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New Zealand School Nurses Ltd

New Zealand School Nursing Pay Equity Report

New Zealand School Nurses Ltd

March 2026

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Preface

This report has been produced through the dedication and hard work of school nurses, their allies, and the New Zealand School Nurses Pay Equity Working Group (PEWG). Over the past 24 months, members of the PEWG have volunteered countless hours to research, consultation, and the development of a pathway toward equitable pay and improved working conditions for school nurses across Aotearoa.

We acknowledge the invaluable input and support of the New Zealand Nurses Organisation (NZNO), as well as Principals, School Leaders, and Nurses who have provided feedback and guidance throughout this mahi (work). Their contributions have been central to understanding the real-world experiences of school nurses and the structural challenges that have shaped and continue to shape the workforce.

This report presents findings from a national workforce survey of school nurses, alongside analysis of employment conditions, pay equity, workload, and sustainability. Its purpose is to document current realities, identify systemic risks, and provide evidence-informed recommendations to those who fund, employ, manage, and advocate for school nursing services.

The preface of this report is guided by the tongikura:

“Ki te kotahi te kākaho, ka whati; ki te kāpuia, e kore e whati.”
“When a reed stands alone it is vulnerable, but a group of reeds together is unbreakable”.

This tongikura whakataukākī, attributed to King Tāwhiao, reflects the spirit of collaboration, advocacy, and collective strength that has underpinned the work of the Pay Equity Working Group and the commitment of school nurses across Aotearoa New Zealand to securing fair, safe, and equitable conditions for the profession.

Executive Summary

School nurses play a critical role in supporting the health, wellbeing, and safety of children and young people across Aotearoa New Zealand. Working at the intersection of health and education, they deliver complex clinical care, mental health support, safeguarding (protecting children from harm and ensuring their wellbeing), care coordination, and health system navigation in environments that are often fast-paced, resource-constrained, and high risk. Despite the essential nature of this role, the employment conditions of school nurses have remained largely invisible at a national level.

This report presents the findings of the first national survey focused specifically on pay and employment conditions for school nurses in Aotearoa New Zealand. Commissioned by the New Zealand School Nurses (NZSN) Pay Equity Working Group (PEWG), the survey captures responses from approximately 45–48% of the estimated school nursing workforce. The survey represents nurses working across 128 New Zealand schools, from a wide range of education settings, who work under different funding models, and for a variety of different employers.

The findings confirm that this is a highly fragmented workforce, with school nurses employed through both health and education sectors, including District Health Boards (DHBs), Primary Health Organisations (PHOs), Non-Governmental Organisations (NGOs), and sometimes directly by schools. While this haphazard approach to employment, which is based essentially on structural diversity, has long been recognised, the report provides new evidence of the unacceptable consequences inherent in it for pay equity, service safety, and indeed, workforce sustainability.

Across all nursing roles surveyed, including Enrolled Nurses, Registered Nurses, Lead Nurses, and Nurse Managers, the average hourly pay rates were commonly found to sit below the current Multi Employer Collective Agreement (MECA) benchmarks. In some cases, nurses reported being paid at least \$10 per hour less than comparable MECA-aligned roles. Dissatisfaction with pay was widespread among the respondents. This was strongly linked to perceptions of being undervalued relative to their level of professional responsibility, to the professional isolation that often comes with the role, and to the high level of clinical risk school nurses are often required to undertake within their school nursing roles.

The report also identifies extensive unpaid labour across the workforce. Nurses frequently described working beyond contracted hours, missing meal breaks, and completing clinical documentation, follow-up care, and administrative tasks in their own time in order to maintain safe practice. The expectations by employers that school nurses would work beyond their contracted hours were often informal, unrecorded, and without compensation.

In addition, the practice by some employers of only contracting and paying school nurses for their work during each school term (known as ‘term-time-only employment’) further increases financial insecurity for many nurses. While hourly rates may appear reasonable in isolation,

reduced weeks of paid employment significantly lower annual income, in some cases by tens of thousands of dollars. This employment arrangement was identified by many school nurses as a major contributor to stress, burnout, and the decision to seek additional employment or leave school nursing roles altogether.

Collectively, the findings from the survey highlight a workforce under sustained pressure, with clear risks to retention, continuity of care, and service safety if current employment practices persist. The report identifies a strong alignment between poor employment conditions and workforce attrition, raising concerns about the long-term viability of school nursing services under existing funding and contracting models.

In response, this report presents a set of targeted, evidence-informed recommendations directed at key stakeholders, including government agencies, funders, employers, managers, unions, and school nurses themselves. The recommendations broadly focus on establishing nationally consistent contracts and pay frameworks while strengthening employer accountability and the auditing of funded services. In addition, improving staffing ratios, supporting full-year employment models and ensuring all school nurses have access to professional supervision and development are key to attracting and retaining quality school nurses.

Taken together, the findings and recommendations provide a clear mandate for coordinated action. Addressing pay equity and employment conditions is not only a workforce issue, but a matter of service quality, clinical safety, and equity for the rangatahi (children and young people) who rely on school nursing services across Aotearoa New Zealand.

Foreword

Across Aotearoa New Zealand, school nurses occupy a uniquely critical position at the intersection of health, education, and social wellbeing. They are often the first, and sometimes the only, qualified health professional accessible to rangatahi within the school environment. This report lays bare a reality that can no longer be ignored: while school nurses are entrusted with complex, high-risk, and highly skilled work, their pay and employment conditions do not reflect the value, responsibility, or impact of that work.

The findings presented here provide compelling evidence of systemic pay inequities that persist across regions, employers, and funding models. These inequities are not marginal or incidental. They are entrenched, structural, and consequential. School nurses are frequently paid below comparable nursing roles, often significantly so, despite working at full scope of practice, and, in many cases, at an advanced scope that includes autonomous clinical decision-making, mental health assessment, sexual and reproductive health care, safeguarding responsibilities, prescribing, and complex care coordination.

This mismatch between responsibility and remuneration sends a clear and troubling message: that the work of school nurses is undervalued. Yet the evidence demonstrates the opposite. International and Aotearoa-based research consistently shows that well-resourced, well-functioning school nursing services deliver substantial benefits for young people. These services are associated with improved mental health outcomes, increased access to sexual health care, reduced substance-related harm, earlier identification of safeguarding concerns, and stronger engagement with the wider health system, particularly for those least able to access care elsewhere.

In a context where youth mental distress, family violence, poverty, and unmet health needs are increasing, school nurses are not peripheral to the solution, they are central to it. They work relationally and preventatively, often over many years, building trust with students who may otherwise disengage entirely from health services. The downstream social and economic benefits of this work are significant, yet the current employment framework fails to recognise or reward it.

This report also highlights the human cost of inequity. Chronic underpayment, unpaid overtime, term-time-only contracts, and inconsistent employment arrangements contribute directly to burnout, moral distress, and workforce attrition. When experienced school nurses leave, the loss is not only professional expertise but continuity of care, trusted relationships, and institutional knowledge that cannot be easily replaced. Pay inequity is therefore not merely a workforce issue; it is a risk to service quality, safety, and equity for rangatahi themselves.

The evidence presented here makes a clear case for action. Fair and nationally consistent pay, transparent employment conditions, and recognition of school nursing as a specialised and essential area of practice are not aspirational goals; they are necessary foundations for a sustainable service. Addressing pay inequity is both a matter of justice for the workforce and an investment in the health and wellbeing of young people across Aotearoa New Zealand.

This report provides the data, the voices, and the mandate. The challenge now lies with those who fund, employ, and govern school nursing services to respond with urgency, courage, and commitment.

Professor Simon Denny

Director, Mater Young Adult Health Centre

February 2026

Introduction

Purpose of the Report

School nurses play a critical role in supporting the physical, mental, and emotional wellbeing of rangatahi across Aotearoa New Zealand. Working predominantly in secondary school settings, they provide accessible, timely health care to school-aged rangatahi, often as the sole health professional within a school. Despite the importance and complexity of this work, school nurses have long reported inconsistent employment conditions, professional isolation, and significant variation in pay.

The purpose of this report is to provide a snapshot of the current state of employment, remuneration, and working conditions for school nurses across Aotearoa in 2025. Drawing on data from a national survey conducted in November 2025, the report documents workforce experiences and highlights inequities that persist across regions, employers, and funding models.

Specifically, this report aims to:

- Provide a contemporary overview of school nurses' employment conditions and pay.
- Identify pay inequities and disparities across different roles, employers, and locations.
- Capture the voices of school nurses through narrative commentary, illustrating the realities of their work.
- Support evidence-based advocacy and decision-making for government, policymakers, funders, unions and leaders in school nurse services and schools.
- Provide evidence to guide the development and finalisation of a national School Nursing Salary Scale (currently in draft status).

By presenting both quantitative and qualitative data this report seeks to establish a clear evidence base to support equitable pay, improved employment practices, and a more sustainable school nursing workforce nationwide.

School Nursing 2026 – has it reached a crisis point?

School nursing in Aotearoa New Zealand is at a critical juncture. The health and wellbeing needs of rangatahi have intensified in recent years, while the structures supporting school nurses have not kept pace. Mental health concerns, declining child and youth wellbeing, increasing social complexity for many families, and persistent health inequities particularly for Māori and Pasifika youth are placing sustained pressure on the school nursing workforce (Denny et al, 2014; Denny et al, 2018; Flemming et al, 2022).

At the same time, schools are increasingly expected to respond to a broad and expanding range of health-related issues, including chronic conditions, acute presentations, sexual and reproductive health, mental distress, neurodiversity, family and domestic violence, and safeguarding concerns. Much of this responsibility falls to school nurses, many of whom work largely in isolation within school settings, with limited professional support, inconsistent clinical governance, and variable access to supervision.

As demand continues to rise, national standards, infrastructure, and resourcing for school nursing services remain inconsistent across regions, employing entities, and school types. These conditions are contributing to escalating workforce pressures, including recruitment and retention challenges, high turnover in some settings, and increased risk for both nurses and the young people who rely on them.

Taken together, these developments make it imperative that the current state of the school nursing workforce - how it is supported and what systemic changes are required to strengthen its sustainability - is clearly understood by all stakeholders.

By capturing a national snapshot of school nursing in 2025, this report provides timely, data-driven insight to support immediate decision-making, future workforce planning, and improved health outcomes for young people across Aotearoa New Zealand.

Background and Employment Context

School nurses in Aotearoa are employed through two main sectors: Health or Education. Largely these are funded through public funding, with the exceptions of private schools, who may employ a school nurse funded through private school fees, and NGOs funded by philanthropic funding. Employment arrangements vary widely across all sectors, with implications for pay equity, access to support, and workforce stability. The variety of funding streams contributes to inconsistencies in remuneration and working conditions and presents challenges when advocating for equitable pay.

Health Sector Employers of School Nurses

- District Health Boards (DHBs)
- Primary Health Organisations (PHOs)
- Non-Governmental Organisations (NGOs)

Education Sector Employers of School Nurses

- State (public) schools
- Private schools
- Special charter schools

Each sector and employer type operates under different funding models, which influence school nurses' salaries, access to professional development, clinical supervision, and other entitlements. For example, nurses employed directly by schools may be funded through the school's education budget, while others employed also by schools can be funded through a DHB or NGO, each with its own pay structures and conditions. A few schools adopt a hybrid funding arrangement, receiving health funding, and adding additional education operational funding to the mix allowing them to employ more nursing FTE (full time equivalents).

Historical and Research Context

School nursing has existed in Aotearoa New Zealand for over a century. Over time, the role has evolved from a predominantly first-aid and welfare function into a modern primary health care role, reflecting changing youth health needs, growing recognition of the importance of accessible health services for young people, and sustained investment in school-based health services.

Early school nursing in the 1900's developed as part of a centrally directed public health and education response, with a strong focus on communicable disease control, hygiene, and student welfare. As health and education systems evolved, responsibility for school-based health services became increasingly decentralised. Health sector reforms, changes to funding mechanisms, and the introduction of contracted service models shifted decision-making to local and regional levels. While this enabled greater responsiveness to community need, it also reduced national consistency in how school nursing services were structured, funded, and supported.

From the 1990s onwards, school-based health services expanded significantly in response to a growing awareness of inequities in adolescent health outcomes. A key early initiative was the Achievement in Multicultural High Schools (AIMHI) programme, established in 1996 by principals of ten decile 1 secondary schools. The decile system ranked New Zealand schools from 1 to 10 based on the socio-economic status of their student communities, with lower-decile schools receiving higher additional funding to support students facing greater barriers to learning. AIMHI recognised that unmet health and social needs were undermining student attendance, engagement, and learning, particularly for Māori and Pacific students. The inclusion of nurses through partnership with the local DHB was a deliberate strategy to reduce health-related barriers to education.

Building on initiatives such as AIMHI, school-based health services were progressively extended to additional low-decile secondary schools. Expansion into decile 1–2 schools nationally began in 2006, followed by formalisation through the Ministry of Health ‘School-Based Health Services service specification’ in 2009, including extension into decile 1–3 schools, along with Teen Parent Units (TPUs), Te Kura Kaupapa Māori Schools (TKKM), and Alternative Education (AE) sites. Over time, in-school services developed along a continuum, ranging from limited nurse-led clinics to well-resourced multidisciplinary teams.

In parallel, a different pattern of development occurred in higher decile schools. From the early 2000s, some decile 9–10 secondary schools began employing school nurses directly. These decisions were locally driven, influenced by recognition of unmet student health needs, awareness of similar models elsewhere, expectations of parents and caregivers, or responses to significant health events within school communities. This further contributed to diversity in employment models and service delivery.

While this incremental and locally responsive approach expanded access to school-based health care, it also entrenched a tiered and fragmented system. Services came to be shaped by differing eligibility criteria, funding streams, and contractual arrangements. Nurses employed through health-funded school-based health services initially had access to structured clinical supervision, professional nursing leadership, and funded postgraduate education in youth health; however, access to these supports has eroded over time. In contrast, nurses employed directly by schools within the education sector have often had limited or no access to clinical supervision, funded professional development, or nurse management structures beyond the school.

Further initiatives layered additional expectations onto existing structures. From 2014, targeted funding supported the placement of general practitioners in some schools, with clinical psychologists also added to some schools from 2019. In 2017, a commitment was made to place a school nurse in every school, signalling strong political recognition of the value of school-based health care. However, implementation occurred within existing funding and contracting arrangements rather than through the creation of a unified national service model, and progress was slow and uneven, with only partial implementation achieved. More recently, MoH funded Tier 3 Service Specification School-Based Health Services contracts have been extended to Decile 1–5 schools, Teen Parent Units, Alternative Education settings, and Kura Kaupapa Māori, increasing access while adding further complexity to the service landscape.

Complicating the existing funding structures further, the Ministry of Education replaced the decile system (often criticised for oversimplifying socio-economic factors and stigmatising schools) with the Equity Index (EQI) in January 2023. The EQI provides a more nuanced measure of students’ socio-economic barriers by combining multiple factors to calculate additional funding and thus more accurately target support to those who need it most. The EQI assigns each student a score between 344 and 569, with higher scores indicating greater socio-economic barriers, which are then aggregated to determine a school’s overall equity funding. Criticism of this model has been widespread across the education sector due to its numerical

complexity and extra administrative load on School Principals and Boards. The Ministry of Health school-based health contracts are still funded based on the decile system. Many schools who were not eligible for government funded School Based Health Services under the decile system would be eligible under the Equity Index, yet because the funding basis has not changed, they still receive no government funding. This represents hundreds of young people across Aotearoa being denied access to convenient, youth-friendly healthcare.

Primary schools (yr 0-6) have received school nursing input from the 2000s onwards, often through Paediatric Community Nursing teams within local DHB/PHO structures. In these models, registered nurses typically hold consultative responsibility across multiple schools, alongside individual care coordination, immunisation catch-up programmes, and occasional classroom-based health promotion, most commonly in higher socio-economic deprivation areas. A small number of primary schools employ a school nurse directly from their operational (education) grants, some of whom took part in this survey.

Few intermediate schools (yr 7-8) in New Zealand have school nurses currently. Some are supported by a public health nurse who has a number of schools within designated school catchment area, for distribution of health information such as meningitis and measles outbreaks. Student wellbeing at most intermediate schools is shared between pastoral care teams/senior leadership teams and a receptionist/first aid officer. Students with high health needs at these schools may have specific support provided through local secondary or tertiary health services such as care plans provided by asthma nurses, or diabetes nurses.

The cumulative effect of this historical pattern of incremental, targeted, and locally driven development across some schools and not others, has been the emergence of a school nursing workforce embedded across multiple organisational structures. School nurses may be employed by health services, primary health organisations, non-government organisations, or directly by schools, with considerable variation in scope of practice, access to clinical support, professional development, resourcing, and remuneration. This diversity reflects evolutionary development rather than deliberate national design.

Research has consistently identified the challenges arising from this complexity. A Ministry of Health-commissioned review led by Buckley (2009) identified inconsistencies in funding, employment arrangements, and access to professional support. Subsequent analyses and reviews (Denny, Fleming, & Kool, 2014; Kool, 2017) confirmed that variable remuneration, limited access to professional development, and uneven administrative and clinical support remain enduring challenges for the school nursing workforce.

While previous reviews have identified variable employment arrangements as a persistent concern, no published analysis has explicitly examined the variation in remuneration for school nurses or absence of a nationally recognised pay scale for school nurses. This report extends this body of work by 1) including the perspectives of school nurses and 2) identifying the structural implications of no designated school nurse collective agreement, including significant variation in pay rates and employment conditions across settings.

These findings demonstrate that the issues identified in this report including inequities in pay, variability in employment conditions, and workforce instability are longstanding and systemic. The absence of coordinated national planning over several decades has resulted in fragmented funding and employment arrangements, making equitable pay, consistent employment conditions, and effective workforce advocacy difficult to achieve. The 2025 survey findings should therefore be understood within this historical context, as part of a continuing pattern rather than an isolated problem. Establishing a recognised national framework for employment arrangements and pay equity is essential if school nursing is to be a viable and sustainable career pathway in the 21st century.

