THE ROLE OF THE HEALTH CARE ASSISTANT, KAIĀWHINA & CARER POLICY

Tōpūtanga Tapuhi Kaitiaki o Aotearoa
NEW ZEALAND NURSES ORGANISATION

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1. Introduction

The New Zealand Nurses Organisation (*NZNO*) Tōpūtanga Tapuhi Kaitiaki o Aotearoa seeks to articulate the role of the Health Care Assistant (HCA), Kaiāwhina and Carer policy for the purpose of informing and influencing government, ministry policy settings, funding decisions and the delivery of health care and services across the health sector.

The roles of the HCA, Kaiāwhina and Carer have evolved over time, and have been defined through, work, education, training and public perception. NZNO's policy describes a future focussed perspective, considering the challenges and current political climate in which the HCA, Kaiāwhina and Carer work.

The role of the HCA, Kaiāwhina and Carer policy should be read in conjunction with other NZNO policies.

2. Terminology

In Aotearoa New Zealand, the HCA, Kaiāwhina, and Carer are widely recognised occupational titles used consistently across hospitals, primary and community care, and aged residential care.

HCA, Kaiāwhina, and Carer are unregulated practitioners under the Health Practitioners Competence Assurance Act 2003[1]. They do not have a professional qualification or belong to a regulatory authority, but they are explicitly recognised in national guidance and workforce planning[2].

The title of the unregulated health care worker terminology is used interchangeable and often determined by their employer. The terminology includes:

- Kaiāwhina
- Health Care Assistant (HCA)
- Carer
- Carer Support
- Health Care Support Worker
- Mental Health Support Worker
- Maternity assistants
- Disability support workers
- Allied Health Assistant
- Technician
- Radiology Assistant, and
- Primary Care Assistant

[1] https://www.health.govt.nz/regulation-legislation/health-practitioners/about-the-act#:~:text=The%20Health%20Practitioners%20Competence%20Assurance%20Act%202003%20(the%20Act)%20is,and%20fitness%20of%20health%20practitioners.

[2] https://healthify.nz/hauora-wellbeing/h/healthcare-assistant

The title HCA needs to be preserved as the dominant national term, while allowing for role variation *within* the title, not through proliferating new titles. This action also supports workforce mobility, planning, and shared professional identity.

Although HCAs play a vital role in clinical support, the Kaiāwhina role extends this work by integrating cultural knowledge and relational engagement into care delivery. This difference underscores the unique value Kaiāwhina bring to the health system. The next section outlines the distinct role of Kaiāwhina, including their cultural expertise, relational practice, and contribution to equitable care.

3. Kaiāwhina

The term *Kaiāwhina* is a taonga (treasure), a term that embodies the essence and nature of a workforce that is passionate, resilient, diverse, skilled and committed to supporting hauora (holistic wellbeing) outcomes of all in Aotearoa New Zealand. This taonga carries a whakapapa, origins that stem from a desire to create a term to replace demeaning labels such as the *non-regulated* or *unregulated* workforce, to recognise the mana and value that Kaiāwhina hold in the health and disability sectors.

This taonga aligns with the shared nature of the diverse workforce as highly skilled practitioners of āwhina, supporting and assisting tāngata through aroha (compassion and empathy).

This distinctive role is captured within te reo Māori to reflect the ngako, the deeper meaning of the term:

- Kai is a person performing a role, and
- Āwhina to support and assist.

Kaumātua Wikepa Keelan (Ngāti Porou / Ngāti Kahungunu / Rongomaiwahine) who held the role of Chief Advisor Māori, at the Ministry of Health in 2014, championed the taonga for this workforce. Kaiāwhina encompasses, yet still respects, the individual mana of each of the diverse and varying roles within this workforce.

The Kaiāwhina workforce can navigate across te ao Māori (the Māori world) and te ao Tauiwi (the non te reo world) to understand the hauora of a tāngata (person). This bicultural ethos inherent in Aotearoa New Zealand, acknowledges a person's individual sense of belonging, identity and connection to wairua (the spiritual), hinengaro (psychological), tinana (physical), and whānau (social connections) as interwoven elements to encompass collective and relational hauora (wellbeing).

For Māori, hauora is not only wellbeing but the living breath, life essence of a person. People who hold the title of Kaiāwhina take a shared responsibility to ensure the hauora of a person maintains its vitality its life essence. Kaiāwhina represent all people within the health and disability sectors who support tāngata (people) to live well, embrace and exercise tino-rangatiratanga (self-determination) in navigating their own journey to pae ora, a healthy

future. The moemoeā (vision and dream) of the taonga is to enhance mana and evoke a sense of Tino rangatiratanga for all Kaiāwhina in Aotearoa New Zealand[3].

