

**Nursing Developments in
Primary Health Care 2001–2007**
A Summary

2009

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Acknowledgement

The report *Evaluation of the Implementation and Intermediate Outcomes of the Primary Health Care Strategy Second Report: Nursing Developments in Primary Health Care 2001–2007* by Associate Professor Mary Finlayson, Dr Nicolette Sheridan and Dr Jacqueline Cumming Health Services Research Centre, School of Government, Victoria University of Wellington forms the basis of this summary document.

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MANATŪ HAUORA

Foreword

The introduction of the *Primary Health Care Strategy* (Minister of Health 2001) (the Strategy) in 2001 provided a new direction for primary health care (PHC), with a greater emphasis on population health, community involvement, health promotion and illness prevention through the establishment of Primary Health Organisations (PHOs).

In contrast to the pre-existing focus on general practitioner (GP)-led practices, the Strategy signalled the need for access to a broad range of health professionals. The new population-based funding model would provide flexibility in the types of practitioners providing the care, opening the way for nurses and other health professionals to provide the most appropriate health services in each situation according to their expertise.

The implications of the Strategy for nurses' roles were significant. Not only were PHC nurses stated to be 'crucial' to its implementation, but the Strategy's population focus and greater range of intended services clearly implied a greater need for skilled and knowledgeable nurses. This required clarification of roles and responsibilities, knowledge and skills, career frameworks and appropriate employment arrangements (Minister of Health 2001).

This publication highlights the significant contribution nurses make to primary health care delivery, and makes some key recommendations as to how we might further build on that capability.

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The Research

The *Evaluation of the Implementation and Intermediate Outcomes of the Primary Health Care Strategy* was undertaken between 2003 and 2008 by the Health Services Research Centre, Victoria University of Wellington, and CBG Health Research Limited, Auckland (Cumming et al 2005).

Incorporated into that research was a review of literature and previous reports on PHC nursing; semi-structured interviews in 2004 and 2006 with PHO and general practice staff, and other key stakeholder organisations; structured interviews with 18 nurse leaders in 2006; and a survey in 2007 of general practice staff.

The aim was to explore the development of PHC nursing since the introduction of the Strategy in 2001 and in particular to what extent the intentions of the Strategy, as they applied to nurses, had been met.

This analysis was contained in the report *Developments in Primary Health Care Nursing 2001–2007* (Finlayson et al 2008), which discusses the research findings and their implications for PHC. This document summarises that report. To read the full document go to www.moh.govt.nz

General Findings

Changing nurses' roles

There has been substantial growth in some nurses' roles and capability especially in the management of chronic conditions and working with people in under-served and vulnerable groups.

Where the role of the practice nurse has developed, it has been underpinned by two influencing factors:

- the PHO has recognised the intentions of the Strategy and has adopted a population health approach and new models of care, and increased collaboration between PHC teams. Nurses report they have received encouragement to pursue post-graduate education, and that District Health Boards (DHBs) and PHOs are actively developing the nursing workforce
- or, PHOs have recognised the potential of additional funding associated with specific services such as Care Plus or Services to Improve Access (SIA)¹ which have been largely nurse-led. In this way nurses have become income generators rather than practice expenses. Among the new programmes they have embraced are specialist diabetes and asthma clinics; mobile mental health, school-based and youth clinics; health expos and Māori health hui.

Barriers to expansion

The following were seen as impediments to the expanded role of practice nurses:

- practice funding models tied to GPs – particularly the 'fee for service'
- nurses unable to access resources to develop services
- the employer–employee relationship making it difficult for nurses to argue for change
- lack of support and motivation for employment of Nurse Practitioners
- low numbers of Māori and Pacific nurses. These nurses are in high demand and are often 'poached' by other health organisations
- salary differential between primary and secondary health care nurses
- heavy workloads
- lack of educational opportunities
- lack of nursing leadership and mentors
- lack of a career pathway and educational framework
- lack of physical space
- some nurses not being keen to upskill.

1 Services to Improve Access (SIA) funding is available for all PHOs to reduce inequalities among those populations that are known to have the worst health status: Māori, Pacific people and those living in NZDep index 9–10 decile areas. The funding is for new services or improved access. Examples of the successful use of SIA funding are: the provision of clinics at work sites, marae, church groups and schools; transport services to help people get to clinics.