Survey Methodology

The pay equity data and information regarding contractual arrangements and employment conditions contained in this report were captured through a national survey conducted by New Zealand School Nurses Ltd in November 2025. The survey was distributed through snowball recruitment via email to members of the New Zealand School Nurses Organisation, with a request to forward the survey onto school nursing colleagues. This was followed up with several targeted email reminders further distributed by regional school health leads. Participants were informed that their responses to this survey would be included in the report and were assured anything identifiable would be removed to protect confidentiality. This assurance was essential in capturing a true reflection of the current state of contractual arrangements, working conditions and pay issues in school nursing. The survey asked a short range of questions estimated to take 5-10 minutes to complete. These included the nurse's role, hourly rate, employment model, type of school/s that the nurse worked in (i.e. state, private etc.), and finally the survey included a free text box option for any additional details nurses wanted to share with the research group of the New Zealand School Nurses Pay Equity Working Group (PEWG).

Survey Results

Responses

The survey captured responses from approximately 45–48% of the school nursing workforce and represented the perspectives of nurses working across 128 schools throughout Aotearoa New Zealand. Respondents were drawn from a range of educational settings, including primary schools, intermediate schools, secondary schools, Te Kura Kaupapa Māori (TKKM), Teen Parent Units (TPUs), and Alternative Education Units. This breadth of settings provides a meaningful cross-section of practice environments and reflects the diversity of contexts in which school nurses operate.

For the purposes of this dataset, inclusion was limited to nurses employed specifically to work directly within a school environment. This definition ensured that the data reflects the experiences, scope, and priorities of nurses embedded in educational settings, whose roles are shaped by ongoing engagement with students, staff, and school communities. By applying this inclusion criterion, the survey sought to capture a clearer representation of the school nursing workforce itself rather than the broader health workforce interacting with schools.

The first map below illustrates the distribution of schools with identified school nursing services in relation to the wider national school network. All schools are represented to provide context for service reach (depicted as grey dots), with those known to have school nursing provision highlighted (depicted as blue markers). This comparison demonstrates the uneven footprint of the workforce across the education sector. Workforce coverage remains limited: approximately half of secondary schools in Aotearoa New Zealand do not have access to a school nurse, alongside more than 80% of intermediate schools and approximately 95% of primary schools. There are also regions where school nursing positions are absent entirely, indicating areas where students have no access to school-based nursing services.

The second map depicts the geographical distribution of survey respondents (shown as blue markers). While responses demonstrate national representation across regions where school nurses are employed, they must be interpreted within the context of the uneven service distribution illustrated below. Areas without school nursing provision are inherently absent from workforce-based data collection, resulting in no local representation within the survey dataset.

Taken together, these maps highlight structural inequities in access to school-based health services and reinforce the importance of interpreting the survey findings as reflective of the current workforce footprint rather than national student need. Geographic variation in provision, influenced by regional funding and service models, continues to shape both service reach and workforce planning considerations.

Map of New Zealand

- All Schools in New Zealand
- 📍 Schools with School Nursing Services



Map of New Zealand



Survey Respondent Workplaces



Nursing Roles with school-based health services

Most school nurses in NZ are Registered Nurses. Within a school, the job title varies between the following;

- Enrolled Nurses
- Lead Nurses
- Matrons (usually found at schools with boarding houses)
- Nurse Managers
- Registered Nurses
- School Nurses
- Youth Nurses
- Youth Health Nurses
- Nurse Educators

There is no consistency between the use of these terms. Each school typically has a 'Lead Nurse', even schools employing a sole nurse. The Lead Nurse typically has additional responsibilities such as:

- Ordering and replenishing stock
- Leadership of staff/Overseeing other nurses, first aiders, health center administrators
- Coordination of service delivery
- Ensuring safe, effective operations
- Key liaison with other primary and secondary health professionals working with specific students
- Budgetary duties
- Administration tasks such as invoicing the Accident Compensation Corporation (ACC)
- Incident management
- Documentation auditing
- Medication auditing
- Staffing and duty rosters
- Multidisciplinary meetings
- Reporting duties

It is worth noting here that currently there is no national requirement for a school nurse to have a state registered nurse qualification, enrolled nurse qualification, or current Annual Practicing Certificate (APC). Enrolled Nurses differ from Registered Nurses in that they have shorter training and in most settings work under the supervision of a Registered Nurse. In this survey, all those who identified as Lead Nurses were Registered Nurses.

The table below demonstrates the role of those who completed the survey. Those considered eligible had to be working in a clinical role with students and were employed to work within one

school or across several schools. For this survey, we allowed respondents to choose the title they self-identified with.

A few respondents in the survey had previously been registered with the Nursing Council but their registration had lapsed. They were employed as a 'School Nurse' because their school management did not require them to have a current Annual Practicing Certificate (APC) issued by the Nursing Council of New Zealand. They fall into the 'other' category in the table below.

The Nurse Educators and Nurse Managers who participated in this survey indicated they had a hybrid contract which requires some hours in school clinics, alongside some hours of management duties in an office location offsite of school such as a PHO or NGO building.

ROLE	Percentage of Respondents
Enrolled Nurse	2%
Lead Nurse (All Registered Nurses)	3%
Registered Nurses	90%
Nurse Manager	2%
Nurse Educator	1%
Other	2%

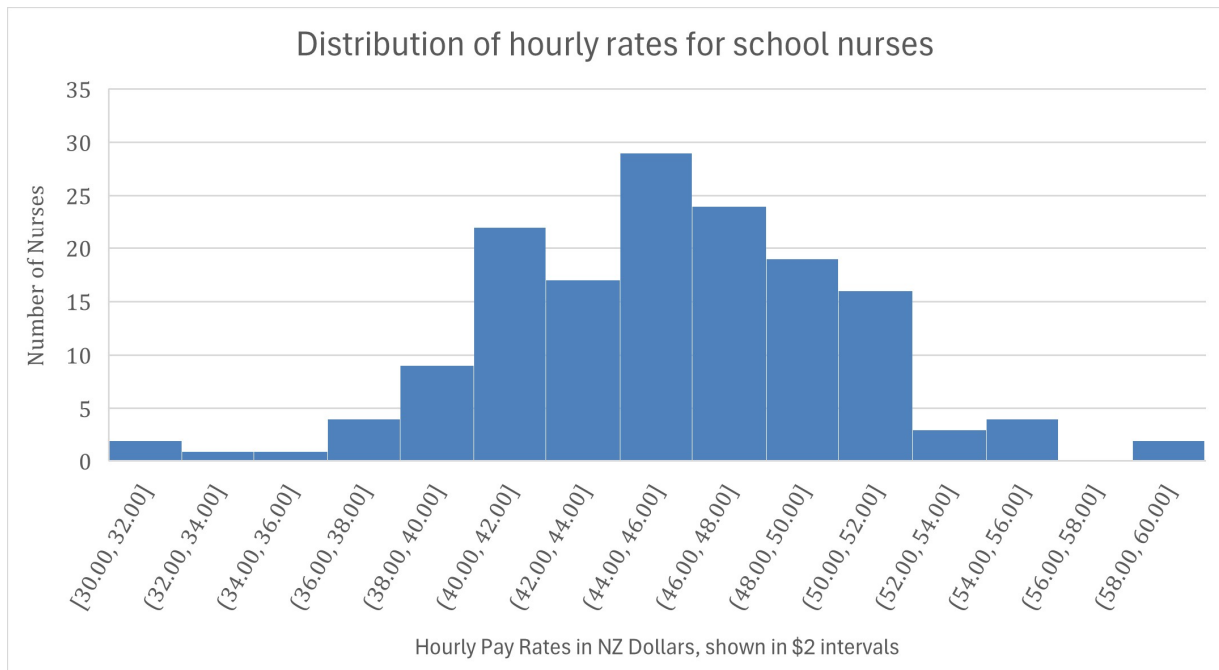
Remuneration

The table below presents the range of hourly pay rates reported by respondents in the 2025 Pay Equity Survey.

ROLE	Lowest Rate	Highest Rate	Mean	Median	Mode
Enrolled Nurses	\$30.26/hr	\$46/hr	\$37.42/hr	\$38.13/hr	N/A
Lead Nurses	\$41.00/hr	\$60.00/hr	\$48.51/hr	\$48.00/hr	\$46.00/hr
Registered Nurses	\$38.80/hr	\$55.79/hr	\$47.53/hr	\$48.00/hr	N/A
Nurse Managers*	\$30.00/hr	\$53.00/hr	\$45.07/hr	\$45.70/hr	\$45.00/hr
Nurse Educators	\$34.00/hr	\$60.00/hr	\$47.77/hr	\$48.55/hr	\$48.55/hr
Other	\$41.00/hr	\$60.00/hr	\$48.51/hr	\$48.00/hr	\$46.00/hr

Note: The survey did not specifically seek responses from all School-Based Health Care Managers. However, several nurses in these roles completed the survey. Due to the wide range of reported rates, these responses have been included.

Distribution of Hourly Pay Rates for School Nurses



Includes Registered Nurses, Lead Nurses, Enrolled Nurses (n=3), and Nurse Managers (n=4).

This histogram illustrates the distribution of hourly pay rates reported by school nurses across all roles. The horizontal axis shows hourly pay in New Zealand dollars, while the vertical axis represents the number of respondents reporting rates within each pay band.

The distribution highlights both the presence of comparatively low hourly rates and substantial variation across the workforce. These findings indicate significant differences in remuneration within the school nursing workforce, with some reported pay rates falling well below benchmark nursing remuneration in the wider health sector

There is currently no Multi-Employment Collective Agreement (MECA) specific to school nursing in New Zealand. This reflects the varied employment arrangements that exist across the sector.

The largest collective agreement covering nurses nationally is the New Zealand Nurses Organisation (NZNO) MECA for nurses employed by Health New Zealand – Te Whatu Ora. This agreement is updated periodically and is publicly available. At the time this report was prepared, the most recent published agreement covered the period 31 March 2023 – 31 October 2024 (Te Whatu Ora – Health New Zealand & New Zealand Nurses Organisation, 2023).

To provide context for the hourly pay rates reported in this survey, the relevant salary bands within the NZNO MECA are presented below. Direct comparison is not always straightforward, as salary progression within the MECA depends on factors including years of experience, qualifications, role designation, and applicable allowances.

Historically, initiatives such as the AIMHI project required nurses working in school settings to have a minimum of five years’ postgraduate experience before transitioning into community-based roles. This requirement was intended to ensure nurses had a strong clinical foundation before practising with a high degree of autonomy in community settings. Over time this expectation has changed, moving from a requirement to a recommendation, and more recently allowing the introduction of New Graduate nurses into some school nursing positions. These changes have occurred alongside broader workforce pressures affecting the nursing profession. Under the NZNO MECA, a new graduate registered nurse currently commences on an annual salary of \$75,773, while a registered nurse with approximately five years’ experience commences on \$103,750. These figures are subject to change as new collective agreements are negotiated.

To enable comparison with the hourly rates reported by survey participants, these annual salary figures were converted to approximate hourly rates. Examples are provided in the table below.

Te Whatu Ora remuneration (base) rates

Registered Nurse	New Grad Annual Sum	New Grad Hourly Rate	5 years experience Annual Sum	5 years experience Hourly Rate
Enrolled Nurses	\$69,934	\$33.62	\$83,349	\$40.07
Lead Nurses	N/A	N/A	\$114,025	\$54.82
Registered Nurses	\$75,773	\$36.40	\$103,750	\$49.88
Nurse Managers*	N/A	N/A	\$122,086	\$58.70
Nurse Educators	N/A	N/A	\$116,040	\$55.79

The table above should be interpreted with caution. Hourly rates have been calculated using a 40-hour working week across 52 weeks of the year. These figures represent base salary rates only. Additional allowances may apply under the MECA, including shift allowances, meal allowances, and Professional Development and Recognition Programme (PDRP) payments.

Some schools choose to remunerate nurses in alignment with the NZNO and Health New Zealand MECA, despite having no formal requirement to do so. In these cases, school leadership may view equitable remuneration as important for attracting and retaining skilled nursing staff. Typically, allowances that may apply in Te Whatu Ora employment arrangements are not included in school-based roles.

Other schools do not align pay with the NZNO MECA, as they are not contractually required to do so. In these cases, remuneration may instead be determined using the NZEI Support Staff Collective Agreement (New Zealand Educational Institute Te Riu Roa & E tū, 2022), which is commonly applied to school staff employed within education-funded roles.

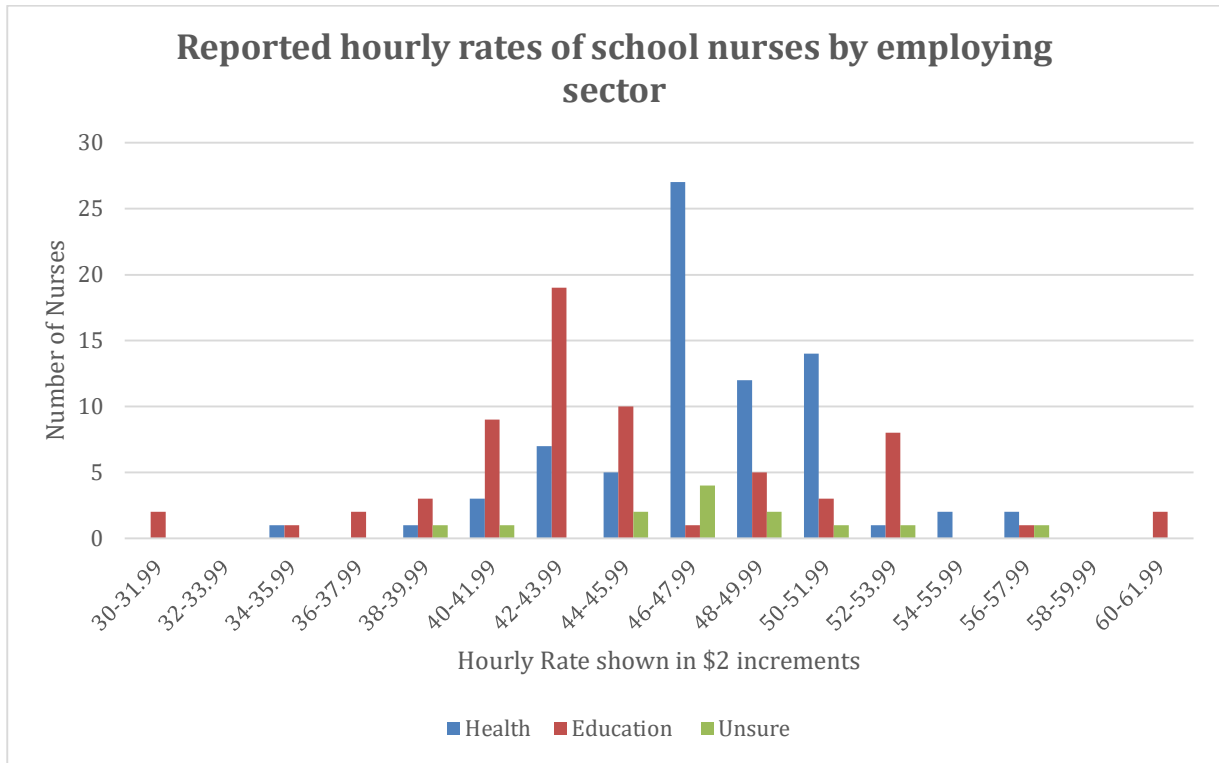
School nurses in New Zealand may be employed under a range of different employment arrangements. In addition to the NZNO MECA described above, some school nurses are remunerated under the NZEI Support Staff Collective Agreement.

NZEI remuneration (base) rates

At the time this report was prepared, the NZEI Support Staff Collective Agreement indicated that school nurses should be remunerated at Grade D, Step 7. The hourly rate for this pay band was \$38.77, effective 1 December 2023. An additional payment of \$0.58 per hour may be applied for recognised qualifications, to a maximum of \$1,225 per annum. The collective agreement also provides for additional payments, including a higher duties allowance (clause 3.11), as well as other expenses and allowances outlined in Part 5 of the agreement. Several survey respondents reported that they were paid according to Grade D within the NZEI collective. Among these respondents, hourly rates varied by approximately \$2–3 per hour. This variation may reflect the application of qualification payments or other allowances available under the collective agreement.

The collective agreement also includes provisions for an annual salary review (clause 3.82) and the opportunity for employees to request a salary review through their school board (clause 3.83).

Survey participants were asked to indicate whether their role was funded through health or education funding streams. This enabled a comparison of reported hourly pay rates by funding source. Some respondents indicated that they were unsure which funding stream supported their role. For the purposes of this analysis, these responses have been presented as a third category labelled “unsure”.



The table illustrates the range of hourly pay rates reported by respondents across the different funding categories and should be interpreted with caution. Hourly rates varied across respondents, and several participants were unsure of the funding source for their role. In addition, the results reflect only the proportion of the school nursing workforce who participated in this survey (approximately 45%).

