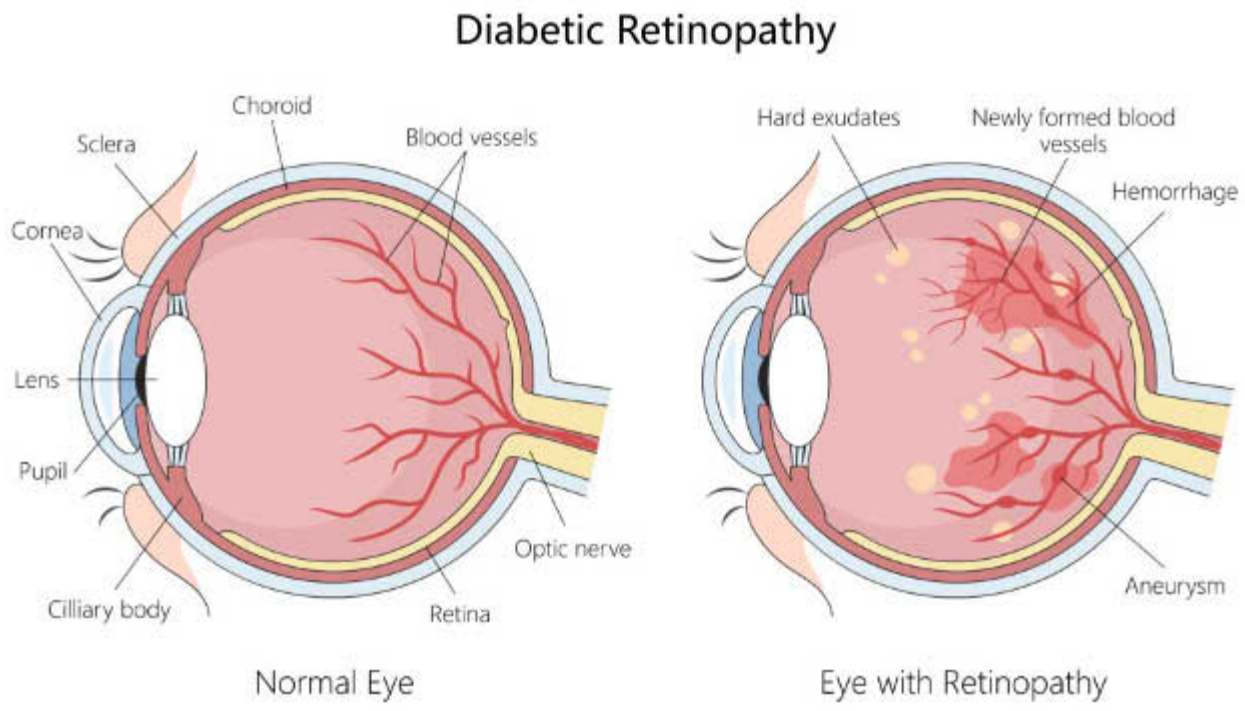


Diagram: Adobe Stock

Peripheral neuropathy: In addition to chronic hyperglycaemia, central obesity (visceral abdominal fat, indicating insulin resistance), elevated blood pressure and dyslipidaemia all increase the risk of peripheral neuropathy.[29]

Loss of capillaries serving peripheral nerves affects motor, sensory and autonomic nerves, causing numbness, pain and paraesthesia in hands or feet, and most commonly results in accidental, unnoticed injuries leading to foot disease.

Peripheral neuropathy is more prevalent in youth with type 2 than type 1 diabetes, with 26 per cent, compared to 8 per cent, of each developing peripheral neuropathy after eight years in the SEARCH cohort.[19,29] For youth with type 2 in the TODAY cohort, 32 per cent developed peripheral neuropathy within 15 years of diagnosis.[20]

Peripheral neuropathy is under-reported for this population in New Zealand,[25] as is the incidence of all lower leg and foot disease in the TODAY and SEARCH cohorts, suggesting a later onset of neuropathic-associated foot disease.

Macrovascular / cardiovascular complications

Dyslipidaemia (elevated LDL-C and TAGs and reduced HDL-C) and smoking drive atherosclerosis (plaque formation), and, along with hypertension, greatly increase the risk of major cardiovascular events (myocardial infarction, stroke and peripheral vascular events).[21,28]

Renal disease and retinopathy are also correlated with a higher risk of cardiovascular disease,[25] reflecting common risk factors.