Kaiāwhina establish and maintain trusted relationships (whanaungatanga) with their whānau. This relational approach strengthens engagement with services and supports improved continuity of care.

Culturally meaningful communication between whānau and clinical teams is part of the support Kaiāwhina offer. By providing cultural context to clinicians, including insight into whānau dynamics, tikanga, priorities, and assist in translating clinical information into forms that are accessible and relevant for Māori. Therefore, Kaiāwhina function as a critical interface between clinical models of care and te ao Māori.

Whānau are assisted to navigate complex health and social systems, including supporting access to appointments, treatment, medications, and community based services by Kaiāwhina. This includes addressing practical barriers such as transport, communication, and service coordination, thereby reducing structural barriers that contribute to inequities in access.

The implementations of care plans within home and community settings are supported by Kaiāwhina. They assist with follow-up on practical and social needs and support whānau to manage ongoing wellbeing requirements. This extends care beyond clinical environments into the contexts where whānau live and experience health and wellbeing.

Kaiāwhina embed tikanga Māori and culturally appropriate practices into everyday care including the use of te reo Māori, support for culturally appropriate processes such as karakia, and ensuring care is delivered in a way that upholds mana and respects individual and whānau preferences. This contributes to culturally safe and mana enhancing care environments.

The role of Kaiāwhina in integrating tikanga Māori into everyday care is critical to delivering culturally safe, responsive, and mana enhancing services that uphold the dignity of individuals and their whānau. To realise this potential, targeted investment is required to strengthen the Kaiāwhina workforce, including clearer role definition, expanded training and career pathways, and recognition of their cultural expertise. Strengthening this workforce will be essential to advancing equitable, whānau-centred care and ensuring the health system is responsive to Māori and diverse communities.

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[3] Ministry of Health & Careerforce. (2021). *Kaiāwhina workforce action plan 2020–2025*. Toitū te Waiora / Ministry of Health. https://kaiawhinaplan.org.nz/wp-content/uploads/2021/10/Kaia%CC%84whina-Workforce-Plan-2020-2025.pdf

4. The Workforce

Infometrics[4] estimates that there were around 55,700 nursing support workers employed in 2024, or just under 47,800 Full-time Equivalents (*FTEs*). This estimate is based on Census occupation employment data projected forward to 2024[5]. Census data collection relies on people accurately recording their job title on their Census form and these job titles being mapped to occupations in the Australia and Aotearoa New Zealand Standard Classification of Occupations (ANZSCO)[6].

Health New Zealand Te Whatu Ora reports that it employs 8,230 FTE care and support workers and estimate that around another 70,000 might work in the community outside of Health New Zealand Te Whatu Ora funded services[7]. Health New Zealand Te Whatu Ora's estimate might include a broader range of roles than the Infometrics estimate.

Based on New Zealand Aged Care Association (NZACA) survey data, Infometrics estimates that there was a total of 16,790 HCA funded roles (employed plus vacancies) in 2023.
Te Pou estimated that around 5,126 support workers (including lived experience, Māori and Pasifika cultural roles, health coaches, and other roles that do not require a professional registration) worked in mental health and addiction (MHA) settings across primary, secondary and community settings in 2022.[8]

A 2023 Cabinet paper entitled *Addressing the impacts of pay disparities in the health funded sector*[9] estimated 36,447 HCA FTE. This number includes:

- 21,905 FTEs in ARC (this is larger than the Infometrics estimate),
- 4,403 FTEs in general practice primary care
- 1,700 FTEs in Māori health providers
- 2,386 FTEs in MHA, (this is lower than the Te Pou estimate, perhaps because the role definitions differ)
- 13,325 FTEs in other community (homecare, hospices, rural hospitals, Well Child Tamariki Ora, telehealth, and a range of other health-funded settings), and
- 2,755 FTEs in other residential care.

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[4] R Hayes. Are nursing support roles a threat to the nursing profession? Infometrics May 2025.
[5] Statistics New Zealand. (2023). *2023 Census: Occupation – Information by concept*. https://datainfoplus.stats.govt.nz/item/nz.govt.stats/0c478e73-c8f5-4a90-a142-df2416a19954
[6] Australian Bureau of Statistics. (2022). *Australian and New Zealand Standard Classification of Occupations (ANZSCO): Introduction*. https://www.abs.gov.au/statistics/classifications/anzsco-australian-and-new-zealand-standard-classification-occupations/2022/introduction
[7] https://www.tewhatuora.govt.nz/corporate-information/planning-and-performance/health-workforce/health-workforce-plan-2024/profession-specific-analysis/kaiawhina-and-care-roles
[8] Mental health and addiction workforce: 2022 primary, community, and secondary healthcare services, Te Pou, (2023), https://www.tepou.co.nz/resources/mental-health-and-addiction-workforce-2022-primary-community-and-secondary-healthcare-services
[9] https://www.health.govt.nz/system/files/2023-01/cabinet_paper_addressing_the_impacts_of_pay_disparities_in_the_health_funded_sector.pdf

5. Policy Objectives

The Primary objective is to improve patient safety and workforce sustainability by providing clear national guidance on the HCA role without introducing statutory regulation.