Hours of Employment

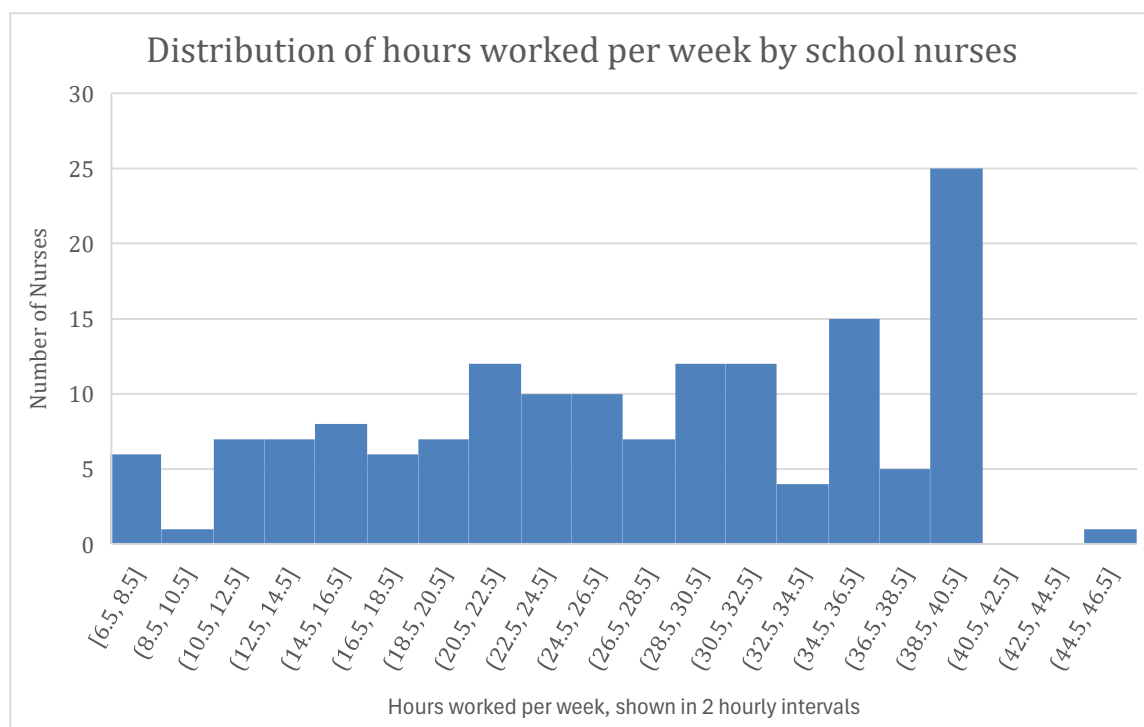
The table below shows the current range of hours worked by school nurses reported as part of the 2025 Pay Equity Survey.

ROLE	Lowest	Highest	Mean	Median	Mode
Enrolled Nurses	28hrs/wk	40hrs/wk	36hrs/wk	40hrs/wk	40hrs/wk
Lead Nurses	8hrs/wk	40hrs/wk	31hrs/wk	37hrs/wk	40hrs/wk
Registered Nurses	6.5hrs/wk	46hrs/wk	25.5hrs/wk	25hrs/wk	40hrs/wk
Nurse Managers*	26hrs/wk	36hrs/wk	31.15hrs/wk	32hrs/wk	32hrs/wk
Nurse Educators	\$34.00/hr	\$60.00/hr	\$47.77/hr	\$48.55/hr	\$48.55/hr
Other	30hrs/wk	33.5hrs/wk	32hrs/wk	32hrs/wk	N/A

*Note is made that the survey did not seek the salary ranges of all School Based Health Care Managers, however, some nurses in those roles completed the survey and due to the significant range in rates, we have chosen to include the hourly rates of those who did participate.

Nursing hours are negotiated between what the service requires, and what the nurse is willing to undertake. Many nurses expressed frustration that they were not paid enough hours to complete the work expected of them (detailed further below in this report). Note is made that one registered nurse indicated they worked 46hrs per week. Typically, within DHBs, nurses have a maximum number of hours that can be worked per week (including overtime and penal rates) to avoid burning out. This is not tracked within school-based nursing.

Distribution of weekly hours worked by School Nurses



This histogram shows the range and frequency of hours worked per week by school nurses. The x-axis represents weekly hours worked, and the y-axis represents the number of nurses reporting each range. The distribution illustrates variation in weekly workloads, including part-time and term-time-only arrangements, and highlights the inconsistency in hours across the workforce.

Weeks of Employment per year

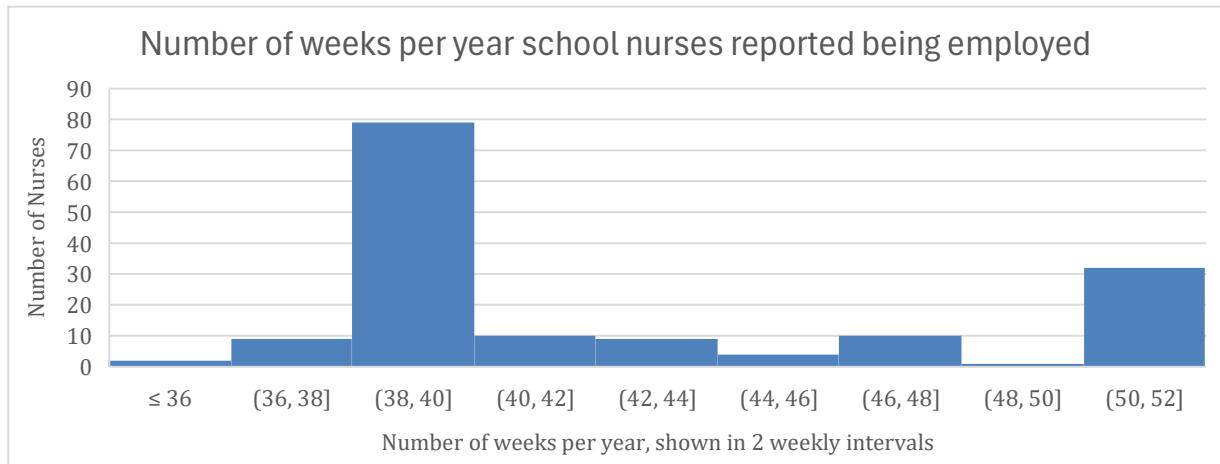
The table below shows the number of weeks per year that nurses reported being employed for, collected as part of the 2025 Pay Equity Survey.

ROLE	Lowest	Highest	Mean	Median	Mode
Enrolled Nurses	40wks/yr	40wks/yr	40wks/yr	40wks/yr	40wks/yr
Lead Nurses	38wks/yr	52wks/yr	46wks/yr	44wks/yr	52wks/yr
Registered Nurses	27wks/yr	52wks/yr	42.5wks/yr	40wks/yr	40wks/yr
Nurse Managers	52wks/yr	52wks/yr	52wks/yr	52wks/yr	52wks/yr
Other	40wks/yr	44wks/yr	41.5wks/yr	40wks/yr	40wks/yr

Enrolled nurses responding to this survey were only employed for 40 weeks of the year. This 40 weeks per year employment model has become more common over the last 30 years as schools seek to only pay nurses during term-time-only (TTO) in order to save money. Lead nurses and Registered Nurses varied in the number of weeks per year they were employed, whereas those in Nurse Manager positions were paid for a full year.

Term-time-only work proves contentious for school nurses. For those with school-aged children, the flexibility in having term holidays off is helpful, but for many in this survey, TTO employment proved challenging in terms of household budgeting, with many nurses picking up other work or nursing shifts at other healthcare facilities in order to make ends meet. Alongside this came a strong narrative that much work related to their role as school nurses, needs to be done during school holiday breaks e.g. restocking, ongoing care of vulnerable young people, admin, ACC claims - but no time was allowed for such tasks under the TTO employment model. Many nurses compared their roles with other professional staff working in schools who are employed for 52 weeks of the year and they voiced their frustrations at the disparities. These are documented further on in this report.

Distribution of weekly hours worked by School Nurses



This histogram illustrates the number of weeks per year that school nurses are employed. The x-axis shows weeks worked, and the y-axis represents the number of nurses reporting each range. The distribution highlights that many school nurses are employed on a term-time-only basis, with a notable peak at approximately 40 weeks per year, reflecting alignment with the school calendar.

Free text themes

This section of the survey was optional. Participants were invited to share any information they wanted to add related to school nursing pay equity issues in a free text box. We received over 100 comments, ranging from 1-2 lines from some to several paragraphs from others. These comments provided sobering reading but also rich insight into the working and employment conditions experienced by school nurses.

Due to the sheer volume of comments, we have spent some time analyzing the free text responses using a deductive reasoning methodology for the purpose of this report. In addition, we have grouped comments into the following themes, prefaced by a summary paragraph and followed by key quotes that illustrate them.

Attrition in the school nursing workforce

These respondents told us they were either planning on leaving the profession or had completed the survey having left due to poor pay. Currently there is no workforce data held nationally on the numbers of employed school nurses, nor the turnover rates of the workforce.

Previous research by NZSN on workforce attrition indicated a 20% turnover of school nursing staff within any calendar year. Some school nurses do move from one school to another based on local knowledge of better employment conditions in a different school. Examples include a salary increase, a higher perceived level of support from senior management, allowances, access to professional development (PD), and other related benefits. But overall, the comments below reflect school nurses who are planning on leaving or who have left due to pay dissatisfaction.

'These [responses to the survey] are retrospective answers from the end of 2024. I'm now working as a practice nurse', (1).

'We have lost so many great School Nurses over the last couple of years due to having to work overtime without pay and not being paid 52 weeks per year. I absolutely love my job but I often think 'is it worth it?' Lucky there's not much other nursing jobs out there, but I have been looking...', (16).

'I left my previous MoE school job to gain significantly better pay and PD conditions', (42).

'I love my job but am finishing this term. The hourly rate is low, but tolerable, but 40 weeks a year is not enough for me. Despite all doing the same job, two of my colleagues get paid all year, and three of us do not. Seems like a really weird system!?! My take home pay last year was \$49,000 and I have been nursing for 25 years', (47).

'31K per annum (with no annual leave built into that) for a job 3 days a week is basically volunteer work and I'm going to have to leave school nursing next year after being in it 7 years', (78).

I left 2 previous School Nurse jobs in Private and State schools owing to the refusal to pay me as per Meca. 5 years ago, the private school paid me \$28 / hr, there was no school counselling service, so I dealt with actively suicidal young people by myself (except for the Deans, and Principal). This was a large Year 1 to 13 school with many international students living with host families. The principal said to me "You don't need to be a nurse to do your job". Hence both me and the other RN quit. The state school paid me \$36/hr, two years ago. There, school students I met, had part time jobs working with forklifts, and had higher hourly rates than me', (109).

Acknowledging the burden of School Nursing

Collectively, these comments describe an overwhelming and cumulative burden carried by school nurses, arising from the breadth, intensity, and isolation of their work rather than from any single task alone. Nurses report being solely responsible for the health and wellbeing of

large student populations, often in high-needs communities, with minimal resourcing, limited clinical backup, and inadequate organisational understanding of nursing scope and risk.

The role routinely extends far beyond traditional nursing expectations to include mental health care, sexual health services, crisis response, safeguarding, social work and complex care coordination; frequently without policies, sufficient time, or interdisciplinary support. This burden is further intensified by the fact that school nurses are often the first - and sometimes the only - trusted health professionals that students feel safe accessing, particularly for sensitive or complex health concerns.

This work is emotionally and cognitively taxing, involving repeated exposure to trauma, poverty, violence, suicide risk, and serious medical emergencies, alongside increasing administrative demands and poor physical work environments. Despite carrying high levels of responsibility and clinical decision-making, nurses describe being undervalued, underpaid, and poorly recognised within school structures, leading to chronic stress, moral distress and burnout.

Several respondents describe reducing their scope of practice, declining opportunities to advance their scope without an increase in remuneration, or actively considering leaving school nursing altogether. Together these comments confirm serious concerns about the sustainability of the workforce and the safety of students who rely heavily on the care provided by school nurses.

'Sole nurse for 1300 year 7 – year 10 students. Paid as support staff grade D6. Was declined a pay review in August (my 3rd anniversary). I completed Post Graduate Studies in Youth Health in 2024. Am disappointed and disheartened, cant afford to continue as husband has a new job with less pay. Looking for RN primary care role currently. Feel supported but undervalued. Often give Mental Health support and am a safe person for my students, offer [education] staff health support too. Help! Can't last much longer on this pay!' (8).

'School nurses have long been trying to do the Complex and challenging work of supporting students with health and well-being issues on a shoestring budget, with minimal resources, minimal support from other areas of the school, often working in isolation; taking significant responsibilities and decision making that is way above their level of pay and recognition. It would be so good (and so deserved!) for the role to more recognized and rewarded financially as well as socially in our communities. Thanks', (18).

'I have been a sole nurse for many years and carried the load of two nurses. I have been a nurse prescriber but recently turned down re-applying due to overwhelming stress. I soldier on with everything else'. (24).

'Physical working office internal, no windows. Very small space for many years. We are shifting to new space 2026 still small but has natural light and you can open a window!', (26).

'The emotional and mental toll caring for some of our rangatahi can get overwhelming at times. Learning what many children have to face in their own "safe" environments like home - abuse, harm, MH risks like self-harm and suicide, body image issues, bullying, medical conditions, financial hardship, sexual assault, etc. Being able to give enough time to each of them is so important, time consuming and mentally/emotionally draining. A lot of follow up is involved with this role - ensuring safety for children in their environments. Engagement with whānau and linking with the appropriate community services', (48).

'A friend who has recently started working in a school after years in the corporate world commented recently on how tired she gets. She is often sick the first week of the school holidays so unable to enjoy her break. She puts this down to the school environment being full on, constant all the time, there is no down time. Most people don't understand this as nurses we accept this as a norm. With so many unpaid days in the year my annual salary is below a living wage & not much more than a full timer on minimum wage. We should at least be on the same pay scale as teachers, paid an annual salary as we do the same amount of training to become registered probably more study to keep updated & often spending holidays researching & planning education resources for the Health Center outside of work hours', (50).

'We have a budget of \$4k for health center supplies. We spent over our budget despite bringing \$1300 into the account with ACC payments. We haven't bought anything extreme, just the basics for 3000+students and staff', (53).

'The work is emotional taxing and you need a very good knowledge base to do it effectively', (67).

'The administrative workload has increased', (75).

'There is minimal GP support in the rural community that my school is a part of, so the health and wellness of students is largely on me. If there is an urgent need, students are taken to the local hospital that is 40 min away', (101).

'We do a lot of sexual health and mental health work, and it's the tip of the iceberg to be frank. I am seeing increased food poverty, especially from family's here on work visas. I don't believe the MoH realises the positive impact having Sexual and mental health trained nurses in schools where there is a GP and standing orders. The reality is, low income families do not manage to take their kids to see GPs, and so we support them hugely. Also having a positive experience with a school GP and school nurse service

scaffolds the young person to continue to engage in healthcare through their lifetime', (109).

'We have incredibly high levels of deprivation, poverty, family violence. I have probably done at least 8 Report of Concerns to OT this year. I have personally dealt with 4 suicide attempts at school and one student showing up to school with a rope burn around their neck from a failed hanging attempt. The school has very poor or no policies or processes. I have been surprised to see how many chronic health conditions our students have. I categorized them into high risk, med risk and low. We had 28 high risk kids. 10 Type one diabetics, 3 severe anaphylaxis to multiple allergens, Epileptics with poor compliance and a number of students under investigation for 'cardiac issues'. One emergency I attended was a student collapse, unconscious who was tachycardic with a history of VT and a recent failed ablation. I ended up putting the defib pads on just incase while I waited for the ambulance. It's difficult trying to provide a health care service when you're employed in an education space as they really do not understand our duty or care, our scope of practice, the risk when there is no good policy or procedures in place. I'm lucky at least I'm paid in line with the DHB Mecca, however I doubt there would be increase in pay anytime soon. My principal literally told me to my face that I'll mostly be just dealing with Panadol and plasters! Far from it! Being a school nurse is varied, complex and undervalued. I have just been awarded a full scholarship through Te Whatu Ora to complete a Post Grad Dip to become a Nurse Prescriber. I'm torn about it - it's an amazing opportunity, but will commit me to this job for the next 2-3yrs. Can I do this job sustainably? without burning out?', (115).

'Beyond the pay issue, there are ongoing challenges; when I'm not navigating the nursing complexities, I'm often facing issues with the senior leadership team. As the sole nurse I frequently fill the gaps of both a social worker and a counsellor, since we currently have no social worker and our part time counsellor is often unavailable even when she is there. I've written to our pastoral lead requesting that the need for a school social worker be raised at the next board meeting. Although my email was acknowledged, I've since been told indirectly that the principal believes parents would not be supportive if they knew we had social workers on-site. This mindset makes it extremely challenging to deliver the wrap-around support our students need. This isn't the first time I've faced push-back from the school', (116).

The discrepancies between contracted hours and the actual workload

Comments grouped under this theme describe consistent and widespread discrepancies between contracted hours and the volume of work required to safely and effectively deliver school nursing services. Nurses report routinely working beyond their paid hours in order to complete clinical documentation, manage follow-up care, respond to emergencies, attend

meetings, and maintain continuity of care. This additional work is frequently undertaken in the evenings, at home, during weekends, school holidays and days off, and is often unpaid.

Several respondents described feeling reluctant or guilty about claiming extra hours, even when this option technically exists. This reflects a workplace culture where working beyond contracted hours has become normalised. For nurses in lead or senior roles, these expectations are often accepted as an implicit part of the role, despite not being formally recognised or remunerated. Collectively, these comments indicate that current contracted hours do not adequately reflect the realities of the workload, placing nurses at risk of fatigue, burnout, and ongoing unpaid labour.

'I am barely able to complete my notes within working hours – I take work home a lot to prevent buildup for the next day'. (25).

'The actual workload often exceeds my paid hours, I have spent significant unpaid time completing notes from home in the evening. Stayed late at school in emergencies. Check emails on weekends and days off. Attend meetings unpaid, (49).

'After years working a minimum of 35hrs per week but only paid for 30, I asked recently if I could extend my weekly hours to 35 but was told to just start claiming extra hours which I do now however I still feel guilty doing this & never claim all extra hours worked each week', (50). .

