(NZNO, 2025)
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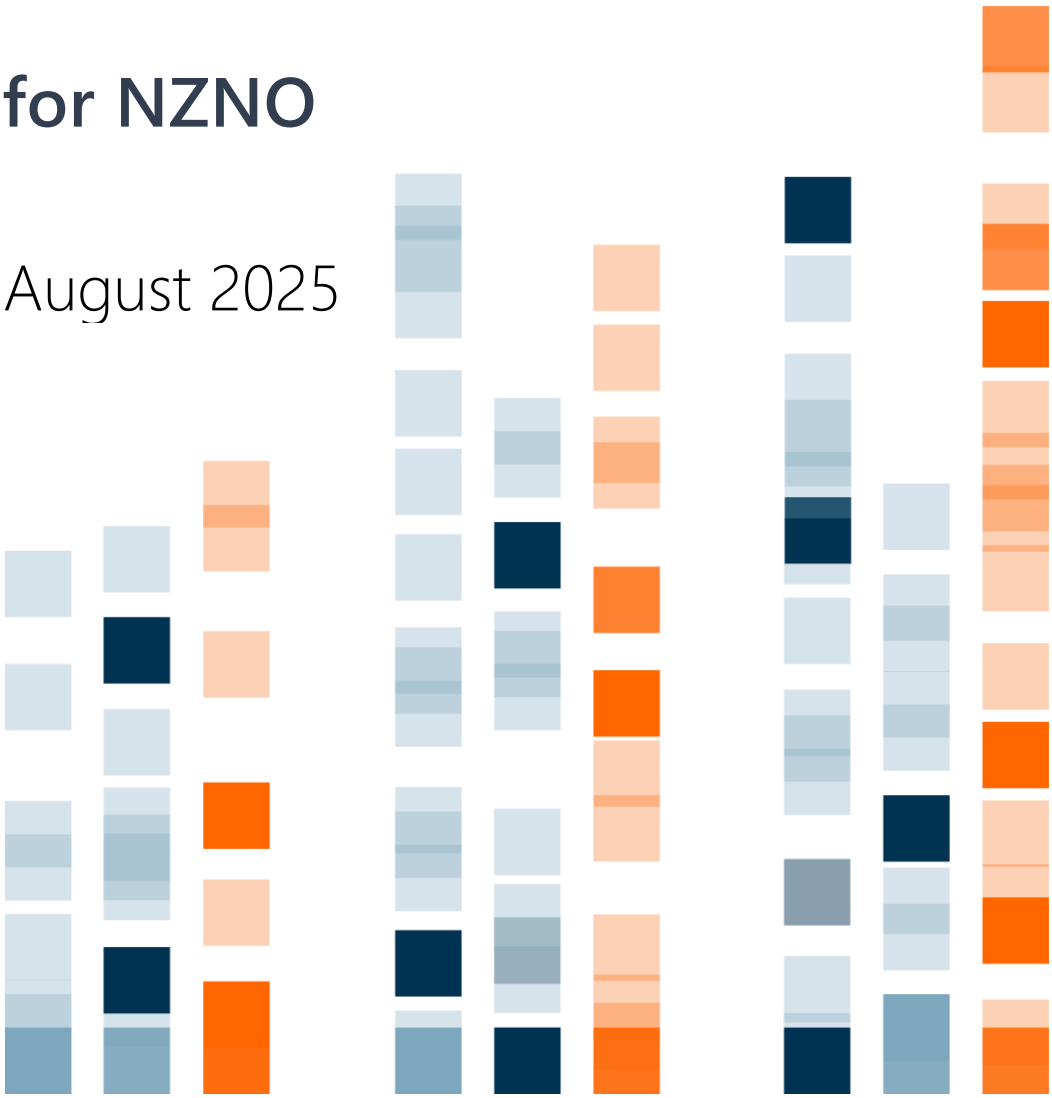
How many more nurses does New Zealand need?

for NZNO

August 2025



Infometrics
Economics put simply

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

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

The nursing shortage

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

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

Table 6

The nursing shortage in public hospitals

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

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

Source: Te Whatu Ora, CCDM data

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

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

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

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

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

Pay disparity

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

Funding mechanisms can lead to under-funding

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

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

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

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

Scaling the service to fit funding

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

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