Implications for policy and practice

There are four key issues that must be addressed if high-quality and accessible individual and population-based health care is to be provided where it is most needed. These issues are:

- funding
- education
- leadership, mentoring and governance
- recruitment and retention.

Funding to increase nursing capability and capacity

- Offer incentives for PHOs to establish Nurse Practitioner positions.
- Enable Nurse Practitioners to access PHC funding.
- Adopt a single baseline funding stream with incentives – replace ‘fee for service’ funding with a ‘global budget’ with clear expectations as to what should be achieved, and concrete outcomes.
- Avoid ad-hoc short-term funding streams.
- Amend Accident Compensation Corporation (ACC) contracts to fully fund PHC nurses to provide comprehensive services to ACC clients.

Education to improve capability

- Advocate for all PHC nurses to have a PHC postgraduate qualification as part of developing necessary knowledge and skills.
- Continue scholarships and funding for postgraduate education.
- Promote quality of clinical placements for undergraduate students – at present it is difficult to find good placements for the ten-week transition period, with some PHOs regarding undergraduates as a liability rather than a possible future asset.

Leadership, mentorship and governance to embed increased capability and capacity

- Appoint directors of PHC nursing to provide leadership to DHBs.
- Appoint nurse leaders in PHOs.
- Establish a mentoring programme within PHOs and DHBs for future governance roles.
- Introduce Professional Development Recognition Programmes for all PHC nurses.
- Develop and implement nursing-sensitive patient outcome indicators.

Recruitment and retention to improve capacity

The PHC nursing workforce is ageing. To counter this, the following is recommended:

- instigate a national advertising campaign to increase awareness of PHC nursing as a career choice and PHC nurses as providers of health care
- target Māori students through schools, workplaces and hui
- target Pacific students through schools, workplaces, churches and fono
- provide incentives to establish Nurse Practitioner positions.

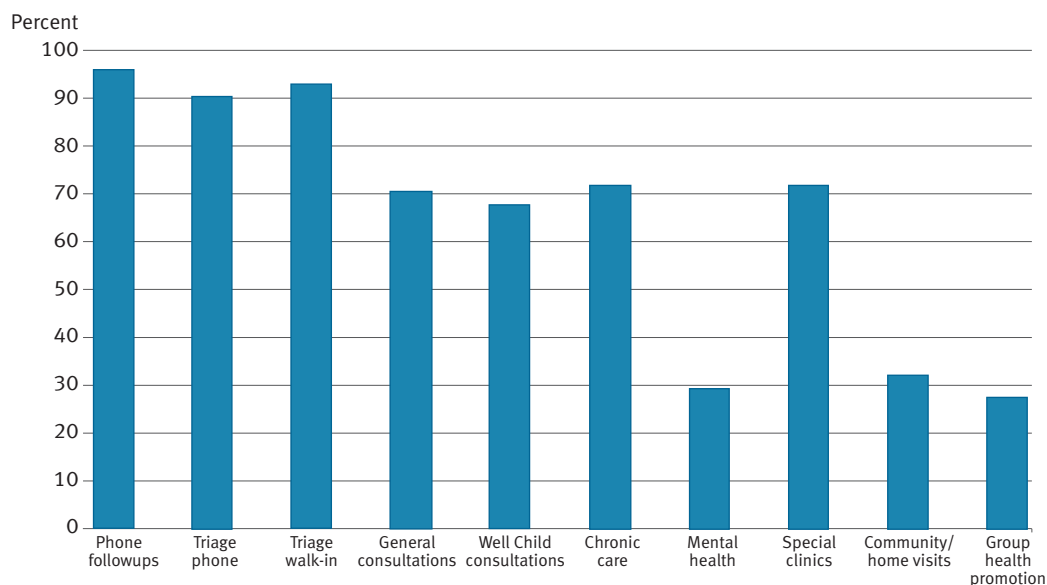
Results of Interviews and the Survey

Capability – knowledge and skill of nurses in PHC

Nurse leaders regarded nursing as crucial to the success of the Strategy, with nurses having the essential knowledge and skills to achieve its goals.

Since the introduction of the Strategy, many nurses had provided more services and were functioning more autonomously, especially in larger practices. It was reported that practice nurses had the responsibility for providing telephone follow-ups, triage of phone calls and triage of walk-in patients in nearly all practices. General consultations, well child consultations, chronic care and speciality clinics – such as diabetes and health promotion – were also widely provided by practice nurses. Forty-five percent of practices said they had outreach nurse services.