'I'm not financially compensated for these additional responsibilities, but I've come to accept that these responsibilities is part of what it means to be a Lead Nurse', (116).

The discrepancies between pay and clinical practice

Across responses, nurses consistently described a significant mismatch between their remuneration and the scope, complexity, responsibility, and risk inherent in school-based nursing roles. While many respondents expressed high job satisfaction and strong commitment to students, they also reported financial strain, lack of recognition, and concern about the long-term sustainability of the role. Expressions of passion for school nursing frequently co-existed within the same responses as frustration about pay and employment conditions.

Nurses described roles that extend far beyond the limited “first aid” perception sometimes held within school settings. Contemporary school nursing involves a high degree of clinical autonomy and responsibility, including comprehensive health assessment, mental health support, safeguarding, care coordination for students with complex needs, prescribing, leadership within school health and pastoral systems, extensive administrative responsibilities, and skilled navigation of education and health systems to achieve positive outcomes for students. Many respondents reported that their pay did not reflect either this expanded scope of practice or the

increasing complexity of student health needs, particularly in communities experiencing high mental health, social and equity-related pressures.

A recurrent concern was the level of autonomy and clinical risk carried by school-based nurses, particularly those working alone, in alternative education settings, or in advanced practice roles such as nurse prescribing. Respondents consistently noted that these responsibilities were not matched by pay parity with other nursing roles, despite often involving greater independent decision-making and professional isolation than hospital-based positions.

Experienced nurses and those in senior, lead, or advanced practice roles reported that additional responsibilities including leadership, mentoring, service development, and clinical governance were frequently unrecognised in remuneration structures. Nurse prescribing, in particular, was described as poorly incentivised, with minimal financial recognition despite increased accountability and risk.

Although many respondents articulated strong job satisfaction, this was often accompanied by acknowledgement that the role would become financially untenable if personal circumstances changed. This suggests that intrinsic motivation and commitment to students may be masking structural underpayment and delaying workforce attrition, rather than preventing it.

Respondents also highlighted wide inconsistency in pay and conditions across schools, often dependent on local leadership decisions or funding arrangements rather than role complexity, experience, or scope of practice. This lack of standardisation was viewed as inequitable and as undermining recognition of school nursing as a cohesive and skilled professional workforce.

'My \$40 is just gone up to include a 3% increase. I definitely don't feel I get paid well, or adequately. I need extra support to keep up with the nursing load and doesn't feel like you can ask for more pay when this is the case', (9).

'As a lead role, there is a lot of extra responsibility which isn't recognised or compensated for. There is no transparency with our funding and what we actually received. There needs to be pay guidelines which are equal across all school nurses' (10).

'Would like to have a pay rate that reflects the complexity of our role. This should be the same across all funded schools and should not depend on one principal offering better conditions than others. We should be paid enough that we are not adversely affected by no pay during school holidays' (15).

'I would like to get paid for the responsibility that I have. I am a community nurse prescriber and lead nurse and my pay definitely does not reflect the work that I do and the responsibility that I have' (22).

'I feel our pay does not match the amount of work we do in SBHC [School Based Health Care] Every term the health needs of our community increases and we are taking the brunt of the young peoples cares' (25)

'Annualisation is offered but I don't use that. Overall our pay is pathetic for the responsibility and intensity of the work we do. However the job satisfaction and rewards of the work has kept me in job 18 years so I am satisfied with the work and keep here because I love that. I also relieve at another school where I am paid \$10.23 more per hour than at my usual school. Because my regular employer funds us themselves [from MoE funding] it's always been the line fed to us that the budget has to be found, but we notice they pay for other stuff when they want to, so don't really buy that argument. Overall I love my job but if my circumstances changed and I had to rely on this income solely, I would have to get another job', (26).

'Responsible for so much more than seeing students in a clinic; Accounts, Ordering, Booking in external providers, health and safety, pastoral care team, High risk students with counsellors, planning and coordination of renovations in the health centre, high health needs [of students], Increasing mental health presentation/self harm/abuse, understaffed by Te Whatu Ora and still expected to do more each year, that's just for starters', (29).

'I have worked as a youth health nurse for 21 years and have been a RN prescriber in community health for the past couple of years. It is frustrating that we do not get the same pay as if I was to work at Te Whatu Ora. The responsibility, autonomy and complexity we see in our school based and community clinics is in my opinion a lot harder than if I was a senior nurse working in a hospital. It is appalling that our pay does not reflect the clinical expertise that we are able to give our rangatahi', (31).

'ALL nurses should have equal pay rates according to their steps and year of experience. School nurses, especially in alternative education, work autonomously, many are nurse prescribers, meaning often our responsibilities and RISK is far greater than those working in the hospital, yet our pay is significantly less. I work in both the hospital and community settings (i have two separate jobs) and i can tell you first hand, that my job working with youth in a community setting is far harder with more risk and responsibility than my job in the hospital. Yes shift work is less than desirable, but thats what the shift credits and penal rates are given for. Having worked in many many different roles and settings as a nurse, do not understand why we are all paid separate rates. We all put the same amount of time and effort in, we all completed the same degree, and we all deserve exactly the same base rate on the pay scales. Compensation for shift work is in the penals. There should be no other exceptions!!!!', (34)

'The personal time spent researching student & staff health concerns as well as reading various updates from many health areas to keep up to date with a broad range of general medical/health knowledge expected from me is not compensated for. With GP appointments becoming so scarce I seem to be a go to for many staff plus parents telling their kids to see me for an assessment first. Which I only do within my scope of practice of course and very careful to remind staff & students of this. We're not just the first aiders in the office anymore though', (50).

'Current pay doesn't reflect the experience or skill required for this job. And when we need to transport a student, our NGO doesn't reimburse us appropriately for this. We always seem to be 3 years+ behind Te Whatu Ora Hospital Nurses in terms of pay rises', (57).

'I feel that our pay has fallen behind, and we are not recognized for prescribing. We are paid an extra 50 cents per hour for taking on the responsibility of prescribing. This does not give incentive for other nurses to take on this responsibility', (62).

Overall, I have felt undervalued and unappreciated. I do believe there is a lack of knowledge about what we do. There is also ageism from comments made to me like "we need to attract younger staff". This comes from Schools as well as Nursing leadership. This doesn't recognise the intricacies of the role. Having worked in PACU the main difference is that in School nursing you need to have confidence in your clinical assessment skills and when to escalate to get a medical opinion. You need to understand the adolescent person, and apply nursing skills that meet their unique needs. It involves using Fraser and Gillick competencies and risk assessments. I feel very privileged to work with young people, especially with tangata whenua, Pacifica and new migrant students. I learn a lot from them, and don't feel my age is a barrier in their view', (109).

The discrepancy between pay and experience

Comments within this theme highlight a persistent disconnect between nurses' experience, qualifications, and advanced scope of practice, and the pay they receive in school nursing roles. Respondents described entering school nursing with extensive clinical backgrounds, often 10-25 or more years of registration, yet being paid at rates they perceive as low relative to their expertise and responsibility. Postgraduate qualifications, including master's level study, public health training, and nurse prescribing, were frequently reported as being recognised with little or no additional remuneration. Several nurses noted that becoming a prescriber or taking on broader school community-based roles increased clinical responsibility and complexity without a corresponding increase in pay, and in some cases involved accepting lower pay than in previous primary care, iwi provider, or hospital roles. Comparisons with Te Whatu Ora, general practice, and other nursing settings reinforced perceptions that experience and advanced

capability are undervalued in school-based roles. Collectively, these comments indicate that current pay structures fail to recognise accumulated experience, postgraduate education, and advanced clinical scope. These inequities contribute to financial strain, and frustration among highly skilled nurses who nonetheless remain in these roles, apparently due to a strong commitment to rangatahi and the job satisfaction they experience.

'I've just started as a school nurse with 10 years experience, getting paid \$47 per hour', (13).

'I've been in my role as a school nurse for over 12 years. Each year, for the past 7 years, my employer has increased my salary by a small percentage. I've been a community nurse prescriber for over 3 years, along with four other team members. There is no extra remuneration for being a prescriber', (20).

'I now work as a RN-Community Health Prescriber, and work across schools, community clinics and Oranga Tamariki residence. My role is varied and I value the work and relationships I have with my service and the young people I work with. I did return to this role from being employed as practice nurse for an iwi provider GP Clinic for 3 years - understanding that I was taking a role with lesser pay than my hospital counterparts, to a role with lesser pay despite my new prescribing qualification - which was lesser pay than my iwi provider/GP clinic practice nurse role. I was also extremely burnt out at my practice nurse role. I really enjoy my role, love my team and the young people I work with, but I do struggle financially... I would rather be happy in my role with lesser money than burnt out with a little bit extra in my pocket....', (27).

'I have a master's in Public Health qualification but do not earn anything extra for this qualification. I also have lots of experience in primary health carer and public health. I do not believe that this is reflected in my pay rate partly because much of it is if from Australia (67).

'Hourly rate is very low in comparison to the experience I have, been registered for 26 years, with 13 years of work place experience' (102).

The need for a nationally recognized and equitable pay scale across school-based health services

Survey respondents consistently describe pay progression not as a routine or transparent process undertaken by their employers and administrators, but as an ongoing battle that requires them as individuals to maintain sustained advocacy, negotiation, and emotional effort if they are to receive any pay increase or adjustment. Nurses report having to repeatedly “fight” or “push” for pay reviews, parity adjustments, alignment with MECA, or recognition of advanced scope of practice, not just once but routinely throughout their time as school nurses. Pay increases, when achieved, are frequently modest, delayed, or contingent on complex

negotiations with principals, school boards, PHOs, or contract managers, rather than being automatically applied through standardised pay systems.

Several nurses describe being required to independently gather market data, seek union advice, write formal submissions, or negotiate individual contract clauses simply to access a level of pay they believe reflects their role and experience. Others report being told there is “no money in the budget,” despite observing funding allocated elsewhere. Nurses even reported being directed by their actual employer to negotiate the pay directly with their schools rather than with them. This seemingly casual and unprofessional approach to remuneration at an individual school nurse level has resulted in widespread disillusionment with school nursing as a serious career choice. When reading the comments below one can only conclude that any semblance of fair pay is dependent on individual persistence rather than an established and nationally recognized remuneration system such as other health professionals would reasonably expect.

‘Pay has been an ongoing battle! I managed to negotiate at the beginning of this year an agreement for yearly pay reviews and to have our monthly school nurses meetings paid for (2 hours outside of school hours). I have typically found that when we request pay review, our principal will talk to the other local schools and decides that we are fairly paid so only get a nominal increase if anything’, (3).

‘On support staff D band but not entitled to pay rises with this band. Had to fight to get annual pay review agreed to’ (4).

‘Started fighting for a pay increase in 2023’, (7).

‘Fighting for pay to be according to MECA for approximately 6 years’ (14).

‘I’ve had a 50 cent pay rise since I started in 2021. Brought this issue up with the Rector and Bursar, not willing to give a pay rise, although I am the only Registered Nurse employed by them’, (17).

‘I have spoken with our business manager and have been negotiating a pay rise for myself and 2 other nurses. This has been confirmed however I do not know what the new hourly rate will be’, (21).

‘We have fought to get better pay over years. Management supportive for domestic and sick leave when required’, (26).

‘We have worked hard to negotiate better conditions’, (33).

‘We have not had a pay rise in 3 years, and then we had to negotiate to be increased from \$35/hour’, (36).

'We had to push to receive pay disparity adjustments. After a lot of discussions and going back and forth the school agreed to pay the disparity adjustment with a 3% increase so I went from \$44.37/hr to currently \$45.70' (37).

'I have had a pay increase as I became an ACC provider and I also do the ACC invoices. I work 3 days of 9.5 hours. I negotiated this myself. From 7 am to 8 am I do ACC invoices and from 3:30 pm to 4:30 pm. I do ACC e- lodgments. In between I am school nursing. When we have asked for pay increases and increased nurse hours they [the school] have been willing to commit to this. The other nurses are on a lesser hourly rate than me, approximately \$47 per hour', (38).

'I have been negotiating this year for more pay, requested \$48.00, only got \$2 more, now on \$42.50.' (39).

'Difficulty getting equity in pay across the board for funded SBHS schools. Very different work environment/conditions in every school which seems unfair. Difficulty fighting for pay parity from 2024/2025, (46).

'I have applied for a pay rise twice and told no money in the budget' (48).

'Cost of living crisis so always keen for more pay!', (65).

'Really disheartening to work so hard for so many years and still be behind a lot of other professions with pay equity, I feel as a nurse, mother and women we get exploited for our caring nature because we naturally want to help people and are not aggressive enough in being heard! They want to throw us some scraps and expect us to be eternally grateful for any morsel we get, meanwhile they pay themselves in management rather handsomely at our expense.... and now the expense of patient safety being compromised', (72).

'I have been challenging the PHO for better pay for about 3 years. I earn more at other nursing jobs', (76).

'We were able to convince the school (last year) to keep us in line with hospital level MECA pay, after collecting some local data about nurse pay in the local market. However we would like to ask for nurse supervisor funding. Currently considering asking for registration to be paid for (they pay teachers and counsellors), (84).

'I started working here 8 years ago as the sole nurse for 2200+ students. I had been fighting to increase my hours and get another part time RN for more than 6 years because it was impossible to complete all my admin in a 6 hour shift. I was completing my notes and remained exhausted. Finally, a year ago it changed. I was granted an increase in my hours from 6.5 hours to 8 hours per day, and we employed another part time RN. I had also requested as the Lead Nurse to go on a salary to be paid for 52

weeks in order to get admin completed and to do PD hours during school holidays. That was turned down. I am now trying to negotiate an extra 4 weeks' pay per annum during school holidays, (88).

'I have been fighting for more pay since I started in 2023. I am a community nurse prescriber, so I work beyond the level of other step six nurses, but I am paid significantly less' (90).

'We have had to fight hard for pay increases, we fought to be paid in accordance with the MECA and will expect a pay increase when there is a new MECA', (95).

'To get a pay rise from \$30 an hour in 2018, we firstly had (with the advice of NZEI) to put a case forward to move from Grade C to Grade D. I have another part time casual bureau job at Te Whatu Ora and have had to fight hard to get the school to price-match in accordance with the MECA and our expectation is that when the MECA goes up, we go up for the school to match it', (96).

'We went through a very long and drawn out process to get the hourly rate we are currently on- and entitled to. We have also negotiated to have this rate and any MECA pay rate changes added to our individual contracts – to ensure they become effective immediately, IE. New rate of pay will take effect on the date of any MECA ratification to pay scales', (97).

'Haven't had a payrise in 2 years', (99).

'I negotiate my pay and currently I am paid what the primary health nurses get. I'm hoping for this to be increased early next year to \$46.97 as primary health nurses had a rise in July 25', (101).

'I'm due for pay rise but no one wants to hear this. I wrote a very strong letter to the Ministry of Health Contract manager, their response was that the pay and rates are based on the school and ACC funding can be used as a top up for nurses if the principal wants to', (113).

'I'm currently on an annualised salary equivalent to \$32.71 per hour'. I haven't yet approached my school regarding a pay increase, although I've now been in my role for over a year. My manager has advised that any adjustment would need to be negotiated directly with the school as I'm a step 7 nurse', (116).

Unclear remuneration and conditions disadvantage school nurses

Many school nurses reported uncertainty about their pay, pay progression, and entitlements. This ambiguity often leaves nurses unsure whether they are being compensated fairly, and it can make negotiating pay increases challenging. Some nurses indicated that they are unclear about how their contracts compare with other nurses in similar roles, the impact of additional qualifications on pay, or the differences between casual, part-time, and full-time rates. The very absence of knowledge about how to progress pay or address inequities further compounds the issue, as nurses may not advocate for themselves effectively or may accept suboptimal conditions without realising alternatives exist. This lack of transparency can compound the stress of the school nursing role and may unfairly compromise nurses who are less confident advocating for themselves.

'As a casual employee I believe I am on the same hourly rate as permanent part time and full time RNs', (61).

'I think it would be helpful to have some sort of pay scale for school nurses. I have recently become a community nurse prescriber and found it very difficult to work out what I should expect to be paid. I also find the pay scales used by my PHO are very corporate and are not user friendly and almost feel intentionally difficult to understand to make fighting an increase more difficult. I continue to feel that the responsibilities we have in the role of a school nurse do warrant better pay and I am very aware of the gap between nurses working in primary care vs those working in tertiary care, and it would be nice to see this more fair, (64).

'My contract says this, not sure wat that even means.... You will be appointed on Grade D and will be paid \$47.58 per hour, plus a degree allowance of 0.58cents per hour to a maximum of \$1,125.00 pa. I asked whether I will be getting a pay increase since completing my masters, was a hard no response!! Only been here a year so unsure what previous nurses have been paid here', (81).

'I haven't been in the role long enough to answer this question properly but everyone wants more pay!' (87).

Overtime - uncompensated work for school nurses

Comments relating to overtime highlight a significant disconnect between contracted hours and the realities of school nursing work. Many respondents describe regularly working beyond their paid hours in order to meet clinical demand, complete essential administrative tasks, respond to emergencies, or maintain safe continuity of care. Nurses reported that frequently there was no process to reliably record these extra hours of work and neither did they receive any financial

compensation or time-in-lieu. Where overtime is paid, it is frequently conditional on pre-approval, subject to scrutiny, or limited to exceptional circumstances. This despite the obvious reality that overtime is a consequence of predictable workload pressures such as high student numbers, under-resourcing, and increasing complexity of care.

Several respondents noted the expectation to work through lunch breaks, stay late at school, take work home, or monitor email communications and the like outside contracted hours, including during school holidays. While a minority of respondents reported adequate safeguards within their day to ensure their personal break time, and access to paid overtime or time-in-lieu, these arrangements were inconsistent and determined by the awareness, respect and relationships a nurse has with senior leadership in an individual school rather than recognised as a nationally standard entitlement. Overall, these comments indicate that unpaid or under-recognised overtime is not incidental but embedded within the school nursing role, raising concerns about fairness, sustainability, and the normalisation of unpaid labour within school nursing.