Secondary objectives are to prevent substitution of regulated health professionals with HCAs, support Nurse Practitioners (NP) Registered Nurses (RN) and Enrolled Nurses (EN) accountability and delegation obligations, while supporting culturally safe care through system design, worker availability and improve consistency across all health settings.

Furthermore, there needs to be alignment with the Health New Zealand Health Workforce Implementation Plan (the Plan)[10] (or equivalent employer workforce plans). The Plan relies heavily on HCAs (and Kaiāwhina) to deliver more care, improve productivity, and support new models of care. Yet it fails to explicitly to recognise them as a workforce with defined roles, protections, and investment.

6. The Current Situation

The RN scope of practice[11] explicitly states that RNs:

- Are responsible and accountable for directing and delegating to members of the healthcare team
- Must ensure all care provided (including delegated care) is consistent with their education, assessed competence, and professional standards
- Practise independently and collaboratively, using comprehensive assessment and clinical judgement, and
- Provide support and guidance to other team members, including non-regulated workers such as HCAs.

It is also important to note that HCAs also work under the direction and delegation of ENs.

HCA are widely recognised as an essential and growing part of the health workforce. As the system responds to workforce shortages, including RNs, the absence of a coherent national workforce framework, increasing patient acuity, and new models of care that shift services closer to communities necessitates consideration of the role of the HCA in future planning.

Currently the HCA role is governed indirectly through:

- Workforce strategy documents (the Health Workforce Plan, care role analysis)[12][13]

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[10] Health New Zealand | Te Whatu Ora. (2025). *Health Workforce Implementation Plan*. Wellington: Health New Zealand | Te Whatu Ora

[11] Nursing Council of New Zealand (January 2025). *Registered Nurse Scope of Practice*. https://www.nursingcouncil.org.nz/common/Uploaded%20files/RN%20scope%20of%20practice%20-%20Jan%202025.pdf

[12] Health New Zealand | Te Whatu Ora (2024). *Health workforce plan — Kaiāwhina and care roles analysis*. https://www.healthnz.govt.nz/about-us/what-we-do/planning-and-performance/health-workforce-planning/health-workforce-plan-2024-detailed-analysis-and-data/workforce-plan-profession-specific-analysis/health-workforce-plan-kaiawhina-and-care-roles-analysis

[13] Health New Zealand | Te Whatu Ora (2024). *New Zealand Health Workforce Plan 2024*. https://www.tewhatuora.govt.nz/assets/Publications/Workforce/Health-Workforce-Plan-2024/New-Zealand-Health-Workforce-Plan-2024.pdf

- Employment agreements[14]
- The Ngā Paerewa Health and Disability Services Standards[15], and
- The Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996[16].

We note that there is no national role definition, boundary framework, or substitution safeguard specific to HCAs. This has resulted in:

- Wide variation in HCA roles across settings
- Informal expansion of tasks in response to workforce pressure
- Increasing supervision and accountability burden on nurses
- Emerging safety and wellbeing risks for both patients and HCAs, and
- Recent workforce analysis and incident reporting indicate that role enhancement is occurring faster than governance, particularly in high pressure environments such as patient observation (*watches*), inpatient wards, and aged residential care.

The absence of a coherent national framework means the HCA role is currently:

- Relied on as a flexible pressure valve for workforce shortages, rather than a deliberately designed role and employer organisational policy, and
- Associated with increasing risk of unsafe task delegation, accountability confusion, and moral distress.

The NZNO report *Care in Crisis: Manaaki i te Raru (the Report)* [17] provides important insight into the lived experiences of HCAs and highlights the pressures facing this workforce. Drawing on interviews and surveys of nearly 500 nurses and HCAs, the report shows that understaffing is widespread, with many workers describing their environments as unsafe.

These findings emphasise that HCAs are central to care delivery and directly affected by system-level constraints. A consistent theme is the rationing of care. HCAs report not having enough time to assist with basic needs such as toileting, hygiene, and feeding, resulting in missed care and compromised dignity for residents.