Figure 1: Services provided by practice nurses



The majority of interviewees saw the expanded nursing role resulting from changes in the funding of PHC which enabled them to provide many innovative programmes. But some nurse leaders said the development of PHOs had made little difference to overall nursing practice. This was, they suggested, because they or their GPs had not embraced the opportunities afforded by the Strategy, or because they were already offering expanded and innovative services, particularly nurses working for Māori health providers.

Accident-related care

The nurse leaders suggested PHC nurses could take a lead role in providing acute accident-related care. But ACC contracts do not allow full funding for nurses to provide comprehensive accident-related care. When nurses do undertake consultations with ACC clients, GPs also see these clients to access maximum funding.

Nurse Practitioners

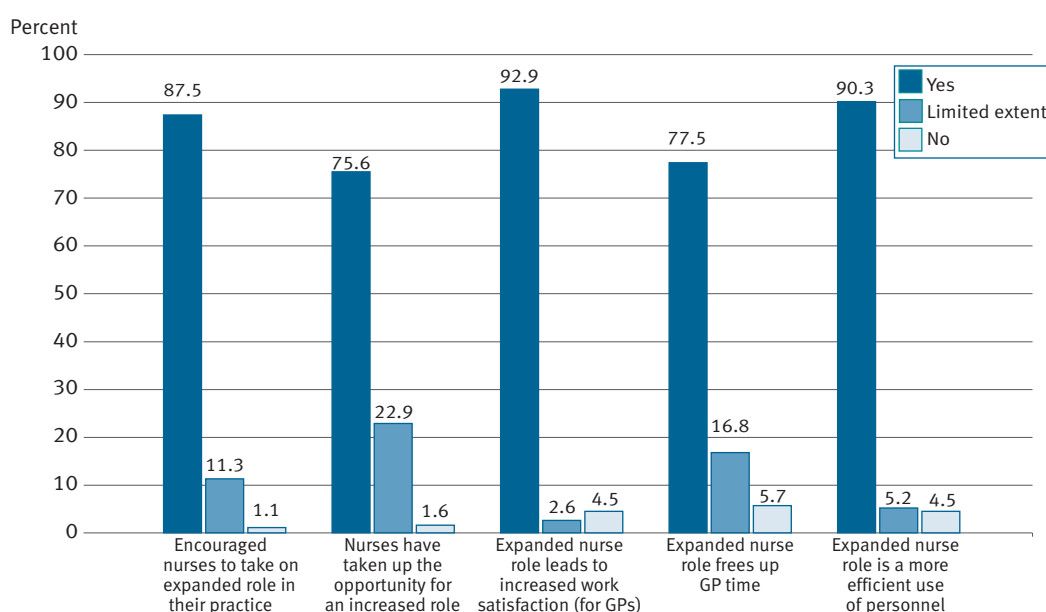
Nurse leaders saw Nurse Practitioners as having the potential to significantly improve PHC. Despite this, nurse leaders reported there was a lack of employment opportunities and funding streams to develop the role, and Nurse Practitioners often lacked appropriate support.

‘...half the Nurse Practitioners that are qualified still haven’t got jobs [as nurse practitioners].’
– Nurse leader

GP responsiveness to the changing role of the practice nurse

The majority of GPs said they encouraged their practice nurses to increase their role and 75 percent of GPs reported their practice nurses had taken on an increased role.

Figure 2: GP responses to the expanded role of practice nurses



A PHO manager, who is also a GP, suggested that nurses were able to provide a large number of PHC services, and that there was no need for a doctor for much of the work.

‘... we have a Care Plus nurse and an outreach nurse. We have a phone nurse on all the time who triages calls and we have an acute nurse who triages the walk-in acute patients to decide if they need to be seen by the doctor and we have a consulting nurse running a clinic. . . we have some specialised clinics. . . it works smoothly.’

Such a system was seen to free up doctors’ time, be cost-effective, lead to greater job satisfaction for team members, increase acceptance by communities of nurses as the first port of call and provide a wider choice for patients of health professional.

But other practices, where nurses continued to be seen as ‘supporters’ of GPs, argued there were no financial incentives to use nurses fully.

‘A patient comes in to have some stitches out – if a nurse saw them it was about \$15, if a doctor saw them it was about \$32. . . the doctors are running the business and they do not want to lose out on any money.’