'As senior nurse there is an expectation that I continue to monitor emails and at times do admin work during holidays which is generally unpaid (3).

'Not paid for overtime', (7).

'Primary school has grown a lot so at the moment I will get paid my normal rate if I do overtime', (9).

'I work a lot more hours than what I'm paid for because we run a very busy clinic and are under-resourced in terms of nurse hours', (16).

'We do not get paid for overtime yet are expected to work overtime when requested (ie. Work during the holidays), (21).

'Generally I leave later than contracted hours and try do lunch break but inconsistent', (26).

'No overtime pay', (29).

'I don't get overtime but I can put extra hours towards leave when needed', (30).

'Paid for overtime' (41).

'I am contracted to work 2 days per week only however I work 4 days per week most weeks' (48).

'I often stay late to finish things, or do some work at home. I do very little extra study- so far have done such in the holidays", (57).

'No overtime for myself or my team, however we have a fair time in lieu policy which acts in its place. I believe the pay is fair, its based off performance reviews', (58).

'No pay for hours worked over 33 per week, often no breaks, heavy busy days taking notes home to write (60). '

'We do get overtime if it is warranted (such as an injury or emergency that occurs near the very end of the day) but the business manager does not like it at all and heavily questions the need for us to stay (which we would only do if it was absolutely necessary)', (63).

'Haven't needed to work overtime, as our day generally does include a buffer for admin catch up anyway', (65).

'There is no overtime although there are a number of instances when this occurs', (66).

'Overtime is not paid', (68).

'No overtime available', (69).

'They do pay overtime - I actually had my hours increased as I was doing so much of it, I wasn't able to finish at 3.30 due to the high student numbers I was seeing', (73).

'Overtime – we are unable to adequately record this', (75).

'No overtime', (76).

'We often work more than we are paid to do' (79).

'We will be paid overtime if it occurs and is pre-approved but this is rare', (95).

'We can get overtime if it is pre-approved and overtime is rarely required. One of the Deans commented that in the 1970s the teacher went from 40 hours pay a year to 52 hours pay a year and maintained same pay- wouldn't that be amazing if nurses/support staff were the same. I don't do any out-of-hours help with student activities at the school as don't get paid outside my contracted 21 hours', (96).

'We are able to work extra hours to cover staff/colleague sickness or Annual Leave', (97)

'I get paid overtime' (98).

'If we need to stay late we get paid for it', (100).

'I do not get paid overtime. Often working overtime for no pay because the job is so demanding and menial tasks (like restocking etc) cannot be done by an employed Hca or similar due to funding, (106).

'I do first aid for after hours sports events/tournaments and receive 1.5 x my hourly rate', (108).

'I'm not compensated for overtime, despite regularly working beyond my hours. I've recently reduced this practice, which has caused some tension with my nurse manager, due to unfinished work', (116).

Lunch breaks - the lack of and the impact on school nurses

Comments relating to lunch breaks highlight that, despite being a standard and essential component of any professional nursing practice, many school nurses are unable to take adequate or uninterrupted breaks during the school day. Respondents described skipping or shortening their lunch break due to high workloads, lack of cover during their lunch break, and ongoing student care responsibilities. While a small number reported negotiated break arrangements supported by understanding leadership, these were frequently interrupted by urgent matters or clinical demands. The cumulative effect of having insufficient break time during a working day is fatigue, diminished capacity to sustain care throughout the day, and reduced opportunity to participate in wider school functions or meetings. These comments underline that scheduled, protected lunch breaks are not a luxury, but a critical element of safe, sustainable nursing practice, and that organisational support is required to make them consistently achievable.

'Can't recall my last lunch break and often one of the last staff members to leave at the end of the day.(3) '

Don't get paid for half hour lunch and usually can't take a full lunch and always interrupted for things', (9).

Although I'm paid from 8am - 4pm, I generally don't get proper meal breaks and often won't be finished until 6pm (16).

'We close the clinic during period 4 for a lunch break', (33).

We do not get any scheduled breaks for lunch or morning tea. We also miss out on special functions in the staff room, health and safety meetings etc because of our workload. We are unable to get away from the Health Centre', (38).

'Lunch is always a quick bite to eat when possible doing admin at my computer as there is no one to relieve me however I was told I cannot claim extra for missed lunch breaks', (50).

'We have managed to negotiate a dedicated breaktime (a lot of times this is interrupted with urgent matters which we need to assist with). We have an understanding principal and senior leadership team who understand the importance of breaks. Overall very happy here at the school', (54).

'There is an unpaid half hour lunch break but if needed I must be available', (76).

'During our busy school terms, it can be difficult to actually have a break', (75).

'I generally don't take lunch breaks and come home drained by the end of the day. But I love my job', (109).

'We don't get paid lunch breaks' (112).

The effects of Term-Time-Only employment arrangements

Comments relating to term-time-only (TTO) employment highlight a significant, structural inequity within school nursing. Many nurses are employed for only the school term, typically 40–47 weeks per year, meaning that even with an hourly rate aligned with the MECA, their annual income is substantially lower than it would be on a full-year (52-week) contract.

For example:

Hourly Rate	Weeks Paid	Annual Income	Difference to 52 weeks
\$50	40	\$41,600	-\$12,400
\$50	47	\$49,400	-\$4,600
\$50	52	\$54,000	\$0.00

This table illustrates that even when the hourly rate is reasonable, being employed on a term-time-only basis results in a substantial reduction in total earnings per annum, which has a real impact on living expenses and financial planning.

Many schools that offer TTO employment give employees the option to annualise their salary. Annualisation spreads pay evenly across the year, resulting in a lower but consistent fortnightly

income. This can make household budgeting more predictable compared with receiving no income during the non-working weeks of a school nurse employment contract.

Respondents receiving a TTO salary with and without annualisation described the stress of managing costs during unpaid school holidays, with some taking additional employment including working extra nursing shifts or working additional days in their week to compensate.

By contrast, teachers, another highly trained professional workforce, who are consistently employed on 52-week contracts, receive full-year remuneration, and are expected to complete substantial administrative work outside classroom hours. School nurses, who also complete significant administration, planning, and coordination outside school hours to perform their roles effectively, rarely receive the same consistency or financial security as teachers. Even where annualised salaries are used, TTO contracts limit flexibility, constrain leave, and create ongoing financial insecurity. Nurses emphasised that while TTO schedules allow for time off, the lack of full-year remuneration does not reflect the responsibilities, autonomy, and risk inherent in their roles. These comments indicate that TTO arrangements are a structural barrier to fair pay, workforce sustainability, and equity in school-based health services.

'I was previously on a 52 week contract, but not anymore and now paid term-time-only. Start of this year I increased my hours by 4 hours and have non clinic protected time for admin. However recently relayed struggles to management as lead nurse with keeping up with admin despite these 4 hours e.g. new enrolments, international students, board reports, ACC, referrals, emails etc and are waiting response on a plan around hours. I proposed going back to 52 week contract. I do have a really supportive management team who acknowledge concerns expressed and strive to navigate any concerns/challenges etc', (2).

'Keeping head above water financially over the holiday's when we don't get paid is always very stressful. Although the hourly rate sounds good, I find it appalling what we get paid on a weekly basis (works out to be approx \$1000 in the hand a week) for the level of knowledge, autonomy, responsibility and risk that we hold. My grocery bill alone with three teenage boys has recently started hitting \$600/wk with the latest increase in food prices, so my income goes nowhere', (16).

"Our employer has changed the school nurse contracts for all newly employed nurses as of this year to only being paid for the school term. Just over a year ago I took on an extra job working for Te Whatu Ora at the local hospital so I could work extra shifts in the holidays and take some leave without pay for my school nurse job. I'm not able to just work casually in the holidays, so also pick up an extra shift every other weekend. These weeks mean working 6 days a week. Not ideal but it helps makes ends meet. All outstanding annual leave is taken in the school holidays. Recruiting experienced nurses for school nurse positions where there is no pay for 12 weeks of the year is unsurprisingly becoming more difficult', (20).

'Our School is funded by Te Whatu Ora. I am only paid term time in this job, so there is about 14 weeks that I don't receive any income. This is incredibly difficult, as there are five nurses in our clinic, with only two who receive 52 week contracts. This has resulted in many nurses resigning or finding new jobs that pay better. We have difficulty retaining experienced nurses that lend valuable skills to the job. I believe all nurses should be offered 52-week contracts in SBHS, (40).

'I would rather be paid 52 weeks a year, the weeks of no pay are a challenge', (56).

'Sick of low rate when we only earn for 47 weeks of the year. With the cost of living I've now applied and start 2 casual nursing jobs also. Its about time School Based Nurses were paid the same across NZ and funded the same and recognized as one profession', (59).

'Unpaid leave due to contract being 47 weeks during the year is challenging at times', (66).

'I would work full time if I could. I find the 8 weeks unpaid to be very difficult to manage financially. I'm not sure how long I will be able to continue in the role due to the low income', (67).

'I am annualized so it works out to be about \$36 per hour' (83).

'Because we only get paid for 47 weeks a year it really lowers the hourly rate. Becoming very difficult to live off this wage with the costs of living ever increasing' (89).

'It is unfortunate that it is not recognised that we need to be available term time but not paid in the holidays overall (unlike teachers), but at the same time I appreciate the time off', (92).

'I feel fortunate to have this job and I do quite enjoy it. I certainly have no plans to leave. It is hard to make ends meet however, being part time and not being paid during the school holidays', (95)

'My 21 hours (3 days) working week over 40 weeks, is the equivalent of 2.5 days worked if was 52 weeks. I started on \$30 an hour 8 years ago and with persistent over time, now on \$51 an hour. I get paid annualized, so less over the 52 weeks, but the same pay as my colleague who also works 21 hours a week at the end of financial year', (96).

Contractual issues and their impact on school nurses

School nurses described ongoing challenges with employment contracts that are inconsistent, outdated, or insufficient to support the role. Many employed under the NZEI support staff collective agreement identified these were not designed with nursing responsibilities in mind. This has created confusion about pay, leave entitlements, and professional development opportunities.

Several nurses highlighted that their contracts often fail to adequately recognise the work they do or the qualifications and experience they bring to the role. Some are employed under Te Whatu Ora contracts but receive no additional recognition or financial incentive for completing the portfolio required by their employer - something other nurses in similar roles would be compensated for. Others work across multiple funding streams (e.g. school and public health) and experience uncertainty about which contract governs their pay and entitlements. A recurring theme was the financial stress caused by delayed contracts, partial-term employment, or misalignment between their pay and clinical practice. One nurse described being promised working conditions equivalent to a previous role, only to have the contract and job description arrive over a year later, resulting in unpaid weeks and significant personal hardship.

Compounding these challenges is a lack of transparency: nurses are consistently held accountable for delivering services under the terms of joint contracts between schools and Te Whatu Ora but are rarely privy to the details of those contracts. This leaves them responsible for outcomes without clarity on the obligations, expectations, or funding arrangements, which undermines both fairness and their ability to advocate for appropriate support and pay.

Funding arrangements between schools and Te Whatu Ora were also frequently raised. Nurses noted that Te Whatu Ora contracts with schools often did not include a budget that covered the full costs of wages, professional development, and supplies, leaving schools to top up salaries from operational grants.

This inconsistency, coupled with lack of clarity in collective agreements, made it difficult for schools to determine appropriate pay rates and for nurses to be fairly compensated for experience and qualifications. These comments illustrate that regardless of whether employed by health or education, school nurses can experience inequitable treatment, despite undertaking similar responsibilities and demonstrating comparable professional commitment.

Overall, for many school nurses these unsatisfactory contractual issues contribute to a sense of being undervalued while being expected to work under very uncertain and poorly defined contractual arrangements despite the complex and essential work they perform in schools.

'Contract with Te Whatu Ora, but [as school nurses] we don't get financial recognition for completing our Te Whatu Ora Portfolio [that other] Te Whatu Ora employees do' (6).

'Discrepancy on the Job Title (Evening Nurse) and Job Description (Matron Duties)', (17).

'We have individual contracts but based on the Support workers collective contract which has never been satisfactory. We are part of Student support faculty but work closely with Admin support who cover for us on breaks etc', (26).

'My role is paid from a mix of the Te Whatu Ora Contract to support the local SBHS and from individual school contracts', (58).

'Education dollars are added to our role funding to support our hourly rate, supplies and the general running of the clinic', (63).

'I would like to earn the same as other Registered Nurses in the hospital as we also deal with some heavy complexities (74).

'Havent has a pay rise in 2 years – disappointing', (78).

'Behind MECA scale with 10 years+ nursing experience. No pay increase or recognition after completing community nurse prescribing course', (93).

'My pay rate is decided by the Board Of Trustees', (104).

'The funding for RN hours was not increased to match the students needs and so the school is funding my additional day from money the nurses made claiming ACC', (109).

'The schools contract with Te Whatu Ora TeToka Tumai doesn't cover the costs of the nurses wages, PD and supplies. We run a deficit budget. The school passes on what they get from Te Toka Tumai who say they are paying MECA rates but the schools contract is always out of date and they are paying Step 6 on the MECA when most of the school nurses have more than 6 years experience. Te Toka Tumai need to increase it to cover the nurses with more than 6 years experience. I also manage other staff in the pastoral care team-social workers, counsellors. I should be on Step 8 at least. Most of our schools in the ESBHS are having to top up the nurses pay from the operations grant. The ESBHS contract was supposed to be a joint project between education and health but schools get no extra funding in the operations funding from MOE for having a health service on site. School nurses, that are employed by the school, come under the support staff collective and are not in the list of support staff that are exempt from it. They are also not mentioned in it in terms of pay scales and conditions. This makes deciding on pay difficult for these schools. School nurses need to be exempt from the support staff collective. My experience in the past as a Public Health Nurse working in schools, was that we got pulled out every time the DHB wanted nurses elsewhere. It is important that nurses are employed by the school to avoid this. Also it enables the nurse to be part of the school culture and build better connections with staff and students alike', (111).

'Firstly, my current school did not have any nurse working here for around 2 years. They hired agency nurses and paid big dollars. I used to live in [redacted for anonymity] in [region], where I worked for a big school called [redacted for anonymity] and was employed by the local PHO working 52 paid weeks + 4 weeks of annual leave ,10 sick days, unlimited study leave to support my post grad papers. I chose to move to [another region]. I applied for job as a school nurse at {school name redacted for anonymity} and had a zoom interview with the Principal, Nurse Manager and the student services HOD. I was promised over the phone that I will have exactly the same working conditions as my previous job and so I accepted the offer and started work on the 27th of October 2024. I did not receive my job description or full contract until over a year later. As a single mother I struggled with no pay from 13th of Dec till the first pay in Feb 2025. With my 2 little kids I was in front of MSD every 3 days asking for food vouchers, asking for money. We did not celebrate x-mas. Kids did not get any gifts as we did not have any money and the house we rented was \$840 per week. I was doing relevant post graduate study, and the principal did not even give me a day to complete my paper. I involved NZNO and the union needed proof of what was said in the interview and what I agreed on. The Nurse Manager present at my interview could not recall what had been agreed on as it happened a long time ago and she forgot what was said. The HOD said that he cannot go against the school as it's a conflict of interest, as he is employed here. I had no one to support me. Finally with repeated emails to the principal, the school agreed to increase my working weeks to 46 weeks, but I am still not happy. The principal delays in every communication, I earn thousands of dollars through ACC for them and there is not even the slightest appreciation. (113).

Concerns about the delivery of safe, effective school nursing services in the context of widespread inadequate staffing ratios

A recurring theme among respondents was concern about staffing levels and the impact on safe, effective service delivery. Nurses reported being the sole registered nurse responsible for large student and staff populations, sometimes exceeding 2,000 students per site. The complexity of student health needs, including mental health and special needs, adds to the intensity of the workload.

Respondents described their difficulty accessing relief or additional nursing support due to funding constraints, inadequate pay rates for relievers, or a lack of applicants. Many reported working extended hours, missing breaks, and managing emergency situations without backup. These conditions were identified as placing both the service and student safety at risk.

Several nurses highlighted the discrepancies between staffing and funding, noting that despite keeping detailed records of student visits and unmet student needs, requests for additional nursing support were often declined. These experiences underscore the ongoing challenge of maintaining safe nurse-to-student ratios in schools, particularly as student rolls and health complexities continue to increase.

'We are also concerned about the nurse: student ratios. We have one full time equivalent nurse to 2242 students Year 7- Year 13 (5).

'The job is intense, relentless and so misunderstood', (28). The job is becoming more and more risky with students having complex needs and behavioral issues, I love my job, but I definitely feel undervalued by our crap pay', (28).

'We are trying to get another registered Nurse part time for a few extra hours a day to support the main nurse. We can't get relievers as I believe the pay is not adequate', (9).

'Happy with my pay, but the role is very isolated', (35).

'We can often see up to 60 students a day. We have recently been told we cannot find relief nurse cover for term 1 and term 4 due to budget constraints. I keep our stats for each of these terms, and we definitely can still see the same number of students in term 1, and term 4 can be just as busy. If we are here working alone, we do not get a morning tea or lunch break. We have a school of 2900 students this year. On average across the whole 3 terms (1-3) we see 37 students per day', (36).

'We have one nurse for the whole day and then we have another nurse from 11:30 am to 3:30 pm. Next year this role will increase and be from 10:30 am to 3:30 pm due to our increasing workload and increasing school roll. On average, we see between 45 and 70 students per day. We also have a boarding hostel which creates extra demands on us. We are very overworked, however, our school does listen to us', (38).

'I am the only nurse for 1500 students & 100+ staff', (50).