Participants also described making *impossible choices* about which residents receive care first, reflecting the ethical and clinical pressures created by chronic understaffing. These conditions contribute to a task focused model of care, limiting the ability of HCAs to provide

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[14] https://www.tewhatuora.govt.nz/assets/Whats-happening/What-to-expect/For-the-health-workforce/Employment-relations/Employment-agreements/NZNO-HNZ-Collective-Agreement-2023-2024-signed-v2.pdf

[15] Ministry of Health & Standards New Zealand (2021). *Ngā Paerewa Health and Disability Services Standard (NZS 8134:2021)*. https://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-and-disability-services

[16] Code of Health and Disability Services Consumers' Rights. Health & Disability Commissioner

[17] New Zealand Nurses Organisation (NZNO). (2025). Care in Crisis: Manaaki i te Raru. https://www.nzno.org.nz/about_us/media_releases/artmid/4731/articleid/6944/new-report-finds-broken-aged-care-sector-harming-our-elderly

relational and culturally responsive support. Cultural care, including tikanga Māori aligned practice, is often described as minimal and inconsistent due to time constraints. At the same time, high workloads are driving stress and burnout, with many HCAs considering leaving the sector.

Overall, the report demonstrates that while HCAs are essential to delivering day to day care, current staffing and funding levels constrain their ability to provide safe, dignified, and culturally appropriate care. These findings highlight the need for targeted investment in the HCA workforce as a critical component of a safe, equitable, and responsive health system.

Without intervention, these risks are likely to increase as workforce pressure intensifies, potentially leading to adverse events, reactive regulatory or contractual responses, and loss of trust among HCAs, nurses, and affected communities.

This issue is particularly evident in the Pacific, where workforce migration is contributing to a loss of skilled health professionals and placing additional strain on already resource constrained health systems.

The migration of nurses from Pacific countries to New Zealand and Australia, can redirect highly trained health professionals into HCA and personal care worker roles in aged care. From the perspective of Pacific health systems, this represents a significant loss of scarce professional expertise. Senior nurses are leaving Pacific health services that are struggling to maintain safe staffing, provide adequate supervision, and mentor newly graduated nurses. When these nurses migrate into HCA roles, Pacific countries lose not only individual workers but also the knowledge, leadership and teaching capacity required to sustain the future workforce[18].

We question if the destination countries are making the best use of the skills these workers bring. Pacific trained nurses work in aged care as HCAs with qualifications and experience well beyond the requirements of those positions. This raises questions about whether aged care systems are obtaining the benefits of nursing expertise without providing the professional recognition, remuneration or scope of practice associated with nursing roles. Therefore, this is not only a migration issue but also a workforce utilisation issue.

The challenge for both sending and receiving countries is to create migration arrangements that support workforce development rather than workforce depletion. Stronger safeguards against the recruitment of qualified nurses into lower skilled care roles could deliver benefits for all parties and avoid further erosion of Pacific health workforce capacity.

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[18] Macdonald, F., Heap, L., & Joyce, C. (2025). *Meeting the Challenges: Health Care Worker Labour Migration in the Pacific Region* (Draft report prepared for Public Services International). Centre for Future Work, The Australia Institute. https://australiainstitute.org.au/report/addressing-the-health-workforce-crisis-in-the-pacific/

7. Te Tiriti o Waitangi

NZNO's policies are deeply grounded in the principles of Te Tiriti o Waitangi (te Tiriti), fostering genuine partnership and prioritising equity, cultural competence, and the empowerment of Māori. By integrating Māori health models and perspectives into the HCAs training and practice, HCAs are supported to deliver culturally respectful and effective care. This includes incorporating concepts such as kaitiakitanga (guardianship, stewardship, and protection), kawakawa (healing), manaakitanga (hospitality, kindness), and kawa whakaruruhau (cultural safety) into everyday practice, alongside the meaningful use of te reo Māori and respect for tikanga.

Through the principle of tino rangatiratanga, HCAs support patients and their whānau to exercise choice, autonomy, and control over their care. Through ōritetanga (equity), HCAs contribute to achieving equity by recognising and addressing barriers to care and advocating for fair and appropriate access to services. Kāwanatanga (governance) is reflected in the delivery of care that aligns with te Tiriti based organisational commitments and policies.

The influence of Te Tiriti on the HCA role is both profound and multifaceted. HCA are clinically skilled, and many are culturally responsive practitioners who play a critical role in creating culturally safe environments. Given their close and often continuous contact with patients, HCAs are uniquely positioned to build trust, support whānau centred care, and recognise when care does not meet cultural or equity expectations. This includes respecting tikanga practices, such as the involvement of whānau in care, observing tapu and noa, and enabling cultural practices such as karakia.

HCAs also contribute to addressing inequities within the health system by identifying and escalating concerns about institutional bias or barriers to care. The HCA role extends beyond task based care to active participation in upholding dignity, respect, and equity for Māori and all communities. This highlights the importance of empowering HCAs to speak up safely and to be recognised as vital members of the healthcare team.