In the TODAY cohort, 54 per cent of youth with type 2 diabetes developed ≥2 cardiovascular risk factors within 14 years of diagnosis, including 59 per cent with hypertension, 33 per cent with elevated LDL-C levels, and 37 per cent with high TAGs. Furthermore, 17 young people (2.5 per cent) had a major cardiovascular event over 17 years.[11] Youth of non-European ethnicity also had increased risk of macrovascular complications compared with Europeans.[19]

In Auckland, 57 per cent of youth with type 2 diabetes had hypertension and 38 per cent and 33 per cent had elevated LDL-C and TAGs, respectively, at the time of diagnosis.[23] In the Taranaki region, 43 per cent of obese children and adolescents (including 61 per cent with type 2 diabetes) had dyslipidaemia, and 11 per cent had hypertension or pre-hypertension, while smoking was not reported.[8]

Smoking increases LDL-C, inflammatory changes in the endothelial layer, increasing atherosclerosis and risk of cardiovascular events.[21] Reports are limited on the prevalence of youth with type 2 who smoke but high rates were reported in Australia (38 per cent),[27] 39 per cent[29] and 23 per cent[11] in the SEARCH and TODAY cohorts, and for young Māori (43 per cent) and Pacific (24 per cent) adults in Auckland with type 2 diabetes.[25]

Young people with type 2 diabetes often struggle to manage glycaemic levels

Management

Outcomes are improved by holistic care, family involvement for lifestyle changes, and follow-up from a multi-disciplinary team, including dietitians, psychologists, doctors, and nurses, with clear communication between primary and secondary care services.[12]

Management recommendations for children and youth with type 2 diabetes in New Zealand are based on Australian,[30] American ADA and the UK NICE guidelines.[10] Lifestyle and pharmaceutical intervention guidelines are largely based on adult randomised controlled trials and aim to normalise HbA1c to <48 mmol/mol,[10] or <53 mmol/mol[9] and blood pressure, improve lipid profiles and support smoking cessation.

- **Lifestyle interventions**

Recommended lifestyle changes are based on attaining age and developmentally appropriate nutrition,[9] 60 minutes of moderate to vigorous exercise each day and strength-based exercises three times a week.[30] Additional recommendations include limiting recreational screen time to less than two hours a day and ensuring adequate sleep.[9]

Lifestyle interventions improve cardiometabolic risk profiles (hypertension and dyslipidaemia) and are broadly recommended for those not meeting targets, but improvements decline if nutritional and exercise programmes are not maintained.[12,17]

Recommended lifestyle changes include 60 minutes of moderate to vigorous physical exercise a day. Photo: Adobe Stock, AI-generated.

Despite recommendations, several activity-based interventions have been tried with limited success in this population in Australasia, including "Push Play NZ" (1999-2002) and the Australian "It's Your Move" (2006-08), with similar results for lifestyle interventions in other countries. Most youth are unable to achieve or maintain good glycaemic control with lifestyle changes or meet and maintain recommended physical activity levels.17

Smoking: Preventing smoking is ideal and smoking cessation vital for reducing complications in this population.26 Although not reported in New Zealand, it is expected that the proportion of youth with type 2 diabetes who smoke is similar to the 23–39 per cent reported for Australia and North America.11,27,29 Reporting of these rates and evaluation of management strategies would be helpful.

- **Pharmacotherapy**

Hyperglycaemia: Until recently, only metformin and insulin were approved for children and youth with type 2 diabetes in New Zealand. Metformin (biguanide) <2 g daily remains the first-line treatment for children10 and people ≥15 years.26

Metformin reduces insulin resistance, promotes glucose uptake in liver, adipose and skeletal muscle, reduces the breakdown of glycogen and release of glucose and TAGs,26 and improves both microvascular and macrovascular outcomes, highlighted in the first adult metformin UK Prospective Diabetes Study Group (UKPDS-34) trial.

Despite metformin therapy, beta-cell function declined 20-35 per cent each year among youth in the TODAY cohort, (more rapidly than the 7-11 per cent expected for adults) necessitating insulin therapy for half of the cohort in the first year after diagnosis.11

Insulin is recommended in New Zealand if HbA1c is >90 mmol/mol.26 However, insulin, an anabolic hormone, often leads to weight gain, increases episodes of hypoglycaemia17 and stigma, and presents administration challenges for youth.17

> **Most youth are unable to achieve or maintain good glycaemic control with lifestyle changes or meet and maintain recommended physical activity levels**

Second-line therapies now recommended are sodium-glucose cotransporter-2 inhibitors (SGLT2i: empagliflozin), or glucagon-like peptide-1 receptor agonists (GLP-1RA: liraglutide and dulaglutide) and are largely used "off label" as they are not registered in New Zealand for people under 18 years of age.[9,26]