'We were told at the beginning of this year that we would have a nursing freeze /reduction of relievers, which meant I could be working solo at a school of over 3000 students. I think I worked solo for at least 10 days this year (either no relievers available or SLT suggested no reliever). My team of nurses have expressed they wouldn't want to come in to work if they were solo (this means that I have come in when unwell because we didn't have another nurse', (52).

'I am concerned that with a roll of approximately 2,300 students – when we have a full school (during terms 1-3) we are working at over-capacity. Second RN is only funded for 14 hrs per week. Safe and timely documentation and follow up is, at times, at risk', (68).

'There is only 1 registered nurse per day with a student role of 2,320 students. On average I see 45 students a day, but it can increase to 60 + students. We have asked for another R/N but were declined and possibly offered a first aider to help, which I would think would increase the workload checking on them', (73).

'School Based Health Services have become the access point for rangatahi and whānau when they are unable to access external providers (such as own GP or local A&E). This places a lot more pressure on us, and the service. The complexity of health needs has increased – especially mental health' (75).

'The school I'm currently employed with is understaffed by School Nurses, we have struggled to manage Heeadss Assessments and Youthchat, even though I have worked an additional 1 day per week since term two', (109).

'I worked here at [redacted for anonymity] alone for nearly a year despite there being FTE for 2 nurses due to no applicants. We finally have another nurse on board this term', (113).

'I am the only RN in a decile 1 school of 1300 students. Included in those numbers we have a special needs unit of 40 students with complex needs- toileting, hoisting onto beds, wheelchair bound, PEG feeds etc. We have 2 other special units, those with learning challenges, and the 'bad' kids. I've been told by the principal there's no way the school will take on another nurse because there's no funding for it. Despite me keeping statistics around how many students I see vs. how many are turned away or sent home without seeing the nurses to build a case for another nurse', (115).

Issues arising from a lack of awareness and understanding of the role of a school nurse

School nurses frequently reported a lack of clarity and recognition around their professional role within educational settings. Many feel that they are regarded primarily as support staff rather than healthcare professionals, despite the complex clinical, educational, and pastoral responsibilities they undertake. Role ambiguity also affects opportunities for professional growth because performance reviews are infrequent or absent, and their scope of practice is often constrained by the school environment or lack of funding.

Several nurses highlighted the fact that their work was undervalued compared with other school staff, including counsellors. This was the case even when nurses were the first to identify mental health or safety concerns in students. Many navigate a delicate balance between meeting the school's expectations and maintaining professional boundaries to safeguard students' health. Nurses also expressed a desire to expand their scope of practice, for example through prescribing or advanced practice, but cited structural limitations, lack of GP oversight, or non-funded positions as barriers.

The following survey responses reveal that a lack of understanding regarding their role as highly-qualified health professionals contributes to school nurses feeling undervalued, isolated, and constrained in their professional development, despite being highly skilled and deeply committed to student wellbeing.

'Seen as a support member of staff in school and not a profession like teaching', (14).

'I feel that as a profession working within this school, we are undervalued for the work that we do (often behind the scenes). Often the counsellors are very recognised for their support and input into the health of the school, but nurses are not given any value for what we do (often bringing to light/identifying mental health concerns or issues that we notice when assessing our students). 'I think it is hard when it is the school/ministry who is deciding our value/worth/pay without being aware of the role/tasks/skill of a Registered Nurse (all our background study/health and safety awareness/updates etc...). The only real perk for me is that I have a carpark onsite (at present!), and get to have some time in the holidays with my family. Would love to see some pay equity (and an Auckland waiting/extra pay for living in this costly area!!!)', (36).

I would like to see our scope of practice increase e.g. to prescribing, even though we are a non-funded school,' (52).

'Working in kura is different, you cant just say 'oh no, we only work with yr 9-13'. We have aimed to fit in with kura, be quiet and watchful, take time to build trusting relationships with staff and slt. And if they ask something of us, if we can do it, we do. This is so much different to the massive mainstream schools, where we still do our yr 9 Kōrero hauora, which gives each and every student the opportunity to feel seen and heard, even if they dont want to chat with us, we have to chance to sow the seed of what we may be able to help with if they ever need it. In these big schools, we often have to boundary our role, so as not to get asked to every single incident that occurs, needing to push back to the school what their role is health wise. This is a great role, we could be doing so much more, training as NP, if we had GP oversight. This is a future goal', (56).

'Haven't had a performance review in the 4 years I've been here. They don't really care', (78).

'Good work environment, some difficulties with being a health educator and provider in an education setting', (102).

'I have 5 young adult children, and have experienced the range of issues with them, including TOP, STIs, depression, school anxiety, school suspension and exclusion, ADHD, Dyslexia, drugs -all the current favourites with youth. I hope this personal experience enhances my compassion and care as well as my nursing skills, my goal is that young people feel better from being with me', (109).

'Having support from my nurse manager for the stuff that actually matters would be great', (116).

Career progression for school nurses

Nurses consistently reported limited opportunities for recognition, pay progression, or career advancement despite gaining additional qualifications, experience, and responsibilities. Many highlighted that being a Nurse Prescriber or holding postgraduate qualifications in youth health or community health was not adequately reflected in pay, with only token increases (for example, a dollar per hour) if any. Several respondents noted that comparable roles in primary care or other sectors offered greater financial recognition for the same responsibilities.

Some nurses also described structural barriers that limited their professional development. This included difficulty accessing courses, delays in portfolio sign-off processes, and a lack of financial incentives to pursue further study. The absence of clear pathways for career progression left some feeling isolated, undervalued, or discouraged despite the significant expertise they bring to the school setting.

For nurses employed under support staff agreements or in non-RN roles, pay progression was particularly constrained. Even when taking on additional responsibilities or managing significant workloads, these nurses reported starting at the top of the pay scale for support staff with little or no prospect for incremental increases based on experience or achievement. One respondent emphasised that while their school provided some professional development opportunities, they were still employed at a level equivalent to a first aider, with no formal recognition in pay despite the complexity of the role.

Overall, these experiences further highlight the totally unacceptable discrepancies between professional qualifications, responsibilities and inadequate financial recognition, which, for many school nurses across the motu (country), contributes to frustration, lack of motivation, and a perceived inequity across the school nursing workforce. All of which jeopardises the sustainability of school nursing under these existing arrangements.

'I am now a community nurse prescriber with a level 4 portfolio and I have not had any compensation for the new responsibility and the projects I have worked on', (28).

'Nurse Prescriber and not paid anywhere like others in the community', (29).

'I am a Registered Nurse Prescriber in Community Health (RNPCH) so I get paid a dollar extra for this. I have a post graduate certificate in youth health (UoA) but this is not recognised in my pay', (70).

'I'm working in a secondary school as a school nurse but I'm not an RN with a pract cert (would love to have it, and have tried to regain this but no courses available at present), and in this way am in a similar role to those in primary schools/intermediates. I feel a sense of isolation and lack of support due to this - am not allowed to meet with the "school nurses" meeting in the area, or have the nurse specialist visit our school.

I hope my pay rate isn't put beside my school name anywhere that is published. I considered not filling it in but want to be included in a r/v to represent others in schools who are employed to manage first aid, be they ambulance trained or other. Librarians and science techs have their pay rate in the school contracts despite only being one or two per school, but we fall in with receptionists, data administrators, etc who have completely different responsibilities. I would like to see school sick bay managers, first aid officers etc, (even if RN organisations disagree from a professional level), included and recognised in any pay equity, even if the category is a sub category - we do exist, there is no government law against first aiders in a workplace, and we should have support and oversight. My school does support me with occasional PD, which I'd be paid while going to - eg PHEC course, asthma study day, EPIpen use... I can access Goodfellow for free. I do very occasional overtime, and from next year the school has agreed to pay a second first aider due to the size of the school/workload issues. I'm probably underpaid for how busy this school is but recognise I'm working at the first aider level. I am never offered pay rises but have to ask as I am employed under the support staff C scale, I started at the top of this scale with a little extra top up so there is no pay progression even with extra years of experience', (92).

I am a community nurse prescriber, (I get no extra for this but practice nurses do)', (101).

'My nurse manager is in the process of signing me off from competent to proficient level. I've already submitted my completed portfolio and am waiting for her to finalise it, as this is urgent for securing funding to complete my postgraduate diploma next year. While she's aware of the urgency, it hasn't yet been actioned. At present there's no financial incentive to pursue further study, though the knowledge I've gained has significantly enhanced the quality of care I provide in my daily practice. Despite this, I'm feeling increasingly discouraged working within youth health', (116).

Access to professional development for school nurses

Responses relating to professional development (PD) highlight significant variation not only in whether PD is supported, but in how it is practically accessed and enabled. While many respondents report well-resourced arrangements, including paid study time, reimbursement of course and conference costs, supervision, and organisational encouragement, others describe barriers related to time, funding, clinical cover, and relevance.

In many cases, PD is theoretically available but difficult to undertake due to pressure to keep clinics open, lack of backfill, expectations that PD should be undertaken outside paid work hours or during school holidays, or limits on costs or PD days. Several respondents reported PD budgets being reduced or removed entirely due to organisational or funding changes, resulting in missed conferences, loss of professional memberships, and restricted access to sector-specific learning. Others noted challenges in identifying PD that adequately reflects the complexity of contemporary school nursing practice, particularly in relation to youth mental health.

Taken together, these comments suggest that access to professional development is uneven, fragile, and highly dependent on local arrangements, rather than being consistently protected as an essential component of safe and sustainable nursing practice.

'Proposed to senior management last year having paid PD. We now have 60 hours Paid PD across 3 years (commenced Nov 2024). We have access to paid supervision (recently this has been asked to be completed outside of school hours)', (2).

'Have access to PD', (7).

'I do get paid for PD', (9).

'School covers cost of annual practicing certificate, membership to college of nurses, ASNG study days, reimbursement of parking from a study day' (11).

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'Our PD budget has been completely cut in the last few months because of a significant loss of income to the PHO who employs us (came about with the departure of [named contract] and [another named contract]', (16).

'We have recently attended a 2 day youth conference which school paid and paid for our time to attend (we had to ask but they were happy to pay us)', (19).

'I can access funding for PD -i.e. conferences and am paid mileage to attend these. I'm required to submit a work plan to cover full time hours over the school holidays. This work plan includes planning days in the city and professional development and is modified by our management team, so each team member's workplan and hours are considered relevant and justified. Finding relevant and justified tasks and PD that I haven't already done to cover 12 weeks of school holidays has become increasingly difficult', (20).

'We can access Professional Development although under \$200 per day is preferred. We do get paid for Professional Development'. (25).

'PD is supported and we are paid if out of our normal hours and supervision is paid for', (26).

'Not enough time for PD in term time', (29).

'We are paid for PD' (37).

'Minimal PDRP is paid for, not paid for study day if lands on your day off (39)

'Can access paid PD' (41).

'We were not given paid PD until last year when we insisted that we need to be doing PD and the school needs to sort cover for the 2 days per year of ASNG PD, (43).

'We are very fortunate, we have full access to all PD and have been given pay increases set by Te Whatu Ora' (44).

"I get 2 paid PD days per year- these are 7 hour days so a total of 14 hours paid PD' (48).

'No capacity for professional development in paid time, (49).

'I do get paid PD days but I usually only book 2 or 3 days annually as finding cover can be difficult', (50).

We get 20 hours PD per year - if this is used outside of school hours, we can claim hourly rate for this. (Harder for full time nurse to access training outside of school hours)', (52).

'There has never been any issue with accessing PD', (54).

'We facilitate our own education and workshops at [redacted for anonymity] using a range of formats (online, internal education or external facilitators)', (58).

'We often get questioned about the professional learning development we do, although we are never denied PLD or payment for it. We also get a lot of backlash when the clinic needs to close (due to meetings or sickness)', (63).

'We get regular paid PD opportunities', (65).

'Only free PD can be accessed', (69).

"I work for [redacted for anonymity] and they have lost several other contracts so as a result school-based health services have lost all professional development budget. As a further consequence, none of the school nurses (in our region) made it to the school nurses' conference. We also do not have membership to the NZSN website as there is no budget for this', (70).

The school does pay for our PD but we do not get paid if it falls on our day off, but they will pay for cover', (73).

'Funding for PD is available but there is no one to cover should I need the PD time off, I'm currently doing counselling papers that work will not support me in doing during work hours so I'm doing it at home in my spare time as they feel it is not relevant to my role,

but I am dealing with a lot of mental health especially during HEEADSSS assessments', (74).

'Appropriate PD for School Based Health Service is minimal or lacking', (75).

'Can access PD but have not have a lot of opportunity to do so', (77).

'Yes we get paid for 20hrs PD – this has to be done outside of work hours', (78).

'We are entitled to PD and yes we get paid for this', (80).

'Easy access to PD, its encouraged', (81).

'PD is not well defined in terms of monetary support but has generally been supported on request (84).

'PD is paid for', (85).

'We get paid study leave and days paid if below \$250', (86).

"School is aware we require this but we access it ourselves and if during the day we can only do this in school holidays, or only one of us goes which means the other one misses out', (91).

'School is very good at paying for all PD &APC for all nurses here' (94).

'We can access PD and are paid for it- the courses we attend are paid for, and we are paid for our time when attending a study day', (95).

'We can access paid PD 20 hours a year (60 hours over 3 years) and are reimbursed for course costs (96).

'We are able to access PD hours', (97).

'I get paid PD, they also pay for any PD costs' (98).

'Can access PD, but this is not funded by Te Whatu Ora (my employer)', (99).

'Easy access to PD as much as we wish', (100).

'I attend PD, some is paid by the school, some is self-funded and some is online learning. If I attend a PD course, I am paid to attend and the course is paid for', (101).

'Overall, fairly happy with PD opportunities and school paying expenses for them etc', (102).

'Very supported in my role. Lots of funded PD and many other perks', (103).

'We have supervision paid for us, paid education and time off for study, paid annual conferences (taken from education allowance', (105).

"I can access PD and am paid when I do (106).

'Professional development is not an issue with my school', (116)

Allowances for school nurses

Comments relating to allowances and additional benefits reveal a highly inconsistent and fragmented picture across school nursing roles. Some respondents report receiving limited practical support such as reimbursement of Annual Practising Certificate (APC) fees, indemnity insurance, or small qualification allowances, while others receive no additional benefits at all.

Where allowances do exist, they are often modest, variable, and dependent on individual school policies rather than recognised as standard entitlements linked to professional responsibility, experience, or scope of practice. Several respondents noted the absence of access to professional development, health insurance, or inclusion in wider staff benefits, contributing to feelings of isolation and undervaluation.

In some cases, non-financial benefits such as subsidised school fees for employees' children were described as compensating for lower pay, highlighting how allowances are sometimes relied upon to offset pay inequities rather than addressing them directly. Overall, these comments suggest that allowances for school nurses are uneven, discretionary, and insufficiently aligned with the professional requirements, workload, and wellbeing needs of the role.

'APC reimbursed', (7).

'Our school pays for our practicing certificate and NZNO fees for us, we have onboarded one reliever who they dont pay that for but paid her to do first aid course', (26).

'I don't get any perks at all and do not get to do things with other school nurses. I do not get access to PD, no health insurance, I don't get invited to Christmas end of year functions. I believe as a nurse with 40+ years of nursing experience, I should get paid more per hour', (61).

'I also have to use up all entitled annual leave before I can take annualized ordinary leave, which means I can never build up holiday leave to take an extended holiday after an extensive term with a heavy and sometimes jarring workload. I should be able to build my leave and take some much needed rest as school holidays I am home with children so burn out is always ever existing', (74).

'We do get subsidized fees for our own children to attend the school - not much but still a drawcard and makes up the difference in pay gap with the DHB', (82).

'Our nursing registration and nursing indemnity insurance is paid by our employer', (85).

'I get a \$0.50 per hour qualification allowance (this is included in my hourly rate). Our APCs are paid for', (95).

'We do get our APC \$130 reimbursed annually. We do not get the Tiaki Allowance, even though this is in the support staff collective. I get a qualifications allowance, as per the support staff collective, for my degree (\$0.50 per hour). I pay for NZNO and NZEI memberships and am not reimbursed for either (96).

'I have been asking for health insurance over the last year, but have been unsuccessful', (108).

Professional isolation in the school nursing service

School nurses often face the challenge of evaluating which aspects of their work are most difficult, yet their isolated roles make it hard to see the full picture. One nurse reflected on the possibility that different governance or funding structures might alleviate daily obstacles in her work:

"I wish I was governed by MoH rather than MOE, I feel that would remove so many barriers to doing a good job for the kids that need it" (115),

Similarly, the decision to pursue professional advancement can feel fraught. One nurse shared their ambition to become a Nurse Prescriber (52), while others chose not to renew their Nurse Prescriber license (24) due to the extra workload with no financial gain (20). These experiences highlight that even aspirational roles carry unseen challenges — what may appear “greener” from afar does not always deliver relief or improvement.

The underlying issue is the isolation inherent in many school nursing positions. Working physically separated from their peers, nurses often lack opportunities to share their experiences, benchmark against others, or gain insight into alternative arrangements. Some nurses have even reported that they are not permitted to attend local school nurse meetings.

This professional isolation perpetuates the uncertainty many school nurses reported around contractual and pay-related issues. In addition, the clinical burden reported by many school nurses could to some extent be relieved if they were able to reflect and share with colleagues. But without regular access to the broader professional network of colleagues, school nurses are limited in their clinical support and cannot fully assess the benefits or drawbacks of different systems, employment models, or career choices.

By capturing these reflections, this report aims to shed light on the nuanced pressures of school nursing, exposing both structural inequities and the hidden impacts of professional isolation across Aotearoa.