Through collaborative decision making and strong partnerships with whānau, Iwi, Māori providers, and multidisciplinary teams, NZNO continues to articulate and strengthen the HCA role.

In doing so, NZNO ensures that the role of the HCA not only meets the highest standards of care, but also actively honours and upholds the unique cultural identity, values, and health needs of Māori. This contributes to improved health outcomes and supports a more equitable, inclusive, Aotearoa New Zealand.

8. Ways of Working

The expected ways of working for HCAs follow, emphasising their critical role in delivering safe, high quality, and whanau centred care within multidisciplinary health teams. We recognise that HCA are valuable members of the workforce who contribute to clinical care, while working under the delegation and supervision of RNs and ENs.

We acknowledge the importance of effective communication, teamwork, and clear accountability**,** ensuring that HCA are supported to work to their full potential while maintaining patient safety and dignity. We underscore the need for culturally safe practice**,** including upholding te Tiriti o Waitangi and supporting equitable health outcomes for Māori and all communities.

What are the work issues for HCAs that need to be considered?
No task without a visible delegation chain

Every delegated HCA task must have:

- A named delegating role (not *the team*)
- Visible supervision expectations, and
- Clarity on when escalation is required

This will prevent *everyone thought someone else was responsible and* nurses holding liability for work they do not control. Delegation must be explicit, reviewable, and documented, not assumed.

Hard red lines (not just flexible role)
Most employers or organisations define what HCA *can* do. Very few define what they must not do. Aspects of care which HCA should not do include:

- Exercising independent clinical judgement
- Diagnostic interpretation
- Unsupervised medication decisions and
- Assisted patient flow

This will prevent HCAs taking on aspects of care that they have not been academically prepared for or trained in high pressure environments leading to post-incident blame falling on the least powerful worker.

Substitution check attached to workforce decisions
Any expansion of HCA roles must answer a single, question - *What regulated role are we implicitly compensating for here, and why?*

If the answer is *because we don't have enough nurses / allied staff*, or predominantly financial or not in the best interests of the patient then the decision must be framed as a short term risk trade off, not innovation. Safeguards must be strengthened, not relaxed. This prevents HCA becoming a structural pressure valve for systemic under investment.

Career Progression that does not include role boundary incursions
Workforce planning must define clear long term outcomes for HCA who remain HCA. This includes:

- Senior HCA roles with protected work (not quasi nursing)
- Recognition of expertise without upward clinical substitution, and
- Remuneration progression *without role drift.*

Failure to do this may cause burnout, frustration in the role, a risk of acting outside role boundaries and retention issues among experienced HCA.

Risk follows the work, not the pay band
If HCA are expected to manage patient and whānau distress, monitor deterioration and be responsive to the changing needs in the healthcare environment. We must ensure:

- Appropriate ratios
- Escalation support, and
- Psychological safety provisions.

This will prevent systematic transfer of safety and emotional risk onto the least protected workers

HCAs must have somewhere to escalate concerns when they have concerns about practice safety
All services using HCA must have:

- A protected mechanism for HCA to raise boundary concerns, and
- Assurance that speaking up about their work will not be treated as poor performance or reluctance to work.

How do we protect meaning, identity, and relational authority?
Where are the restraints, and who is responsible for applying them?
If those restraints are missing, the HCA will eventually be blamed for failures they were never empowered to prevent.

8. Escalation of Concerns, a Shared Responsibility

HCAs are often the first to observe changes in a patient's condition, behaviour, or wellbeing due to the amount of direct contact they have with patients, residents, and whānau. As health needs become increasingly complex, the ability to recognise and escalate concerns in a timely manner is essential.

Effective escalation relies on strong collaboration between HCAs, registered nurses, and management. Registered nurses have responsibility for clinical assessment and decision-making, while managers are responsible for establishing clear reporting pathways, providing appropriate training, and maintaining staffing levels that support timely responses to concerns.

Without these supports, there is a risk that early warning signs may be missed or acted on too late, increasing the likelihood of adverse events and poorer outcomes. Recognising and supporting the contribution of HCAs within escalation processes is therefore critical to maintaining safe, high-quality care.

9. Supporting a Safe Return to Work

Effective return-to-work processes are essential to supporting the health, wellbeing, and retention of HCAs following injury or illness. Given the physically and emotionally demanding nature of the role, HCAs may require temporary workplace adjustments, modified duties, or phased returns to enable a safe transition back into practice.

Employers, managers, and clinical leaders have an important responsibility to foster supportive workplaces that prioritise recovery while maintaining connection to the workforce. Investing in early intervention and well-designed return-to-work arrangements can reduce the likelihood of long-term absence, support workforce sustainability, and enable experienced HCAs to continue contributing their skills and knowledge to patient care.