Some doctors reported feeling anxious about or suspicious of nurses ‘taking over’ their roles. One practice nurse saw the GPs’ anxiety as:

‘[A] key issue . . . for the doctors it’s understanding the role of the nurse . . . that she is not trying to take over. . . that she is not trying to be the doctor. . . she is offering a different service.’

Education and career development

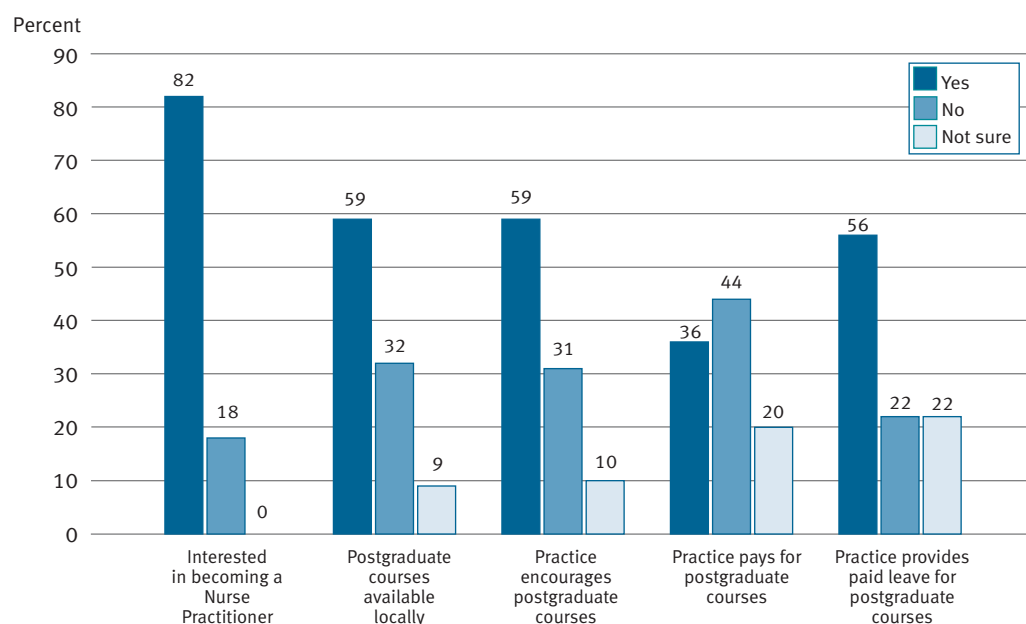
Overall, nurse leaders believed current education programmes were failing to meet the needs of PHC nurses.

They suggested that programmes remained too focused on hospital nursing and that the needs of some groups of nurses, such as Māori nurses, were often overlooked. Although nurse leaders recognised there were increasing PHC nursing postgraduate papers and programmes, the majority said programmes sometimes lacked a coherent framework and that the content varied across institutions.

‘. . . there’s supposed to be a national framework and there isn’t. Lots of PHC papers are available but there is confusion about how to construct them into a programme. The quality varies considerably.’

Some PHOs and practices were reported to be very supportive of nurses’ on-going education, conducting workforce surveys of education and training needs and actively supporting their nurses’ postgraduate studies.

Figure 3: Nurses’ responses to education and career development opportunities



While some progress had been made on improving access to postgraduate education through relief staff bureaus and improving provision for release time, significant barriers to access, both practical and attitudinal remained for many practice nurses. Employers’ attitudes were of particular concern.

‘. . . it’s very hard to get that individual out of the practice [for education] because they’re just seen as that practice’s resource.’ – Nurse leader

Barriers to the expanded role of practice nurse

The nurse leaders considered that for most nurses employed in general practices there had been little or no change in their level of autonomy. Increasingly nurses were expected to undertake a greater workload to meet new contracts agreed by the general practice management.

Lack of time for both nursing and medical staff was also reported to be limiting their ability to take on new initiatives or to develop innovative new services.

Less than 30 percent of practice nurses reported being satisfied with the opportunities currently available to develop their careers.

Access to education and training was thought to limit capability building in some instances, particularly in rural areas. Significant differences in the level of support for nurses were reported between practices.

Historic attitudes of GPs and of the community toward what nurses were ‘capable’ of had limited the development of some practice nurses’ roles. Some nurses themselves had not taken up opportunities to upskill, with one PHO manager saying nurses had to be more ‘proactive and confident’:

‘There are a number of nurses who have not kept up with the play. They actually moved into the regular hours of practice nurse/receptionist role and it suited them...’