Pay progression for some school nurses

While much of the narrative highlights challenges with pay, a small number of respondents shared positive experiences of pay progression and recognition as skilled health professionals and valued members of the school staff. These comments describe workplaces where management has been responsive to requests for pay adjustments, aligned salaries with MECA or DHB benchmarks, and generally appreciated and supported nurses' professional contributions. Nurses in these settings reported timely responses to pay requests, cost-of-living increases, and a sense of being valued for their work. Such experiences stand in contrast to the broader themes of pay inequity and highlight the impact of supportive, responsive management on staff satisfaction and in fact, demonstrate that it remains possible for issues to be addressed and systems improved.

'To be honest we have been very lucky when it comes to being valued in the school. Each time we have approached senior management with any pay concerns (matching DHB rates) they are happy to oblige. They listen when we have any concerns about working conditions, they don't expect overtime', (54).

'Our workplace is supportive and agreed quickly to a increase in pay rate when supplied with the MECA information. I am grateful for this', (80).

'We generally get the cost of living inflation pay rise each year', (85).

"As we come under the umbrella of 'support staff we get some of their increases in hourly rate', (91).

'Im a nurse prescriber and have had fantastic support right from day one employment. Every pay rise we have asked for has been given within 24 hours and never questioned. We are very appreciated', (100).

Discussion

Structural and system drivers of inequity across the School Nursing Service

The findings in this report point to structural and systemic drivers underpinning the inequities experienced by school nurses, rather than isolated or site-specific issues. The split governance between Health and Education creates a structural environment in which responsibility for workforce conditions is diffuse, accountability is unclear, and consistency is difficult to achieve. As demonstrated in the findings, this fragmentation enables wide variation in how school nursing roles are funded, interpreted, and supported, even where services are nominally operating under the same contractual framework.

This lack of coherent national oversight has resulted in inequities across contractual arrangements for school nursing with the resulting impacts of significant discrepancies in pay and conditions, staffing ratios, professional recognition, and access to professional supervision and professional development. Critical decisions relating to matters such as these are heavily dependent on local leadership in both Health and Education, funding pressures, and negotiation by individual school nurses. While some schools and employers have implemented equitable and supportive arrangements, these examples rely on goodwill rather than enforceable standards. The variability itself is a key finding: it signals the absence of mechanisms to ensure fairness, transparency, or clinical safety across the workforce. In this context, inequity is not an anomaly but a predictable outcome of the unsatisfactory and arbitrary manner in which the School Nursing Service has developed in this country.

Workforce experience and the impact on school nurses as health professionals

The findings in this report describe a school nursing workforce operating under sustained professional strain, characterised by isolation, high responsibility, and limited structural support. Unlike many other nursing contexts, school nurses frequently practise as sole clinicians within their settings, with minimal peer support, limited clinical oversight, and few opportunities for informal consultation. In environments of high student-to-nurse ratios and increasing clinical complexity, this model places significant cognitive, emotional, and ethical burden on individual school nurses.

A recurring feature of workforce experience was the normalisation of unpaid, unrecognised, and at times unsafe practice. Nurses reported routinely extending working hours, absorbing additional responsibilities, and prioritising student wellbeing at personal and professional cost. Importantly, these behaviours were often described not as exceptional, but as expected. This reflects the concept of clinician moral distress, where practitioners recognise the standard of

care required but are constrained by structural, contractual, or resource limitations from delivering it safely and sustainably. Over time, moral distress contributes to burnout, disengagement, and workforce attrition.

In the absence of consistent employment frameworks, union leverage, or clear career pathways, many nurses described being required to repeatedly justify their professional value to non-clinical decision-makers. This expectation compounds isolation and creates an inequitable environment in which effective self-advocacy becomes dependent on individual confidence, time, and negotiation capacity rather than clinical expertise or service need.

Even among nurses reporting positive employment experiences, supportive conditions were frequently described as being “fortunate” or “lucky” rather than standard. This language suggests an implicit recognition that equitable pay, supervision, and safe workloads are not consistently embedded within the system. Such framing risks normalising inequity by positioning fair treatment as discretionary rather than fundamental.

Collectively, these findings indicate that current models of school nursing place disproportionate responsibility on individual practitioners to compensate for systemic shortcomings. While commitment to students remains strong, sustainability appears to rely heavily on personal sacrifice rather than structural support.

The challenges of providing safe clinical practice

The consequences of these workforce conditions extend beyond employment matters and into the domain of patient safety. When nurses routinely work unpaid hours, practise in isolation, or manage workloads that exceed safe capacity, responsibility for maintaining care standards shifts from the system to individual clinicians.

Workforce attrition further compounds these risks. High turnover, unfilled vacancies, and reliance on sole practitioners disrupt continuity of care, reduce capacity for preventative work, and erode institutional knowledge. For students and whānau, this may result in delayed assessment, inconsistent management of chronic or complex needs, and diminished trust in the service.

The ethical implications are particularly significant given the increasing clinical complexity of school nursing practice. School nurses are frequently the primary access point for rangatahi facing barriers to general practice or emergency services. Without corresponding increases in staffing, funding, and professional infrastructure, nurses are required to triage high-risk presentations without adequate backup, relief, or protected time for documentation and follow-up. This elevates clinical risk and raises concerns regarding equity of access and quality of care.

Addressing these issues is therefore not solely a workforce matter; it is central to patient safety, service integrity, and equitable access to healthcare for rangatahi.

Access to Professional Support, Supervision & Development

Professional support is essential to safe, sustainable school nursing practice. Yet access to clinical supervision, mentoring, professional development, and collegial networks remains inconsistent across employment models.

Nurses employed through health-funded contracts are more likely to access structured supervision; however, many nurses employed directly by schools report little or no regular clinical supervision. NZSN is frequently contacted by schools seeking guidance only after high turnover of school nursing staff, reflecting a reactive rather than planned approach to professional support.

Clinical supervision plays a critical role in supporting ethical practice, legislative compliance, professional reflection, and ongoing development - particularly for nurses practising in isolation.

Best practice indicates that supervision should be provided by an appropriately qualified external supervisor without managerial responsibility for the nurse. While some Te Whatu Ora contracts require nurse educators or managers to provide supervision, this dual role introduces potential conflicts between managerial and supervisory functions.

Variations in access to independent, high-quality supervision mirror broader inequities within current service and employment arrangements. In the absence of nationally defined expectations and protected provision for supervision, both nurse wellbeing and the safety of professional practice in the school-based health services remain vulnerable.

Strength of findings

The strength of the findings in this report lies not only in the volume of responses received, but in the consistency, depth, and unsolicited nature of the themes identified. Many of the most significant issues, including pay inequity, workload burden, unsafe staffing, contractual opacity, and professional undervaluation, emerged from responses to an open-ended question inviting participants to share anything else they felt was important. With little prompting, similar concerns were raised repeatedly across the dataset.

Respondents represented a wide range of employment arrangements, including nurses employed directly by schools, PHOs, NGOs, and Te Whatu Ora, and worked across diverse regions, school sizes, and community contexts. Despite this heterogeneity, there was striking alignment in the issues described, suggesting that the challenges identified are systemic rather than isolated or employer-specific.

The narrative responses were frequently detailed and reflective, indicating a high level of engagement with the survey and a strong motivation to be heard. Several participants expressed concern about confidentiality or asked that identifying details be removed, highlighting the perceived risks associated with speaking openly about pay and working conditions. This suggests that the findings may, if anything, under-represent the full extent of concern within the workforce.

This work was facilitated by the New Zealand School Nurses Network (NZSN), which was established in response to long-standing gaps in national coordination and advocacy for school nurses. Conducted without government mandate or funding, the survey relied on voluntary participation and professional goodwill. The independence of this process from employing and funding bodies may have enabled a level of candour that is often absent in formal consultation processes.

Taken together, the convergence of themes, the unsolicited emergence of critical issues, and the breadth of respondents lend considerable weight to the findings. These data provide a credible and compelling account of the current realities of school nursing in Aotearoa New Zealand and warrant serious consideration by government, policymakers, funders, and sector leaders.

To the authors' knowledge, this is the first national effort to systematically document the workforce experiences of school nurses in Aotearoa New Zealand. In a sector that has historically lacked dedicated data, these findings contribute a foundational evidence base for future policy, funding, and workforce planning.

Limitations

This report draws on self-reported data from a national survey of school nurses. While the findings provide a rich and consistent picture of workforce conditions, several limitations should be acknowledged.

Absence of a national school nursing workforce register

There is currently no comprehensive national database of school nurses in Aotearoa New Zealand. As a result, the total size of the workforce cannot be confirmed with certainty. An estimated response rate of approximately 45–48% has been calculated using the number of survey responses relative to known school nurse positions recorded through NZSN membership data. While this provides a reasonable indication of reach, it remains an estimate in the absence of formal national workforce data.

Anonymity and absence of individual demographic data

To maximise participation and protect anonymity, the survey did not collect individual demographic information such as age, gender and ethnicity. Consequently, it is not possible to analyse whether known inequities - including those affecting Māori nurses - are reflected in pay, employment conditions, or access to professional support within school nursing. This represents

an important gap and highlights the need for future workforce data collection approaches that enable equity-focused analysis while maintaining confidentiality.

Reliance on self-reported employment information

All data were self-reported by respondents and were not independently verified against employment contracts or payroll records. The wide variation in employment arrangements, including term-time-only versus full-year contracts, annualised salaries, and differing hours of work, limits precise comparison of remuneration across respondents. However, the consistency of themes across responses suggests the findings reflect systemic patterns rather than isolated individual experiences.

Complexity of employment models limits detailed comparative analysis

The diversity of employing organisations and funding pathways (including Health, Education, and non-government arrangements) constrained the ability to undertake more detailed comparative analysis between groups. In particular, variations in weeks paid per year and contracted hours limited the feasibility of comparing pay rates across employment models without introducing significant assumptions.

Scope of free-text responses

While the survey included open-ended questions, the free-text sections did not explicitly prompt respondents to describe grievances or frustrations. It is therefore possible that some nurses, upon reading this report, may recognise additional experiences or perspectives that align with the identified themes but were not captured in their original responses. The findings should be understood as representative rather than exhaustive.

Potential response bias

As with all voluntary surveys, it is possible that nurses experiencing higher levels of workload pressure or dissatisfaction were more likely to respond. However, the inclusion of accounts describing supportive workplaces, adequate professional development, and positive employment conditions suggests the dataset reflects a broad range of experiences across the workforce.

Recommendations

Based on the findings of this report, the following recommendations to support effective and safe practice in school nursing are directed toward the multiple groups who shape, fund, employ, manage, and deliver this service. Collectively, they seek to address identified workforce challenges, strengthen equity, reduce risk, and support the sustainability and safety of school-based nursing services in Aotearoa New Zealand, while recognising the distinct roles and responsibilities held by each group.

For Ministry of Health, and Funding & Planning Teams of School-Based Nursing Services

1. Strengthen audit and accountability mechanisms within contracted school-based health services.

Implement routine auditing of contracted school-based nursing services to ensure public funding is used for its intended purpose, including fair remuneration, safe staffing, professional development, and clinical support. Auditing should apply across commissioning, funding, and delivery arrangements to ensure transparency, consistency, and accountability for investment in school nursing services.

In particular, auditing must verify that the full allocated nursing salary component within contracts is received by the nurse employed in the role, rather than absorbed into broader organisational budgets. While remuneration transparency is critical, auditing mechanisms should also assess the broader conditions that enable safe and sustainable nursing practice.

2. Establish an annual national school-based nursing workforce survey.

Commission the implementation of a regular, standardised workforce survey that captures the *entire* school nursing workforce across Aotearoa New Zealand, including nurses employed through Health, Education, and non-government organisations, regardless of funding or contracting pathway. The survey should monitor employment conditions, pay equity, workload, access to professional development and supervision, and workforce wellbeing, enabling progress to be measured over time and evidence-based work force planning and accountability.

3. Establish and maintain a nationally consistent pay framework for school nurses.

Adopt and endorse the NZSN draft school nurse salary scale as the reference framework for remuneration, with provision for regular review and alignment following each MECA and NZEI Collective ratification. A whole-of-workforce approach is essential to avoid perpetuating inequities between differently funded or employed school nurses and to ensure national policy decisions reflect the realities of the full service.

4. Provide clear national guidance on appropriate remuneration and employment conditions.

Support the development and dissemination of clear, accessible national guidance outlining expected pay ranges, allowances, and employment conditions for school nurses, such as in point 3. Guidance should be distributed nationally to schools and nurses to improve

transparency, reduce inequity driven by lack of awareness, and support consistent implementation of pay frameworks.

5. Review current school nurse staffing ratios against contemporary workloads and complexity.

Commission a review of existing staffing ratios to reflect the expanded scope, acuity, and administrative demands of modern school nursing practice. Current benchmarks (including the 1:700 - 750 ratio) should be reassessed in light of contemporary evidence, with particular consideration for alternative education, TPU, TKKM, and high-needs settings. Any revised ratios should be explicitly linked to funding models that support safe practice and sustainable staffing.

6. Prioritise workforce sustainability through full-year employment models.

Support and incentivise 52-week employment contracts for school nurses as the preferred model, recognising that effective school nursing requires year-round clinical preparation, administration, care coordination, professional development, and recovery time. Full-year employment supports workforce retention, reduces reliance on unpaid labour, improves continuity of care for students, and mitigates operational and clinical risk associated with high staff turnover.

7. Invest in strategic workforce development for the school nursing specialism.

Support national planning to develop school nursing as a recognised area of specialist practice, including funding for targeted professional development, leadership pathways, succession planning, and long-term role sustainability. Investment should be informed by the experience of the frontline workforce and aligned with the realities of school-based practice.

8. Provide transparency of service outcomes to staff delivering contracted services

Ensure that school nurses have access to the outcomes and targets set by the health funder, enabling them to understand expectations, align their practice, and contribute effectively to service delivery.

9. Ensure funding models support safe and sustainable service delivery.

Ensure commissioning and funding arrangements adequately support safe staffing levels, including provision for leave, professional development, clinical supervision, and appropriate clinical cover.

For Ministry of Education, School Principals and employing School Boards of Trustees

10. Ensure transparency and clarity in school nurse employment contracts.

Employment contracts should clearly outline hours of work (per day, week, and year), salary calculations, and the financial implications of terms prior to signing. This supports informed decision-making and reduces unintended inequities, particularly in term-time-only roles.

11. Apply nationally consistent pay guidance when employing school nurses.

Schools should use the NZSN draft school nurse salary scale and associated guidance when determining pay rates, allowances, and progression, ensuring remuneration reflects a school nurse's scope of practice, experience, and responsibility.

12. Develop and implement safe staffing frameworks aligned with actual workload.

Schools should use established school nursing guidelines and frameworks, such as those listed on the NZSN website, to determine staffing arrangements that reflect student population size, complexity, and clinical risk, and ensure contracted hours cover the full scope of work. This includes time for clinical documentation, follow-up care, multidisciplinary meetings, care coordination, crisis response, and administrative tasks. Safe staffing frameworks should support staff retention by contributing to job satisfaction.

13. Support scheduled breaks and clear overtime arrangements.

Principals and school leadership should work collaboratively with school nurses to plan scheduled breaks that align with clinic demand and support safe, effective practice. Clear, shared understanding should be established regarding overtime expectations, how additional hours are recorded, and how they are remunerated or offset.

14. Ensure access to regular professional clinical supervision.

Schools should ensure school nurses have access to professional clinical supervision at a minimum of monthly intervals, recognising supervision as essential to clinical safety, reflective practice, workforce wellbeing, and professional development.

15. Appropriately recognise and remunerate additional responsibilities.

Where school nurses hold responsibilities beyond their core clinical role (for example, leadership of pastoral care teams, service coordination, or advisory roles such as health and safety committee representation), these should be formally recognised and remunerated through management units or equivalent mechanisms. Nurses in these roles who are not yet remunerated for this work should not be removed from these groups as a result of this recommendation.

For Managers (PHO / NGO / service-level)

16. Support consistency and equity across employing organisations.

Managers should work toward consistent employment practices, application of pay guidelines, and access to professional support and clinical supervision, reducing inequities arising from fragmented commissioning and contracting arrangements.

17. Enable professional development that is relevant, accessible and role-specific.

Ensure school nurses have equitable access to professional development that is specific to school nursing practice, including paid time to attend with appropriate backfill where required.

18. Ensure transparency in contracting and employment arrangements.

Managers should ensure that contracting and employment arrangements are transparent and clearly communicated. These include hours of work, weeks of employment, remuneration structures, workload expectations, and, where service delivery contracts exist, the relevant service obligations, deliverables, and performance expectations that shape school nursing practice. Where school nurses are expected to deliver against contractual requirements or service targets, these should be shared directly with the nurses responsible for delivering them, enabling realistic planning, fair accountability and safe clinical practice.

19. Support collective advocacy and regional workforce coordination.

Managers should actively support mechanisms for collective advocacy and regional coordination among school nurses, including engagement with unions, professional bodies, and regional forums. This includes supporting nurses' access to shared information, tools, and resources that strengthen collective voice and eliminate reliance on individual advocacy to address systemic issues.

For Unions and Nurse Advisors

20. Advocate for pay equity, safe staffing, and sustainable employment models
Unions should continue to champion consistent pay scales, full-year employment, and conditions that reflect the scope, responsibility, and complexity of school nursing practice. Advocacy should be grounded in evidence, including insights generated through this report.

21. Direct nurses to practical tools and resources to support collective advocacy

Promote awareness and use of existing and emerging resources, including this report, the NZSN draft salary scale (NZSN Pay Equity Working Group, 2024), and practical tools for monitoring workload, overtime, and working conditions. Ensure nurses remain connected to updated guidance as it is developed, enabling advocacy from a shared, current, and evidence-based platform rather than in isolation.

22. Strengthen collective representation and advocacy

Address the current burden on individual nurses to negotiate and defend their own working conditions by supporting individual union members in their own negotiations, using this report, and more broadly, supporting coordinated, sector-wide advocacy.

