

The Funding Dilemma

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What about me

It isn't fair

I've had enough now

I want my share....

(Shannon Noll)

Wage negotiation time perennially highlights the practice nurse dilemma of maintaining a respectful professional relationship with a colleague whilst negotiating an appropriate wage remuneration as an employee of that colleague.

Some would argue that these two aspects of the relationship can be held separate by both parties but anecdotally this has proven to be difficult, particularly as practice nurses are at the lowest end of the wage scale for nursing, significantly lower than many of their District Health Board nursing peers and are becoming more and more aware and resentful of this discrepancy.

This paper discusses this dilemma from a personal perspective and offers a solution that could be used as a pilot model.

The Current Model

Practice nursing has grown from being a supportive role to general practitioners to a nursing service that complements the general practitioner's medical model, adding a holistic nursing perspective to patient care. The demands on the general practice team have grown as the burden of chronic diseases and the aging population grows. In response to this demand on services, practice nurses have developed skills in chronic disease management, screening interventions and health promotion strategies.

The funding streams into general practice are directed at the general practitioner with whom the consumer is enrolled. This is regardless of who provides the service within the general practice team. Most general practices are modelled on a private business

framework with funding being subsidised by government and by ACC and other funders. Thus the general practitioner holds the risk as well as having the opportunities to reap the benefits of government and other funding streams.

The current funding model restricts the nursing service that practice nurses could deliver by placing the ownership of the nursing services with the general practitioner owner/employer. The risks of the private business model encourages the general practitioner 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.

The dichotomy of general practitioners using a private business model to provide a population health service has been no more pronounced than now, as practice nurses become more skilled and advanced nurse practitioners in general practice begin to explore expanded nursing service opportunities under the Primary Health Organisation (PHOs) framework. General practitioners will be understandably reluctant to relinquish control of nursing services whilst the risk remains with them. Practice nurses will be unable to provide the innovative and expanded nursing services described by the Primary Health Care Strategy whilst the constraints of private business employers remain to limit their opportunities.

Part of owning a private business is the cost of employee labour. As practice nurses are becoming more aware of their professional potential and their expectations of adequate and appropriate remuneration is becoming more urgent; the pressure on the general practitioners to meet these expectations is rising. Neither nurses nor doctors have been trained in business management or negotiations and thus the process of wage negotiations can be fraught with tension.

Added to this is the fact that as an employer, the general practitioner is vicariously liable for my actions and conduct (Carryer & Boyd 2003). General practitioners may perceive this liability as encompassing a nurse's professional practice, which makes them very wary of 'allowing' the expansion of nursing services by nurses in their employ, as this would seem to escalate their liability.

And so we have practice nurses demanding professional respect and increased autonomy with appropriate remuneration and general practitioners who hold the risk of private businesses coupled with uncertainty and change of government policy and health funding structures. This makes an uneasy environment in which to manage the changes demanded by the implementation of the Primary Health Care Strategy and PHOs.

Alternative Model

Imagine a practice nursing service contracted to general practice and managed by an independent source. The contract will be negotiated between two equal parties with a common patient-centred focus. This will encourage and support nurses to practice autonomously and respond to consumer need appropriately whilst minimising the business risk for the general practitioner. Thus the costs and risks associated with being an employer are removed from general practitioners and devolved to the funders of primary health care services, be it PHO's or District Health Boards (DHB's). The tensions of wage negotiations will be removed from the relationship and allow a more collaborative professional relationship between nurse and doctor.

This model will ensure consistent standards of clinical nursing practice by requiring the practice nurse to be able to maintain competency with formal measures of practice standards, e.g. accreditation or post graduate certificate qualifications and funded ongoing continuing nursing education, as agreed by both parties. The professional development requirements of the practice nurses will be built into the contract as is currently done in DHB nursing services and funded by similar streams i.e. clinical training agency, government subsidised schemes.

Nurses providing a nursing service will have access to the subsidies that midwives and general practitioners have traditionally received. This is currently the capitation and fee-for-service monies that is paid to the health provider that the consumer is enrolled with. ACC payments will be at an equal funding level for nurses as it is to other health providers, being paid on the service provided, not the provider. For example if the nurse sees a patient for a wound assessment and dressing, or a plaster, the fee paid by ACC should be the same as for a doctor to do the same service.

This will facilitate nurses to provide an affordable, accessible and appropriate nursing service that continues to compliment general practitioner services, rather than fragmenting and competing for enrolled consumers.

I recognise that the extra funding required for nurses wages and support systems will be problematic but as general practitioners would no longer have the extra costs that are incurred through employees, I suspect that this will be one avenue for the accountants and business experts to investigate. There will also be contractual issues around using practice buildings and structures and how to translate previously unmeasured nursing time and services into a clear contract structure.

The other aspect of this model is that general practitioners may feel some dismay at not being able to 'choose' the nurse who is contracted to their general practice. I suspect that as practice nurses and general practitioners have generally built a mutually agreeable collaborative relationship this may not be so much of an issue. Most practice nurses would agree that job satisfaction is reliant on the good relationship with colleagues and this will not change under a contractual arrangement. I perceive that the perceived loss of control over nursing services may be the issue at stake. A good clear contract should soon allay fears in that direction.

Conclusion.

Wage negotiations have highlighted for me what is an ongoing issue around adequate and appropriate funding issue for primary health care nurses and practice nurses in particular. Until this issue is addressed formerly by national bodies and Government, the primary health care nursing services may never achieve its potential as articulated in Government documents.

Although there are always financial implications for changes of this nature they should never be allowed to get in the way of improving patient centred care and the collaborative relationships that already exist in primary health care. I call upon the Ministry of Health and national professional bodies such to begin to address these issues within a formal consultation process as the implementation of PHOs progresses.

References

Carrier, J. & Boyd, M. (2003). The myth of medical liability for nursing practice. *Nursing Praxis in New Zealand*, 19(3), 4-12.

NB: This is a personal view and not necessarily the view of the NZ College of Practice Nurses, NZNO.

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