

PRACTICE NURSES AS PROVIDERS To Be or Not to Be?

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The Ministry of Health (MoH) states that primary health care nurses are ‘crucial’ to the success of the implementation of the Primary Health Strategy (King 2001). The guide to establishing Primary Health Organisations (PHOs) (MoH 2002, pg. 22) also states that primary health care nurses, including nurse practitioners will be key players. Practice nurses are the largest group of primary health care nurses in the primary healthcare sector and are recognised in the legislation as providers. Despite the rhetoric there appears to be a misunderstanding of the true nature of practice nursing services and the inherent barriers to expanding roles and services within the current general practice environment.

This discussion paper is based on the assumption that:

- ❖ Nursing is a profession, with its own body of knowledge, language, research and legislature.
- ❖ Practice nurses are employed by general practitioners, on the main part, to provide ill-defined nursing services that are not nationally consistent and therefore not easily understood or measured by other health professionals, managers or government.
- ❖ Practice nurses have a generic job description, education standards policy and career framework formulated by practice nurses.
- ❖ The underpinning document is the Primary Health Care Strategy (2001).

FUNDING

The PHO Futures document (2003) released by the MoH states “The flexibility afforded by capitation does not guarantee funding will actually be used flexibly, at least not in these early stages”. This is currently true. ‘Flexibility’ is perhaps a misnomer as it infers that capitation may be used for various services other than by general practitioners (GPs) in their businesses of providing health services.

Capitation as it is, is still as it was- the subsidy funding that pays for GPs to see patients. Calling it by any other name or purpose will not change that reality. Being paid through the PHO has not in any way changed where it goes- to the GP with an enrolled population. Practice nurses (PNs) see no more opportunity from capitation funding now than they did prior to PHOs, particularly those whose practices have already been capitated.

Care Plus

As the PHO Futures document (2003) states, the potential for nurse involvement in Care Plus delivery is significant. This might include for example: running clinics for Care Plus patients with particular chronic illnesses such as diabetes and cardiovascular disease; acting as care managers or co-ordinators; or conducting regular quarterly health checks and initiating any follow-up.

Care Plus has been promoted as being:

- ❖ focused on high need patients, the majority of whom could benefit from nurse or pharmacist consultations, in addition to seeing their GP
- ❖ having significant new money attached and creating a one-off opportunity to provide incentives for teamwork (MoH 2003)

These services under the current funding arrangements, i.e., practice nurses as employees of privately run general practices, may be very difficult to implement:

- ❖ There will be little or no perceived incentive by the PN, as funding will go directly to the GP that the enrolled service user (ESU) is enrolled with and PNs are already working to capacity.
- ❖ The GP in a PHO may be disinclined to participate as the current high user card system is providing a better income, thus denying the PN an opportunity to provide nursing services that assist the PHO in achieving improved health outcomes for a population.

Funding streams into primary health care at present disadvantage nursing services in general practice. For example ACC has a layered level of payment focusing on the provider rather than the services provided. This appears to assume that the service the GP provides is worth more than the PN as the rate is higher despite the fact that often the PN assesses and manages care, for example wound or plaster care, with minimal input from the general practitioner. This funding encourages professional disempowerment of nurses as GPs often insist on seeing all clients every time to gain the higher fee from ACC regardless of the actual need.

Practice nurses are invisible in the funding and billing formulas

The charges for services are billed to and from the PHO through the GP as the provider for ESUs. This makes practice nursing services essentially invisible. Even services such as smear taking and immunisations are billed under individual GPs as providers. It is very difficult if not impossible to measure (and therefore audit) practice nursing services at a PHO level. Some general practices have evolved other means of measuring this income but this is not reflected in national funding arrangements.

Practice nurses have been running nurse clinics for a long time e.g., the Government funded Diabetes Get Checked programme or asthma clinics, but the funding is still paid back to the GP with whom that ESU is enrolled with. This creates a disincentive for PNs to become involved in expanded nursing services and GPs may see little financial gain for their private businesses, as the outcomes are not easily fiscally visible.

ATTITUDES

It has been acknowledged that general practices are private businesses and thus carry significant risk in this new PHC environment (MoH 2003). PNs have been employees of GPs for many years and it may be difficult for many GPs and nurses to separate the employee/employer status from the professional status, particularly as PNs begin to wish to expand their current nursing services to meet PHO services to improve access project opportunities and requirements.

Because of the ad hoc way that practice nurses have had to arrange continuing nurse education through lack of time and funding, nurses may not feel well prepared to take on the role of providing an extended nursing service without significant extra training. There will be a question of who pays for this training, who will replace the PN in the general practice during the training period and how will any extra skills be recognised financially by the employer?

Despite the availability of accreditation as a professional development tool for PNs, many have not completed this or other formal education, thus the knowledge base and skills of PNs is inconsistent nationally.

It is perceived erroneously by some GPs that they are liable for nurses' professional practice. Rather they are responsible vicariously. (Carreyer and Boyd 2003). This causes anxieties amongst GPs, which can be a barrier to expanding nursing services if not managed well.

The Ministry has recommended strongly against tagging components of PHO funding for different health professional groups. They have indicated that they perceive the capitation payments, services to improve access (SIA) and health promotion (HP) funding as 'flexible' funding for the PHO to best deliver services to the enrolled population (MoH 2003).

The attitudes of the GPs are well entrenched in the 'ownership' of the capitation money and the population it pays for, as it has been and still is paid through the population enrolled with particular GPs. The flexibility of capitation use depends entirely on the GP involved. The SIA and HP funding do accord some degree of opportunity to PNs but only that which is achievable within the confines of the general practice workplace rather than as an extra expanded nursing service.

Are practice nurses considered providers?