10. Education and Training Pathways

HCA education and training in Aotearoa New Zealand is flexible, work based, culturally grounded, and supported by nationally recognised NZQA qualifications. However, participation and training are uneven, and qualifications are not mandatory. NZNO strongly supports HCA being supported to receive appropriate education and training to optimise patient safety and to sustainably strengthen the HCA workforce.

HCA education pathways serve two overlapping but distinct purposes:

- Strengthening HCA practice and therefore patient outcomes, and
- Providing pathways into other professions (e.g. Enrolled nursing, Registered nursing and allied health).

Kaupapa Māori and earn as you learn initiatives have successfully enabled some HCAs and Kaiāwhina to progress into regulated professions, reducing barriers related to cost, geography, and life circumstances[19].

However, workforce policy cautions that training or education should not be treated solely as an exit pathway. A sustainable system requires recognition of education and training that strengthens long term HCA opportunities, satisfaction and provides meaningful pathways for further training.

Critically, there is no national framework that explicitly links HCA education levels to role boundaries or limits. This means:

- Higher qualifications can be misinterpreted as permission for role expansion
- Training can unintentionally be used to justify substitution for regulated staff, and
- Educational investment is not always matched by clarity about responsibility or protection.

[19] https://kaitiaki.org.nz/article/a-dream-come-true-kaupapa-maori-kaimahi-to-nursing-initiative-breaks-barriers-to-training/

This gap is recognised in workforce planning documents but not yet resolved through national policy.

The New Zealand Care Guide for Health Care Assistants explicitly incorporates tikanga Māori and culturally responsive care principles[20]. Therefore, we need to retain cultural safety embedded in training, supervision, and performance expectations by treating this as core practice, not contextual *add-on* training.

Authority, accountability, and work remain defined by role design, delegation, and system governance not by qualification level alone.

11. HCA / Patient Ratios

There is no established or evidence based HCA to patient ratios in Aotearoa New Zealand[21] or internationally. Instead, the evidence consistently demonstrates that patient safety and care quality are driven by overall staffing levels and, critically, by the proportion of registered nurses within the care team.

Increasing HCA numbers does not compensate for low nurse staffing and may be associated with poorer care outcomes when skill mix is diluted[22][23]. Policy settings should therefore prioritise safe nurse-to-patient ratios, with HCAs recognised as a vital but complementary workforce.

New Zealand staffing approaches such as Care Capacity Demand Management *(CCDM*)[24] do not use fixed HCA to patient ratios. Instead, they focus on:

- Right staff, right place, right time
- Whole-of-team staffing (including skill mix), and
- Patient acuity and demand.

NZNO's Ratio Justice[25] campaign recognises HCAs as part of the care team, while emphasising that safe staffing is built on funded nurse to patient ratios supported by the wider workforce.

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[20] https://connectngrow.edu.au/solutions-resources/how-to-become-a-health-care-assistant

[21] https://www.healthnz.govt.nz/about-us/what-we-do/planning-and-performance/health-workforce-planning/health-workforce-plan-2024-detailed-analysis-and-data/workforce-plan-profession-specific-analysis/health-workforce-plan-kaiawhina-and-care-roles-analysis

[22] Bridges, J. et al. (2019). *Hospital nurse staffing and staff–patient interactions.* BMJ Quality & Safety. https://qualitysafety.bmj.com/content/qhc/28/9/706.full.pdf

[23] Griffiths, P. et al. (2018). *Nurse staffing levels, missed vital signs and mortality in hospitals https://pubmed.ncbi.nlm.nih.gov/30516947/*

[24] Nursing Advisory Group (2022) Safe Staffing Review (CCDM) https://www.health.govt.nz/system/files/2022-02/nursing-safe-staffing-review-final_report-feb22.pdf

[25] https://maranga-mai.nzno.org.nz/ratio_justice

12. Clinical Care

Clinical care refers to direct, hands-on care that supports a patient's health, wellbeing, and safety**.** It involves face to face interaction with patients or whānau and contributes to monitoring, treatment, or support of their condition. This distinguishes it from non-clinical tasks (e.g., administration), where it does not involve direct patient care.

Activities such as assisting with personal care (hygiene, dressing, feeding), taking, recording and reporting observations for example: vital signs, supporting clinical procedures, and monitoring and reporting changes in patient condition. These tasks are considered clinical because they directly influence patient health outcomes, safety, and dignity.

Additionally, this often includes therapeutic communication and culturally responsive care, such as supporting whānau, applying Māori models of health, and contributing to holistic wellbeing. Overall, clinical work for HCA can be understood as any delegated, patient facing activity that directly contributes to care delivery, even when performed under delegation or supervision rather than as an independent clinician.