It is recommended that an SGLT2i or GLP-1RA is added to metformin if HbA1c remains >64 mmol/mol or there is evident renal disease.[9,26] Currently in New Zealand, SGLT2i and GLP-1RA have special authority approval. Limited supplies of GLP-1RA and funding by PHARMAC to one agent, however, reduces access for most youth with type 2.[26]

SGLT2i block glucose transporters in the kidney tubule cells, reducing glucose and water reabsorption, and, in turn, blood volume and blood pressure, reducing the risk of major cardiovascular events in adult trials.[31] GLP-1RA mimic the peptide-based incretin hormone released by L-cells in the small intestine, thereby increasing insulin secretion, delaying gastric emptying, reducing glucagon secretion from the alpha cells and hepatic insulin resistance, and decreasing appetite — thus promoting weight loss.[31]

DDP-4-inhibitors (vildagliptin and linagliptin) inhibit enzymatic degradation of incretins and GLP-1RA, prolonging their glucose-lowering actions. Responses to novel additional hyperglycaemic agents differ between youth and adults, with SGLT2i (empagliflozin), but not linagliptin, slightly reducing HbA1c in youth, and neither drug reducing blood pressure, differing from improvements in cardiovascular risk factors observed in adult trials.[31]

Vildagliptin can be used as a second-line agent, pioglitazone (a thiazolidinedione that reduces insulin resistance) as a third-line agent, along with sulphonylureas for adults over 18 years, although this may also be considered and recommended by a paediatric endocrinologist for children and adolescents.[9,26]

Body weight: The TODAY participants trialled a lifestyle-intervention programme compared with metformin and showed a similar reduction in body mass index (BMI) but a greater reduction in HbA1c, opposite to results in adult trials.[11]

In addition to reducing HbA1c levels, Ozempic (semaglutide), a GLP-1RA, in combination with lifestyle interventions, achieved a 16 per cent reduction in BMI in adolescents, similar to the reduction observed in adults, with mostly transient gastro-intestinal side-effects.[32]

Longer trials are required to assess maintenance of body weight reductions and potential side effects,[32] as continued use of these novel drugs may be required to maintain weight loss.

Bariatric surgery: There are limited studies examining surgical management of youth obesity. One US-based trial reported that most of these youth (89 per cent) lost at least 10 per cent of their total body weight with a mean loss of 27 per cent, and 95 per cent had achieved remission of diabetes and were normoglycemic at three years.[33]

Improvements in cardiometabolic and renal risk profiles and quality of life were evident for these youth, who had fewer complications than medically-managed youth.[33] Down sides of surgery were its association with band slipping or erosion, staple-line leaks, pulmonary embolism, multiple additional surgeries and micronutrient deficiencies.[33] Evidence on long-term effects on bone density, malnutrition, mental wellbeing and fertility is lacking.[33]

Hypertension: The first UKPDS-38 anti-hypertensive trial among adults with type 2 diabetes showed a 37 per cent risk reduction in microvascular complications and a 44 per cent and 32 per cent reduction in stroke and cardiovascular mortality, respectively.

In the TODAY cohort, 19 per cent of youth had hypertension (>130/80 mmHg) at baseline and 59 per cent after 10 years, including 28 per cent prescribed antihypertensive medication.[11] The potential benefits of pharmacological management of hypertension in youth with type 2 diabetes are not known.

Dyslipidaemia: It is recommended that LDL-C levels are <1.8 mmol and lipid-lowering therapy (statins) prescribed, if elevated in the presence of cardiovascular risk factors or renal disease.[26] One-third of the youth with type 2 develop elevated LDL-C with only 10 per cent prescribed lipid-lowering therapy.[11,12]

Adding a GLP-1RA (liraglutide) slightly improves lipid profiles and hepatic adiposity, and SGLT2i (empagliflozin) delays initiating insulin.[9,31]

- **Management challenges**

Lifestyle interventions are challenging for this population against a background of urban development and unregulated food-industry commercial interests that perpetuate the obesogenic environment, particularly in economically deprived regions.

A lack of monitoring and under-treatment of hypertension, dyslipidaemia and smoking are evident among youth with type 2 diabetes. There is a paucity of reports on the use and effectiveness of antihypertensive and lipid-lowering medications, and on smoking rates and cessation for this population in New Zealand.

Despite this, 44 per cent of young adults with type 2 diabetes in one Auckland study were prescribed antihypertensives and 38 per cent lipid-lowering medications.[25]

A lack of monitoring and under-treatment of hypertension, dyslipidaemia and smoking are evident among youth with type 2 diabetes.