Building capability

Responses about building capability in the practice nursing workforce centred on improvements to the nurses’ knowledge base and improved autonomy in expanded roles.

Some interviewees expressed a need for a more national approach to improving nursing capability, with greater recognition of the learning needs and experiences of nurses in practice.

‘... it’s very, very variable and we desperately need some consistent standards across practices to pull the profession up.’ – Manager, IPA-based PHO

The nurse leaders suggested that control over, and access to, funding was a key concern for practice nurses. They argued that existing funding streams through general practice replicated the old gatekeeper relationship and were an ‘absolute barrier’ to delivering nursing services, promoting autonomous practice, and developing nursing-led service models. Furthermore, they argued, this employer–employee relationship inhibited nurses’ decision-making about how care was offered and reduced their confidence to change things.

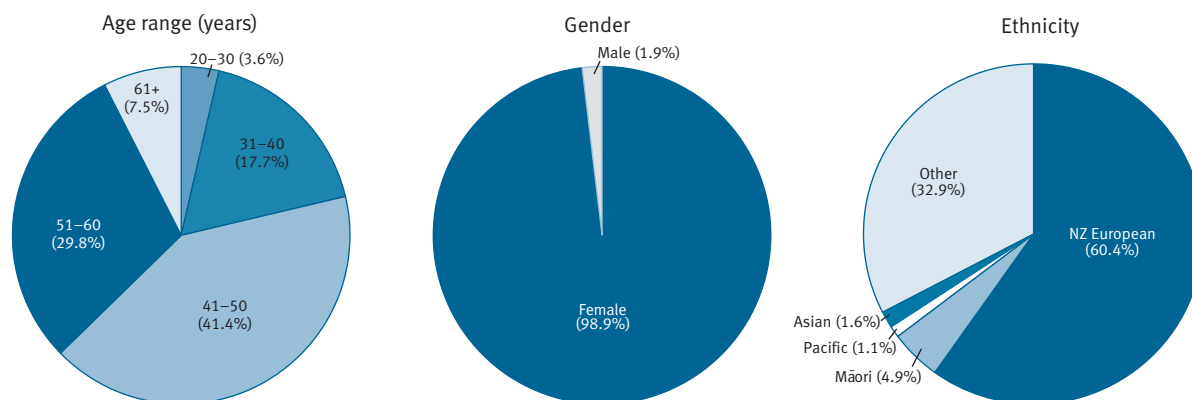
‘... as long as the funding is funnelled through the general practitioner and the nurse doesn’t have any control over the funding – that’s a problem.’ – Nurse leader

The nurse leaders noted some positive funding developments such as Ministry of Health scholarships for nurse education, Care Plus, health promotion and SIA funding, but questioned the sustainability of some of these initiatives.

Capacity

Many practices reported that recruiting nurses in PHC was difficult, particularly experienced nurses. Difficulty attracting young nurses was noted by some but other participants commented that younger nurses were increasingly looking at primary health care options.

Figure 4: Demographics from practice nurse survey



The majority of practice nurses were aged between 41 and 60 years of age; very few were in the 20 to 30 year age group. Of the 364 who responded only four were male. Over 60 percent of practice nurses were NZ European; very few identified as Māori, Pacific or Asian. Nearly a third of respondents identified as 'Other', but it was not specified which ethnicities 'Other' included.

Māori practices were hard hit by recruitment difficulties, and finding Pacific-speaking staff was particularly difficult. Both the nurse leaders and the practice nurses reported that many of the nurses employed in Māori-led practices received lower salaries than other PHC nurses in similar roles. The nurse leaders identified this as a barrier to the development of the Māori PHC nursing workforce and a key factor in influencing nurses' return to a mainstream health provider.

The most common barrier to recruitment and retention of PHC nursing staff was seen to be the salary difference between primary and secondary care. The participants reported the 2005 MECA (multi-employer collective agreement) for DHB nurses caused a migration from primary to secondary care. Many practice nurse participants expressed an urgent need for their employers to address pay parity with DHBs.

Increased demand on infrastructure, including space, was identified by some participants as limiting the ability of practices to take on more staff and initiate more services.

Most informants referred to a serious workload problem, and for many PHOs this was the main issue of concern which had major implications for the retention of nurses. In addition, high nursing staff workloads were leading to division of roles and greater specialisation in nursing and limiting the capacity of the practice nurses to provide support for new graduates.

