

Been There Done That (Got the Degree, So What Now?)

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Whilst nurses in secondary care are able to say ‘been there, done that, got the degree and a job’ this is not so in the primary sector where the Nurse Practitioner role development-particularly in urban areas- has not kept pace with secondary care. There are many reasons for this, with the most obvious reason being the lack of funding available to general practices and Primary Health Organisations (PHOs) to pay for this development. In this article I will describe in part the journey that a group of practice nurses embarked on five years ago and where they find themselves now after completing a clinically focused Masters degree with prescribing papers. I will describe and discuss some of the barriers and issues facing nurses intending to register as Nurse Practitioners in the primary health sector and in general practice, and highlight the importance of having funding and planning personnel aware and positive about the potential for nurse practitioners to make a difference to nursing service delivery and patients lives.

In 2001, a group of intrepid practice nurses started out on a pathway that would lead some of them to where they are today – graduating with a clinically focused Masters in Health Science or Health Practice. Four of the nurses indicate that they intend to continue to progress towards nurse practitioner registration. The Post Graduate Certificate in practice nursing that they initially completed through the Auckland University of Technology will never be achieved by any other nurses, as it no longer exists in that form. This changing landscape of papers towards a clinical Masters has been only one of the challenges the practice nurses endured during their study.

Changing Times

The primary health care environment in 2001 was one of upheaval and change as the Ministry of Health (MOH) began the introduction and implementation of the Primary Health Care (PHC) Strategy. In the Strategy (MOH 2001) nurses are stated as being

‘crucial’ to its implementation, but the funding and employment structures to allow nursing to respond to the challenges have been slow in eventuating from the MOH, or from the PHOs set up to provide the means by which the strategy is implemented. A nursing response to the PHC Strategy was the document ‘Investing in Health (2003)’, written by the PHC nursing expert advisory group to the MOH. It was suggested that this might provide a blueprint to activate the nursing workforce in the PHC sector. The document explores how primary health care nursing could contribute to the health outcomes of New Zealanders and how to utilize effectively the current and future nursing workforce to achieve this. To date there has been little progress nationally to implement the recommendations made in the document despite much activity at a local level around different models of service delivery.

In 2000, the Nurse Practitioner (NP) role was formally endorsed and the title protected by the Nursing Council of New Zealand (NCNZ), following a period of intense consultation and debate, which still continues in some workplaces throughout New Zealand. A nurse practitioner has an advanced clinical career pathway with a set of competencies that must be met and approved by NCNZ. Nurse Practitioners demonstrate leadership as consultants, educators, administrators and researchers in their identified scope of specialty and may or may not choose to prescribe within that scope. There has been consultation and debate over the prescribing rights of NPs that has cumulated in the passing of legislation *Medicines Designates Prescriber: Nurse Practitioners Regulations 2005* and the *Misuse of Drugs Amendments Regulations 2005* in September 2005.

PHOs began to emerge from the confusion of the implementation of the Primary Health Care Strategy with the first two being established in July 2002. By August 2005 there were seventy-nine in existence, all with variations in terms of governance and ownership structure, size, effectiveness and nursing input at all levels. Despite calls from nursing leaders that nurses be included as of right in governance positions within PHOs, there has been no requirement by the MOH for PHOs to include nurses, although many have chosen to do so with varying levels of commitment.

Challenges for PHC Nurses

The challenges of primary health nurses in this environment have been discussed and documented over the past five years. As nurses become more able and willing to utilise advanced nursing skills to offer a nursing service that is more responsive to patients' needs, the restrictions within the current workforce environment in the primary health sector become apparent to them. For some practice nurses this has become a familiar topic of conversation as the current system of nurses being employees of general practitioners in a private business model, partially funded by public health dollars, operating under a PHC Strategy that has a population health focus, is critiqued. The risks of the private business model encourages the general practitioner or owner to manipulate nursing services to fit within the financial constraints of the business, often ignoring the advantages that may be found in a more holistic model of nursing service delivery (Minto 2004b). Practice nurses are finding that the restrictions inherent in this business model do not allow for true autonomy and shared governance of the nursing service delivery.

The challenge for those primary health nurses who choose a clinically focused Masters with prescribing papers continues today with no formal training or funding systems nationally to support their study, and the clinical oversight for practicums being provided by various medical personnel- in the case of our four practice nurses, by general practitioners. A SWOT analysis (Minto 2004a) was completed by one of the practice nurse students to articulate the difficulties the students were experiencing with their practical clinical training. The analysis suggested that there would be positive advantages for general practice to be involved in the training of NPs, including gaining potential business partners and an understanding of the potential for nursing to compliment, not compete, within the general practice workplace. Threats identified were predominantly around the current funding structure not facilitating a funding stream, similar to that which general practitioners have access to, for NPs in general practice. The need to have a formalised government subsidised training system for NPs in general practice and primary health care environment to ensure consistency of training standards was emphasised.

This piece of work remains very relevant today. And there is now another issue facing these graduates. Who can afford or is willing to pay the required pay rates for nurse

practitioners in the primary health care sector, where the predominant model for provision of services is via a privately owned business model? The employers in general practice are stating they can barely exist on current funding and face their nurse employees achieving a multi employer collective agreement which will increase pay rates by approximately \$160.00/week for most practice nurses.

At this time nurses remain unable to claim for any of the capitation funding, ACC payments or immunisation schedule payments that go into general practice accounts despite providing many of the services these payments are reimbursing. The seeming disinterest of the MOH to change these funding arrangements, despite an identified need for the services that NPs could provide in the primary health care sector, has ensured that the nurses providing services in the primary health sector and general practice have difficulty in responding to the recommendations of the PHC nursing expert advisory group or ensuring their services reflect the philosophies of the PHC Strategy (Minto 2004b).

PHOs are not committing to spending the dollars on nurse practitioners as they state the funding from the MOH is insufficient to sustain such positions. And yet research from the USA shows that nurse practitioners improve health outcomes and manage chronic disease extremely well in primary health care settings as well as supporting the positive and cost-effective contribution of the nurse practitioner model for clients, employers and purchasers of health care services (MOH 2002).

There may be hope for the four practice nurses for future employment if they are not in a hurry. The governing body for District Health Boards -District Health Board New Zealand (DHBNZ) -has recognized the issues around the nursing workforce and has responded by setting up a workforce strategy group to facilitate the development of a workforce that can deliver the requirements of the future populations. The Nurse Practitioner Advisory Committee of New Zealand (NPAC-NZ) is also working with the MOH to address sustainable employment and development opportunities for Nurse Practitioners and has been awarded \$500,000 from the MOH to progress this work.

Conclusion

There are primary health nurses completing clinically focused Masters degrees who are prepared educationally and clinically to provide populations with a nursing service that answers the challenges articulated in the PHC Strategy. However, due to historical funding restraints and the lack of a coherent training and placement plan, these nurses must be prepared and willing to develop their own place within the PHC sector, after already battling their way through the degree with minimal support from current or future employers. The lack of recognition by leaders and planning and funding managers within DHBs and PHOs of the future value of the nursing services offered also creates barriers to these nurses. If the barriers to achieving innovation in nursing services become too difficult to overcome so soon after attainment of the required educational and clinical training, these nurses may decide to retreat to previously stable and sustainable work environments and the population will lose a valuable future resource.

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