13. Ethical Guidelines for HCA

HCA do not have a statutory *scope* of practice, or a compulsory profession specific code of ethics. This does not mean ethical practice is absent. Rather, ethical expectations for HCA currently sit across multiple instruments, none of which are designed specifically for them as a workforce. Therefore, ethical guidance exists, but it is fragmented and poorly defined.

HCA ethical practice in Aotearoa New Zealand is guided by general health service ethics, te Tiriti principles, organisational codes of conduct, and delegated professional oversight as well as the HCA own moral and ethical belief system. As the reliance on HCA grows, it creates risks of ethical burden without equivalent authority, clarity, or protection.

The Government needs to strengthen ethical support for HCA by introducing a national ethical principles statement, clarifying system responsibilities for ethical risk, and embedding protections against unsafe or unethical task expectations. This approach recognises the ethical nature of HCA mahi, particularly in whānau centred and kaupapa Māori contexts, while avoiding statutory regulation or additional compliance burden.

14. The Pae Ora (Healthy Futures) Act 2022

The Pae Ora (Healthy Futures) Act 2022 (*the Act*)[26] impacts the role of the HCA by emphasising equity, cultural competence, and community engagement and providing care that aligns with the cultural needs and preferences of Māori and other diverse groups. HCA are encouraged to engage with communities to better understand their health needs and to advocate for services that meet those needs.

The provision of holistic care considers the physical, emotional, social, and cultural needs of patients, and their family and whanau. This approach ensures that all aspects of a patient's

[26] https://www.legislation.govt.nz/act/public/2022/0030/latest/versions.aspx

well-being are addressed. Aotearoa New Zealand should continue to treat cultural safety (including te ao Māori perspectives) as a defining strength of the HCA role.

15. Equity

Equity is often confused with equality, yet the two concepts reflect very different approaches to care. Equality focuses on treating everyone the same, as if identical support will lead to similar outcomes. However, equity recognises that individuals begin from different starting points, shaped by social, cultural, and historical factors. In Aotearoa New Zealand, inequities in health are understood as differences that are not only avoidable but also unfair and unjust. Equity therefore requires recognising that individuals and whānau may need different levels of support and different approaches to reach equitable health outcomes[27].

These differences are often driven by broader determinants of health such as income, housing, education, discrimination, and access to services. Past and ongoing inequities, including the impacts of colonisation and systemic bias, continue to create barriers for many groups, particularly Māori. As a result, providing the same care to everyone does not necessarily result in fair outcomes. Instead, healthcare workers must actively consider these wider influences and work to reduce their impact[28].

A key part of equitable practice is cultural safety. Cultural safety requires healthcare workers to reflect on their own beliefs, assumptions, and potential biases, and to consider how these may impact their interactions with others. It moves beyond cultural awareness or competence by focusing on the experience of the person receiving care and ensuring that care is respectful, inclusive, and free from discrimination. Importantly, the goal of culturally safe practice is to achieve health equity, reinforcing the connection between understanding culture and improving outcomes[29].

Ultimately, an equity based approach requires intentional action. It is about noticing who may be at a disadvantage, understanding why those barriers exist, and doing what is needed to ensure care is fair, appropriate, and effective. By embedding equity into their everyday work, HCAs play a critical role in reducing health disparities, strengthening trust, and improving outcomes for individuals, whānau, and communities.

13. Technology and Artificial Intelligence (AI)

NZNO recognises that utilising technology and AI[30] will increasingly be required. AI is a tool for augmentation, not replacement, designed to enhance workflow, improve documentation, and support patient monitoring. As AI becomes more integrated into healthcare settings, HCA must be supported to understand this technology and how it impacts their role and the care of patients while focussing on maintaining patient safety, privacy, and the human connection in care.

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[27] https://www.health.govt.nz/strategies-initiatives/programmes-and-initiatives/equity

[28] https://www.hqsc.govt.nz/consumer-hub/engaging-consumers-and-whanau/health-equity-links/

[29] https://healthify.nz/healthcare-providers/c/cultural-safety-hcps

[30] https://www.clpna.com/wp-content/uploads/2025/11/HCA-Practice-Guideline-Artificial-Intelligence-Use-in-HCA-Practice-ID-210055.pdf

14. Climate Change Risks and Implications

Climate change presents a growing risk to the HCA workforce, who are often the frontline interface with whānau and communities experiencing climate related health impacts such as heat stress, flooding, housing disruption, and associated physical and mental health effects. Evidence indicates these impacts will disproportionately affect Māori and communities facing socio-economic disadvantage, increasing reliance on relational, navigational, and community based support provided by HCA.