Practice nurses are already a key part of the primary health team and the potential for them to expand their role, especially in managing chronic illness, as well as working with other nurses in the community, is well recognised but not well supported financially at a local or national level.

Although practice nurses and GPs may consider PNs to be ‘providers’ it is not often reflected either in the financial or auditing frameworks of general practice, or in the attitudes of both PNs and GPs. Despite nursing being a profession it is difficult for GP employers to reconcile their private business interests to the need to reimburse the PNs appropriately for their nursing services.

An extra funding stream for GPs is related to performance against specific indicators e.g. cervical smears and immunisation rates. Part of the PHO income is based on providing a high measurable quality of care with specific auditable indicators being targeted. Practice nurses provide health promotion and screening services and are often responsible for maintaining the recall registers for some of these services e.g., cervical smears, immunisations, annual diabetes checks, respiratory programmes, but their efforts are not visible in the outcomes nor remunerated directly from these quality programmes.

SOLUTIONS:

“Nursing is one of the most exciting areas of PHO development under capitation and with new programmes like Care Plus. I would like to see PHO employed practice nurses, district nurses, nurse specialists and nurse practitioners attached to the primary health care centres (Greenslade 2003)”

Above all else there needs to be a separate funding stream directed specifically at primary health care nursing services provision, professional support and related education within the PHO funding allocations. Although SIA projects have an element of education and nursing support factored into their budgets, this is not nationally consistent and in part is increasing the fragmentation of primary health care nursing services.

Some of the recommendations made by Dr Carreyer (2003) are supported in this document. Namely, that the funding structure and the fees policy should:

- 1) Provide for salaried positions for nurses and nurse practitioners in PHOs
- 2) Support direct nursing access to ACC reimbursement rather than channeling that money to GP employers
- 3) Support funding incentives to encourage the creation of NP roles as a criteria of the access formula (Carreyer 2003)

This will ensure that nurses are empowered to expand their nursing services as providers of nursing services, without disadvantaging the GPs private business model, whilst maintaining the collaborative relationship with GPs and minimising fragmentation of care created by separate nursing services outside of general practice.

- ❖ Should GPs maintain the control of revenue for nursing services with the extra burden that the PHC strategy implementation appears to be creating for general practice?
Would it not make more sense that the PHO assume responsibility and accountability

and thus manage risk and maintain quality standards more consistently over the PHO health provider services? This will remove the barrier of financial risk to the GP business model and allow nurses to drive nursing services to better serve the general practice population, adding value to general practice and maintaining continuity of care alongside GP colleagues.

- ❖ The issues around using the general practice business facilities for primary health care nursing services would need to be addressed through the PHO. For example- who would pay the rent for using the room and equipment? Would the practice nurse be responsible or would it be billed to the PHO as the ultimate employer of that PN providing the service (if that was the case?).
- ❖ The attitudes of GP ownership of patients would also need to be addressed. This would involve building and maintaining professional trust and respect between the primary health care nurses and GPs so that the services provided would be mutually complementary and not seen as being in competition.
- ❖ General practice services need to be auditable against the provider of that service- not the GP the ESU is enrolled with. This will allow a visible accurate measurement of nursing services to occur, e.g. cervical smears, immunisation, and diabetes annual checks.
- ❖ Using a Quality Plan as a change management tool has already proven to be successful for IPAs and this may be a means of changing current attitudes. Quality payments should be directed to the provider providing the service, recognising that in some cases this would be the practice nurse. This will in turn entitle a PHO to have some control over quality of nursing care provided- e.g. CNE attended, accreditation as a requirement. This will involve some information technology (IT) issues as these services are presently captured under the GP as provider for funding.
- ❖ Professional Development Recognition Programmes (PDRPs) are a mechanism to recognise the clinical expertise of nurses and to retain professional autonomy and development.

PDRPs are frameworks that:

- Ensure nursing expertise is visible, valued and understood.
- Enable differentiation between the different levels of practice.
- Value and reward clinical practice.
- Identify expert nurse / role models.
- Encourage reflection on practice.
- Encourage evidence- based practice.
- Provide a structure for ongoing education and training.
- Assist nurses to meet the requirements for competence based practising certificates.
- Assist in the retention of nurses.

The PHO could recognise and support The NZ College of Practice Nurses, NZNO Accreditation programme as the accepted beginning point PDRP for practice and support

post graduate education as part of the ongoing PN education pathway, as recommended in The New Zealand College of Practice Nurses, NZNO Education Policy, standards and career development (2003).

Conclusion.

There are many opportunities for primary health care nursing services in the implementation of the Primary Health Care Strategy that have already been identified by government and nursing groups during the implementation of PHOs. However the inherent barriers that exist for practice nurses in particular have not been recognised and well managed to allow the full participation of the largest group of primary health care nurses in PHO service provision.

Funding, or the lack of such, appears to be the main barrier for nursing to overcome in order to be able to be visible and viable as a nursing service to complement the general practitioners in the general practice team. Attitudes of doctors and nurses will need to change to allow the effective implementation of primary health care nursing services to support PHO incentives to provide health services to high need populations.

Strategies such as those described above will allow more accurate representation and data collection of PHC nursing services within the PHO and also the development of practice nursing services in collaboration with GPs that align more closely with PHO objectives and community need. Addressing these issues now will allow a PHO time to resolve issues prior to other PHC nursing groups being included in the PHO as providers.

It is acknowledged that these strategies will need to be undertaken over time to allow for effective change management to be implemented. This will reduce anxiety and confusion amongst providers and allow IT and funding issues to be negotiated successfully at both national and local levels. However these strategies need to be implemented now to ensure that primary health care nurses are able to practice as effective providers as the implementation of the Primary Health Care Strategy continues.

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