Managing hypertension and dyslipidaemia in young women with type 2 diabetes raises safety concerns, given the teratogenicity (risk of causing defects in a developing foetus) of commonly prescribed antihypertensive and lipid-lowering medications. This necessitates caution and, potentially, appropriate contraception.

Conclusion

Youth with type 2 diabetes face an aggressive and treatment-averse condition and experience early and high rates of diabetes-related complications, especially renal disease, within the first and second decades of diagnosis.

Screening and prompt intensive management of hyperglycaemia, hypertension, dyslipidaemia, obesity and smoking are essential to reduce the risk of all diabetes-related complications.

Lifestyle changes and pharmaceutical management pose many challenges for this population, who are more likely to be from economically disadvantaged households.

Family involvement and support, communication between primary and secondary healthcare, and cooperative inter-disciplinary oversight are central to effective management of cardiometabolic risk factors.

Lifestyle changes and pharmaceutical management pose many challenges for this population, who are more likely to be from economically disadvantaged households.

Metformin monotherapy remains the first-line pharmaceutical treatment for managing HbA1c. Most youth with type 2 diabetes require additional glycaemic medications (GLP-1RA or SGLT2i) within one year of diagnosis. Insulin is initiated if HbA1c remains elevated.

More youth intervention and follow-up studies to inform management are required, as current guidelines are largely based on adults who respond differently to some therapies and have a later onset of complications. Central and local government policy changes are urgently required to reduce the current obesogenic environment driving this epidemic among children and youth.

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* *This article was reviewed by Jenny Rayns and Carla Frewen, diabetes clinical nurse specialists in the Te Whatu Ora southern region.*

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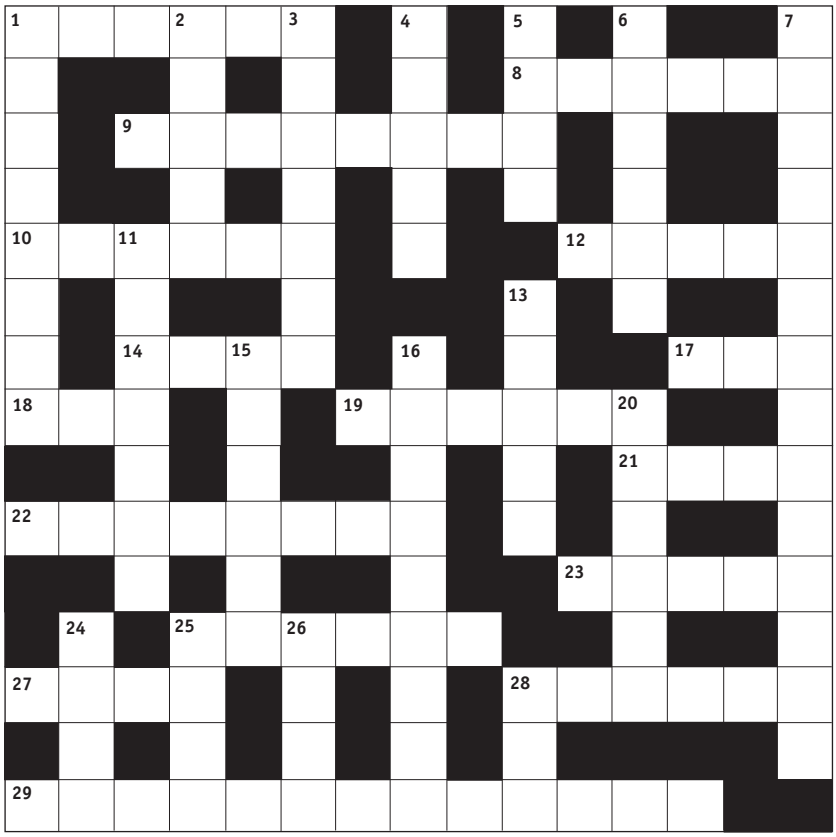
December 2024 crossword



ACROSS

1) Withdraw labour.
8) Sort patients by severity.
9) Another name for coriander.
10) Health service goal.
12) Slang word for “ill”.
14) Imitate.
17) Atmosphere.
18) Organ which aids balance.
19) Tertiary qualification.
21) Scottish lake.
22) Related to nursing practice.
23) Drug derived from poppy.
25) Sibling’s son.
27) Funeral fire.
28) Spending plan.
29) Pertussis.

DOWN

1) Scarcity.
2) Sweet layer on cake.
3) Precisely.
4) Make motion of vomiting.
5) Tiny particle.
6) Under-age people.
7) Greetings of the season (Māori).
11) Hire.
13) Christmas song.
15) Abrasive stone.
16) General healthiness.
20) Ran away to marry.
24) Legend.
25) Roman emperor, son of Claudius.
26) Baby (Māori).
28) Short summary of your life.