Without explicit workforce planning and safeguards, there is a risk that climate related demand will be absorbed informally by HCA roles, increasing exposure to occupational risk, role dilution, and unrecognised cultural and emotional labour. These risks align with findings in New Zealand's Health National Adaptation Plan 2024–2027[31], which emphasises the need for climate resilient health services and workforce preparedness, particularly for priority populations[32][33].

15. A Collaborative Responsibility for Quality Care

HCA are already doing ethical, climate exposed, culturally grounded work at the sharp edge of the system. They are not failing; they are absorbing pressure often invisibly on behalf of services that are under strain. Much of what currently *works* in the system works because HCA stretch themselves relationally, emotionally, and ethically to make up for gaps elsewhere.

That is not resilience. It is uncosted dependence. As demand increases, climate impacts intensify, and workforce shortages persist, the system faces a choice. We can continue to rely on individual goodwill and cultural obligation to hold risk quietly at the lowest paid and least powerful end of the workforce. Or we can accept responsibility collectively for the ethical, safety, and workload pressures that arise from system design decisions.

This work is about choosing the latter. Strengthening guidance for HCA is not about asking them to do more, nor about regulating them into a professional category they have not sought. It is about making responsibility explicit, for boundaries, supervision, resourcing, and decisions made under pressure. It is about ensuring that when demand spikes, when staffing is thin, or when communities are impacted by environmental or social factors, the solution is not simply to stretch HCA further because they are present, capable, and committed.

Ethical harm occurs most often not because people do not care, but because systems quietly assume that someone else will carry the load. In practice, that *someone else* is too

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[31] https://www.health.govt.nz/system/files/2024-0/Health%20National%20Adaptation%20Plan%202024-2027_0.pdf

[32] Masters-Awatere, B., Howard, D. & Awatere, S. Deliberative democracy and te ao Māori in the pursuit of climate change governance. *Humanit Soc Sci Commun* 12, 1498 (2025). https://doi.org/10.1057/s41599-025-05729-4

[33] https://www.nursingcouncil.org.nz/Public/NCNZ/News-section/news-item/2025/03/EN-and-RN-scopes-of-practice-and-new-standards-of-competence.aspx

often an HCA on the floor, in the community, or alongside whānau, making impossible judgments without authority, clarity, or backup. What we are proposing is a shift in weight.

Training should build confidence and safety within a role, not be used as a substitute for proper role design. Ethical guidance should protect workers from being put in untenable positions, not discipline them for navigating them. Cultural and relational labour should be recognised as core system work, not treated as an informal extra. In addition, when trade offs are unavoidable, they should be owned at the level where decisions and resources sit not quietly passed down to those least able to refuse.

This approach does not reduce flexibility it removes silent risk. It does not weaken the system it prevents burnout, moral injury, and failure by exhaustion. It does not add burden, rather shares it more honestly.

Ultimately, this is about integrity. The system that says it values HCAs must be willing to carry its share of the responsibility for the work it asks them to perform especially when conditions are hardest. This work ensures that the system, not individuals acting alone, holds the line when pressure is highest.

20. Conclusion

There are opportunities and risks for HCAs as they navigate a world where the impacts of globalisation, climate change, AI and changes in population demographics will influence health and the provision of care.

NZNO needs to consider exploring a nationally defined HCA role, optional and clearly bounded with options for advancement to ensure that RN and EN accountability remains explicit, education is standardised and that the role does not substitute for regulated professions.

21. Recommendations

1. To support a sustainable HCA workforce through wider recognition, education and training, that optimises patient safety and delivers advanced levels of practice and retention initiatives.

2. To actively work to protect the clarity of the HCA role as workforce pressure increase, avoiding the silent and gradual *task or boundary drift.*

3. To reinforce the need for national guidance that maps indicative work bands to qualification levels (New Zealand Qualifications Authority Level 3 vs Level 4), without turning HCAs into regulated practitioners.

4. To remind employers that the use of HCA as a cost containment strategy does not work.

5. To maintain the HCA New Zealand Nursing Council RN and EN supervision and delegation guidance as a core safety instrument.

6. To ensure that any expansion of HCA responsibilities occurs only through a transparent, nationally agreed policy process that includes workforce consultation, training requirements, regulatory considerations, and appropriate remuneration

7. To strengthen initiatives that contribute to equity and health gain for Māori and Pacific peoples.

8. To develop and strengthen the Kaiāwhina workforce through national recognition, appropriate remuneration, professional development, and clear career pathways.

9. To advocate for a te Tiriti-based approach that requires ongoing investment in workforce development, including culturally grounded education, support for Kaiāwhina and HCA recruitment and retention, and pathways for leadership.

10. To encourage ethical support for HCAs by introducing a national ethical principles statement, clarifying system responsibilities for ethical risk, and embedding protections against unsafe or unethical task expectations.