23. Inform workforce planning and policy engagement

Use the findings of this report to guide strategic workforce planning, research, and policy discussions. Advocate for national consistency in school nursing employment conditions, including pay, career progression, and role clarity.

For School Nurses

24. Familiarise yourself with national pay guidance and tools

School nurses should review and understand the NZSN draft salary scale (NZSN Pay Equity Working Group, 2024), and associated guidelines, including allowances, progression, and employment conditions. This knowledge supports informed negotiation and ensures transparency in remuneration.

25. Use practical monitoring tools to document workload and conditions

Maintain accurate records of overtime, missed breaks, administrative time, and other workload factors. Use available templates and tools and newly developed resources as they are published, in order to provide evidence for advocacy or discussions with employers and unions.

26. Engage proactively in professional development

Seek out relevant professional development, ensuring participation aligns with your learning needs and the requirements of school nursing practice. Make use of employer-supported PD opportunities and document completed training for professional and career development purposes.

27. Participate in clinical supervision

Engage regularly with professional clinical supervision to support reflective practice, clinical decision-making, and professional wellbeing.

28. Understand and clarify employment expectations

Before accepting or renewing contracts, ensure clarity around hours, weeks paid per year, annualised salary, and any contractual obligations. Ask questions and seek guidance to ensure your role and responsibilities are understood and remunerated fairly.

29. Advocate for fair employment conditions*

Work with your union and peers to raise issues related to pay, workload, breaks, staffing, and employment contracts. Use collective tools and guidelines to support these discussions rather than negotiating alone. For those on a NZEI collective agreement, take careful note of the terms of condition for 'overtime' and 'rest and meal breaks'.

30. Participate in workforce surveys and feedback mechanisms*

Provide accurate, honest input into national or regional school nursing surveys and audits to inform workforce planning, measure progress, and highlight areas for improvement.

*(*In making these recommendations, the authors recognise the significant structural constraints faced by the school nursing workforce and do not place responsibility for systemic failures on individual nurses.)*

Conclusion

This report represents a critical turning point in the visibility of school nursing in Aotearoa New Zealand. For the first time, the collective experiences of school nurses have been documented nationally, providing a comprehensive snapshot of employment conditions, pay, and professional realities.

In line with its objectives, this report from a national survey of school nurses in November 2025 has:

- Provided a contemporary overview of school nurses' employment conditions and pay, demonstrating significant variation across roles, employers, and locations.
- Identified systemic pay inequities, with many nurses earning well below comparable health sector rates, contributing to dissatisfaction, workforce attrition, and recruitment and retention challenges.
- Captured the voices of school nurses through narrative commentary, highlighting the realities of working in isolation, managing unrealistically high workloads, and often taking on unpaid overtime to meet the needs of students.
- Supported evidence-based advocacy, offering clear, data-driven insights for government ministries and their policy-makers, funding bodies, unions, and employers/managers in both Health and Education, by clearly illustrating an urgent need for consistent pay and professional support structures.
- Informed the ongoing development of the NZSN School Nursing Salary Scale, providing a foundation for a finalised national framework that ensures fair pay and equitable working conditions across the sector.

While individual progress has been made through advocacy, mentoring, and local negotiations, structural inequities remain. Without coordinated, system-level action, school nurses will continue to face disparities that undermine both their professional wellbeing and the quality of care provided to students.

By presenting both quantitative data and qualitative data arising from lived experience, this report establishes a robust evidence base to guide action. It underscores the mahi undertaken by school nurses' is critical, their voices must be heard, and equitable pay and employment conditions are not optional; they are essential for a sustainable, high-quality school health care system nationwide.

Glossary

The headings in this glossary are grouped, in order to aid understanding of the reader. Groupings are as follows:

- Te Reo Māori
- Nursing Terminology
- Education Terminology
- Health Terminology
- Other Terminology

Te Reo Māori	
Aotearoa	This is a Māori name for New Zealand and is now widely used when referring to this country - Aotearoa New Zealand. It blends Māori heritage with our increasing multi-cultural identity.
Iwi Provider	A Māori-led organization that delivers services such as health, education, housing, and social services, rooted in Māori cultural values, practices, and community needs. These providers are often tribe-based (iwi) or Māori-run (hapū/whānau-based), providing tailored support to improve wellbeing
Kaupapa	In an education setting, particularly a Māori one, kaupapa is used to describe the principles, philosophy and agenda that guide learning. Māori language, knowledge and culture would be prioritised.
Kōrero Hauora	Kōrero hauora: a Māori term -to converse or discuss health, encompassing spiritual, physical, emotional and social well-being.
Kura	This is the Māori word for 'school' and is one of many Te Reo Māori words that have been widely adopted in the New Zealand vernacular.
Mahi	This is the Māori word for 'work' and is one of many Te Reo Māori words that have been widely adopted in the New Zealand vernacular.
Pou	In Te Reo Māori this literally means a post or a pillar. However it is frequently used metaphorically to describe a leader, person or a group of people who are strong supporters or mentors of a particular concept, cause or piece of work.
Rangatahi	Te Reo Māori for the younger generation or youth. It is widely used in everyday language in Aotearoa.
Tangata Whenua	The indigenous people (Māori) who have historic and territorial rights over an area of land.

Te Kura Kaupapa Māori (TKKM)	These are total immersion New Zealand state schools where the curriculum is delivered in Te Reo Māori, the Māori language. Māori culture and Te Ao Māori or a Māori world view, are integral to student learning.
Tongikura	A tongikura is a saying made famous by past Māori Royalty or 'quotes of a monarch'
Whānau	A Māori term used for family. It represents the foundation of Māori society and the network of relatives connected by blood and by shared responsibility, care, and belonging
Nursing Terminology	
Annual Practicing Certificate (APC)	Issued by the New Zealand Nursing Council, anyone who is practising as a Registered or Enrolled Nurse in New Zealand must have an APC. The nurse must pay an annual fee for an APC, and on application must be able to verify hours of practice.
Community Nurse Prescriber	A Community Nurse Prescriber (CNP) is a registered nurse who has undertaken additional education and is authorised by the Nursing Council to prescribe a limited range of medicines for common ailments and conditions. They work in community settings (ideally within collaborative teams) and aim to make health care more accessible to people who are generally healthy.
Enrolled Nurse	An Enrolled Nurse (EN) is authorised by the Nursing Council of New Zealand to provide nursing care and support to individuals and groups in a variety of settings. Enrolled nurses must work with access to, and seek when appropriate, guidance from a registered nurse or other registered health practitioner.
Lead Nurse	In a school situation, a lead nurse provides clinical leadership, staff mentoring, and oversees standards of care to rangatahi in that school.
Nurse Educator	A Nurse Educator (NE) is a senior registered nurse who has undertaken higher education and works in a variety of settings to educate and mentor other nursing staff in order to maintain high-quality, evidence-based clinical care.
Nurse Manager	A Nurse Manager is a senior registered nurse who provides leadership to a team of health professionals in a particular setting. In school nursing they have oversight of school nursing, reporting, budgets, staffing, and clinical outcomes, liaising with school senior management teams and school health teams.
Nurse Practitioner	A Nurse Practitioner (NP) is an advanced clinician with the clinical training and legal authority to practise beyond the level of a registered nurse. They work autonomously and in collaborative teams to manage episodes of care as lead providers, improving health access and outcomes. Combining advanced nursing knowledge with diagnostic reasoning, they diagnose and manage common and complex conditions. Their scope includes providing assessments, ordering and interpreting tests, prescribing medicines, and admitting or discharging from healthcare services. As clinical leaders, they partner with families/whānau to influence health service delivery and the wider profession.

Registered Nurse	A Registered Nurse (RN) is a health professional registered with the Nursing Council of New Zealand. They provide comprehensive care using their knowledge, clinical judgement and cultural awareness and work independently and collaboratively across a wide range of settings.
School Nurses	School-based health nurses (SBHN) or School Nurses (SN): School-based health nurses in New Zealand are enrolled or registered nurses who provide free, confidential, and comprehensive, holistic, and youth-focused health services directly within schools, particularly secondary schools.
Education Terminology	
Primary Schools	In New Zealand, primary schools are educational institutions specifically for students from Years 0–6 (typically aged 5-11).
Intermediate Schools	In New Zealand, intermediate schools are educational institutions specifically for students from Years 7-8 (typically aged 11–13), acting as a bridge between primary (Years 1-6) and secondary (Years 9-13) schools.
Secondary Schools	In New Zealand, secondary schools (often called high schools or colleges) are educational institutions specifically for students from Year 9 to Year 13, (typically catering to ages 13–18).
Te Kura Kaupapa Māori (TKKM)	These are total immersion New Zealand state schools where the curriculum is delivered in Te Reo Māori, the Māori language. Māori culture and Te Ao Māori or a Māori world view, are integral to student learning.
Teen Parent Units (TPUs)	Teen Parent Units (TPUs): These are specialized, school-hosted education centers providing tailored secondary education for pregnant or parenting teenagers, usually aged 19 and under. Classes are semistructured allowing flexibility around infants daily routines (sleeping, feeding etc).
Alternative Education (AEs)	Alternative Education (AE) sites: Alternative Education (AE) in NZ is a formal, Ministry of Education-funded intervention for disengaged students aged 13–16 (Years 9–11) who are unlikely to learn productively in mainstream school.
State Schools	A government-funded school in New Zealand that provides free education to domestic students (may be known abroad as a public school).
Private Schools	Private schools in New Zealand (often called independent schools) are registered, independent, fee-charging institutions that operate outside the state system, representing about 4% of schools.
State-integrated school:	A school that was originally private but is now part of the state system. It follows the national curriculum while retaining its special character (often religious or philosophical).
Special charter schools	Special charter schools in New Zealand (Kura Hourua) are state-funded, independent schools operated by private sponsors under a direct contract with the government.
School Principal	A school principal is like the Chief Executive of a school. Abroad they might be known as a headmaster, headmistress, or headteacher. In New Zealand they are appointed by the school's

	Board of Trustees (BOT) to be responsible for the day-to-day management of the school, operations (including managing budgets) and the pedagogical leadership of the school. They work closely with staff and the BOT to ensure high levels of student achievement.
Boards of Trustees (BOT)	Board of Trustees is a Crown entity responsible for the governance, strategic direction and legal compliance of schools in Aotearoa New Zealand. The members of the BOT are elected by the community of a school.
Senior Leadership Team (SLT)	Within each school, a group of school leaders including principals, deputies, and managers, who are responsible for strategic direction, daily management, and improving teaching standards.
Head of Department (HOD)	A Head of Department (HOD) in education is a senior teacher responsible for leading a specific subject area (e.g., Science, English) or key stage in a school. They provide strategic leadership, manage curriculum development, support staff professional growth, and monitor student achievement data to maintain high academic standards.
Achievement in Multicultural High Schools (AIMHI)	A group of secondary schools in New Zealand that work collaboratively to improve outcomes for students in diverse and high-needs communities.
Ministry of Education (MOE)	This government department is responsible for formulating and overseeing policies, curriculum and funding for schools from kindergarten to secondary schools.
Decile	The decile ranking (1-10) was a historic system used by the Ministry of Education to measure the disadvantage of students in order to allocate additional funding. Decile 1 schools had the highest levels of community socio-economic deprivation whilst decile 10 schools were the least disadvantaged. The system was replaced by the Equity Index in 2023.
EQI/Equity Index	This statistical model is now used by the Ministry of Education to measure the level of socio-economic deprivation of students in a school to better target funding to help student learning. Although EQI replaced the decile ranking system in 2023, the decile ranking system is still used by some organisations, including Health New Zealand to allocate School Nursing resources.
Health Terminology	
District Health Board (DHB)	Former regional organisations responsible for providing and funding public health services in New Zealand. These were replaced by Health New Zealand Te Whatu Ora in 2022.
New Zealand Nurses' Organisation (NZNO)	This is the leading professional body and trade union for more than 55,000 nurses and health care workers in the country.
PACU	The Post-Anaesthesia Care Unit (PACU), or recovery room, is a specialized, high-intensity hospital department where patients are monitored immediately after surgery and anaesthesia.

Primary Care	A Primary Health Care Service is one that usually operates in the community and includes Medical Centres, Family Health Care Centres. Examples of Primary Health Practitioners include General Practitioners (GPs), Practice Nurses, Outreach immunisation nurses, Public Health Nurses, and School Nurses. A school health centre is an example of a primary health care service.
Primary Health Organisation (PHO)	Local organisations in New Zealand that provide and coordinate primary healthcare services within communities.
Ministry of Health (MoH)	The Ministry of Health (MoH) is a government department that provides advice on health priorities and policies. The department regulates the health system and monitors outcomes.
Health New Zealand (formerly known as Te Whatu Ora)	This is the government agency responsible for operating and overseeing the delivery of health care throughout New Zealand. It is responsible for hospital and community-based health care.
Other Terminology used in this report	
ACC (Accident Compensation Corporation)	New Zealand's no-fault accident insurance scheme that provides cover for injury-related treatment, rehabilitation, and support.
ACC Provider	A registered health professional or service provider in New Zealand contracted by the Accident Compensation Corporation (ACC) to deliver injury-related treatment, rehabilitation, or care. They treat injuries covered by New Zealand's no-fault accident insurance scheme and directly invoice ACC, reducing out-of-pocket costs for clients.
Annualisation	Annualisation for New Zealand school nurses (typically term-time-only staff) is the process of spreading earnings from working roughly 40 weeks into equal, regular fortnightly pays across the full 52-week year, including school holidays. This ensures consistent (lower) income, and is calculated based on hours, allowances, and leave entitlements.
Clinical Supervision	A structured, reflective process where a health professional reviews their practice with a trained supervisor to support professional development, wellbeing, and safe practice.
Clinician moral distress	The psychological, emotional, and physical suffering experienced when a nurse knows the ethically correct action to take but is constrained—by institutional policies, power imbalances, or resource limitations—from pursuing it. This results in a compromised moral integrity, often leading to burnout, guilt, and turnover and a high turnover of staff.
HEeADSs assessment	A validated, internationally recognized psychosocial interview tool designed specifically for healthcare professionals to assess the risk and protective factors in the lives of adolescents (roughly 12-18+ years old). It is used to structure interviews in a way that starts with less personal topics, building rapport before discussing sensitive issues.
Fraser and Gillick Competencies	Legal frameworks used to determine if a child under 16 years old can consent to medical care, including contraception, without

	parental consent/ knowledge. A child is "Gillick competent" if they have sufficient understanding and intelligence to fully appreciate the proposed treatment, while Fraser guidelines specifically address sexual health services
FTE	Full time equivalent, calculated as a decimal employment per fortnight. EG 1.0FTE is equal to 10 shifts per fortnight/10 working days. 0.5FTE would be 5 shifts per fortnight/5 working days.
Multi-Employer Collective Agreement (MECA)	A collective employment agreement negotiated between one or more unions and two or more employers, which sets out agreed terms and conditions of employment for employees across those organisations. It enables unionised members to bargain collectively.
Non-Governmental Organisations (NGOs)	In Aotearoa New Zealand these refer to an independent, non-profit, or voluntary entity distinct from government agencies, often focused on social, environmental, or community well-being.
Nurse-to-student ratio	The number of students assigned to one school nurse. This is used as an indicator of workload and service capacity.
NZEI Support Staff Collective Agreement	A national employment agreement in New Zealand that sets pay rates and conditions for school support staff, including some school-based health roles.
Oranga Tamariki (OT)	Oranga Tamariki—Ministry for Children is the NZ government agency responsible for the care, protection, and youth justice of children and young people.
Pasifika	The term represents a, generally, New Zealand-based, collective identity for people of Pacific heritage, encompassing over 16,000 Pacific Island nations.
Pay Equity Working Group (PEWG)	A group established to support and guide the pay equity process, including evidence gathering, workforce analysis, and engagement.
PD Hours	The Nursing Council of New Zealand requires registered nurses to complete a minimum of 60 hours of professional development (PD) relevant to their scope of practice over the previous three years to maintain competency and gain their Annual Practicing Certificate (APC). These hours must be documented, and PD should exceed mandatory workplace training.
PDRP	Professional Development & Recognition Programme, a competency-based framework in New Zealand for nurses and midwives to advance their practice, receive recognition, and often, higher pay. It is an approved recertification program by the Nursing Council of New Zealand, that exempts nurses from audits.
Psychosocial assessment	See HEeADSss assessment.
Report of Concern (ROC)	A Report of Concern (ROC) to Oranga Tamariki (OT) is made when there are worries about a child or young person's safety or wellbeing, such as suspected abuse or neglect. Anyone in New Zealand is able to make a ROC.
Safeguarding	In New Zealand safeguarding refers to the proactive policies, actions, and culture designed to promote the well-being of children, young people, and vulnerable adults, while protecting them from

	abuse, neglect, and harm. It may be used interchangeably with the term 'Child Protection'.
Snowball recruitment	This is a method of research recruitment also known as a chain-referral technique where initial research participants ("seeds") recruit further participants from their own social and professional networks
STI	Sexually Transmitted Infection
Term-time-only (TTO) contract	An employment arrangement where an employee works only during school terms and is not required to work during school holidays. Pay may be structured through annualisation
Term-time-only (TTO) employee	An employee who works less than 52 weeks per year. Their employment includes periods of time when the employee does not have paid work available with the employer i.e., they may not work some or all of the periods when the school is not open for instruction, such as school holidays.
TOP	Termination of pregnancy
Youthchat	An electronic screening and decision-support tool used to help identify mental health, lifestyle, and other issues faced by young people in Aotearoa New Zealand. It is used by some authorised health professionals as part of routine care and, in some settings, research.

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“Ki te kotahi te kākaho, ka whati; ki te kāpuia, e kore e whati.”
“When a reed stands alone it is vulnerable, but a group of reeds together is unbreakable”.