September answers

ACROSS: 1. University. 6. Feud. 8. Inferno. 9. Menu. 11. Gout. 12. Propose. 15. Cue. 16. Elope. 17. Android. 18. Hour. 21. Limp. 22. Target. 23. Hens. 28. Kōrero. 29. Katipo. 30. Pulsates. 32. End. 33. Pipi. 34. Cataract.
DOWN: 1. Union. 2. Info. 3. Error. 4. Snoop. 5. Tom. 6. Frugal. 7. Distress. 10. Eve. 12. Pearls. 13. Oedema. 14. Shift. 15. Clove. 19. Brooms. 20. Dementia. 23. Happen. 24. Naked. 25. Myopic. 26. Corset. 27. Stops. 31. Let.

Kaitiaki
NURSING NEW ZEALAND

LETTERS

Māori and Pacific Island workforce take the hit at Health NZ

BY DR CLIVE ASPIN

December 20, 2024

Māori and Pacific Island workforce are taking the hit as Health NZ restructures one of its arms — National Public Health Service (NPHS) — disestablishing essential roles in public health services.

With the disestablishment of key roles and functions at the NPHS, it is clear that Māori and Pacific workers and their whānau continue to bear the brunt of job cuts in the public sector.

Te Whatu Ora is proposing to downsize both its Māori and Pacific public health teams (https://www.psa.org.nz/our-voice/cuts-to-maori-and-pasifika-health-services-will-harm-communities/) – including disestablishing the NPHS's entire Māori health team.

The magnitude of the job cuts announced by the NPHS will have immediate and long-term negative impacts on the health and wellbeing of some of the most disadvantaged members of our communities.

We know that Māori whānau as well as Pacific peoples endure significantly poorer health outcomes than other people and these job cuts will cement poor health well into the future.

The decision of the Coalition Government to make severe cuts to the public health workforce will have widespread impacts on some of our most disadvantaged communities, and will contribute to an expansion of the health and social disparities that already exist.

While Health NZ claims that their decisions are based on financial constraints, they fail to recognise that the impacts of these cuts will be felt for generations to come.

Already, we are seeing signs of adverse mental health outcomes among the more than 6000 public servants who have lost their jobs. Many of those made redundant are sole income earners and most of them are now faced with applying for jobs that don't exist or relying on benefits.

Moving to other locations to find work, including those across the Tasman, is not an option for Māori and Pacific people because the communities to which they belong are here in Aotearoa.

These cuts are certain to create health and social problems well into the future, with the greatest negative impact being felt in communities that can least afford it.

The reduction in public health services will have widespread repercussions well into the future and beyond.

Dr Clive Aspin
Public health researcher on behalf of STIR (Stop Institutional Racism)

Kaitiaki
NURSING NEW ZEALAND

LETTERS

No more Australian job advertisements in Kaitiaki

BY PAUL GOULTER

December 18, 2024

At a time that our nursing graduates here in Aotearoa are struggling to find work and our biggest health employer Te Whatu Ora says it cannot afford any more nurses, we are facing an unprecedented risk to our nursing workforce which could impact our ability to care safely for patients for years to come.

Photo: AdobeStock.

And by safely, I mean culturally, as well as clinically.

NZNO — Tōptūtanga Tapuhi Kaitiaki o Aotearoa supports a culturally competent nursing workforce which reflects and supports our unique communities. Our Māori and Pasifika peoples continue to experience disproportionately poor health outcomes, yet this Government has discarded an equity-focused approach.

And it is our Māori or Pasifika nurses who can provide the most culturally safe care to those communities. Yet they continue to be under-represented in our workforce. We do not want to lose a single one.

NZNO will continue to press Te Whatu Ora to ensure every graduate nurse gets a job – which we believe they are obliged to do.

NZNO is working hard – through bargaining, through industrial action, through media – to make Aotearoa a safe and appealing place for our New Zealand-trained nurses and kaiāwhina to stay, live, work and support their whānau.

NZNO will continue to press Te Whatu Ora to ensure every graduate nurse gets a job – which we believe they are obliged to do.

We don't want to lose our new graduates – or any of our members, nurses or kaiāwhina – to Australia or elsewhere. Some may never return, and we badly need them here – now and into the future.

This is why I've decided that, from this month, *Kaitiaki* will no longer accept advertisements from Australian recruiters and employers. I believe it is the right thing to do.

We are here to support and help retain our valuable nurses in New Zealand – not train them up then send them away.

Paul Goulter, chief executive
NZNO — Tōpūtanga Tapuhi Kaitiaki o Aotearoa