Although they found practice nursing rewarding in some way, most respondents were unsatisfied with their work-life balance, saying that any extra demands would lead to further fatigue and loss of staff, particularly in rural areas.

Some larger PHOs were reported to be promoting PHC nursing as an exciting career choice, running scholarship programmes and increasing exposure of new graduates to PHC by providing short-term work experience, as described by this practice nurse board member:

'We have worked very hard at promoting primary care nursing and the organisation to students, really selling . . .[it]. . .as an exciting career choice with opportunities for new roles in the future.'

Some DHBs were reported to be actively building the capacity of PHC nursing in their area.

A number of respondents suggested more structured career pathways, professional orientation and support such as Nursing Entry to Practice programmes to make PHC nursing more attractive.

Building capability and capacity within the Māori and Pacific nursing workforce was reported to be particularly important. The current paucity of staff means nurses often had to take on leadership roles and were also susceptible to ‘poaching’ from other organisations.

‘. . . in a lot of Māori PHOs and providers you have to get non-Māori nurses in because there’s such a shortage.’ – Māori nurse leader

To overcome shortages in rural areas, some practices were concentrating on promoting the cultural and lifestyle advantages of the area. Another suggestion was to increase the remuneration of those nurses who work remotely.

Collaboration

There was general agreement among interviewees that teamwork was imperative to the future of PHC. Many practice nurses saw teamwork as incorporating equality, multi-disciplinary care, complementary practice rather than substitution, respect for the nurses’ level of skill and their opinions and, as reflected in the following quote from a practice nurse board member, making best use of each professional’s skills:

‘To me this is the most appropriate person doing the job, utilising the capabilities of each member of the team. We don’t need to have doctors doing things that nurses could do better, or as well as, rather keep the doctors’ skills for what only they can do.’

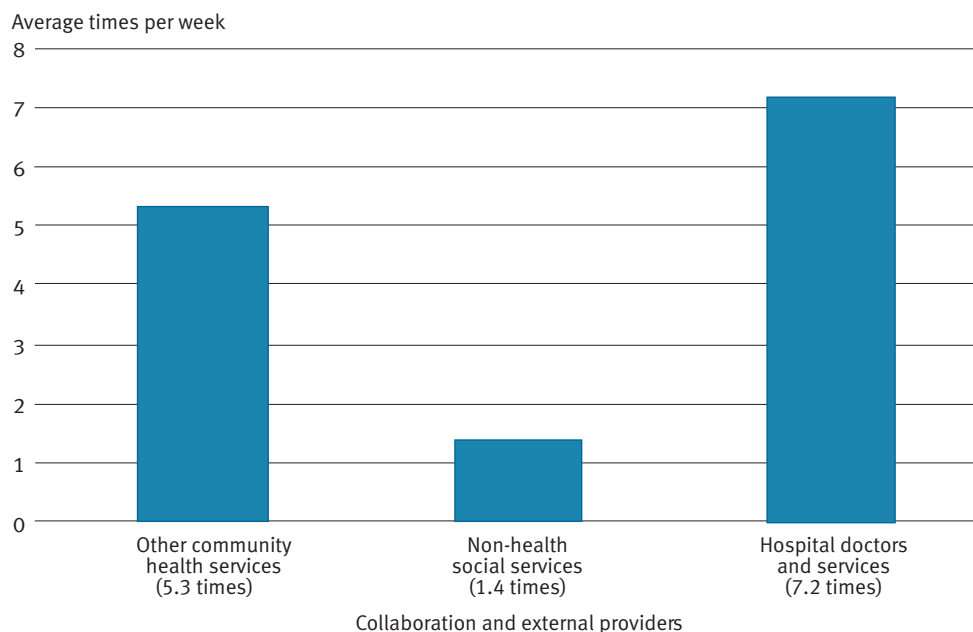
Some practice nurses described being recognised as autonomous members of the practice team and having a collegial relationship with GPs.

Māori and rural teams appeared to have the highest level of teamwork. Pacific PHOs, too, work collaboratively, as one Pacific PHO staff member put it:

‘It’s part of our culture to work as a team, we don’t compete with each other, we work as a team. That is the only way that we work.’

A few practice nurses commented on the real benefit resulting from strong, accessible linkages formed with social workers, mental health nurses and other professionals. The nurse leaders gave examples of collaboration with external providers such as drug and alcohol units, mental health agencies and domestic violence support units.

Figure 5: Nurses' collaboration with external providers



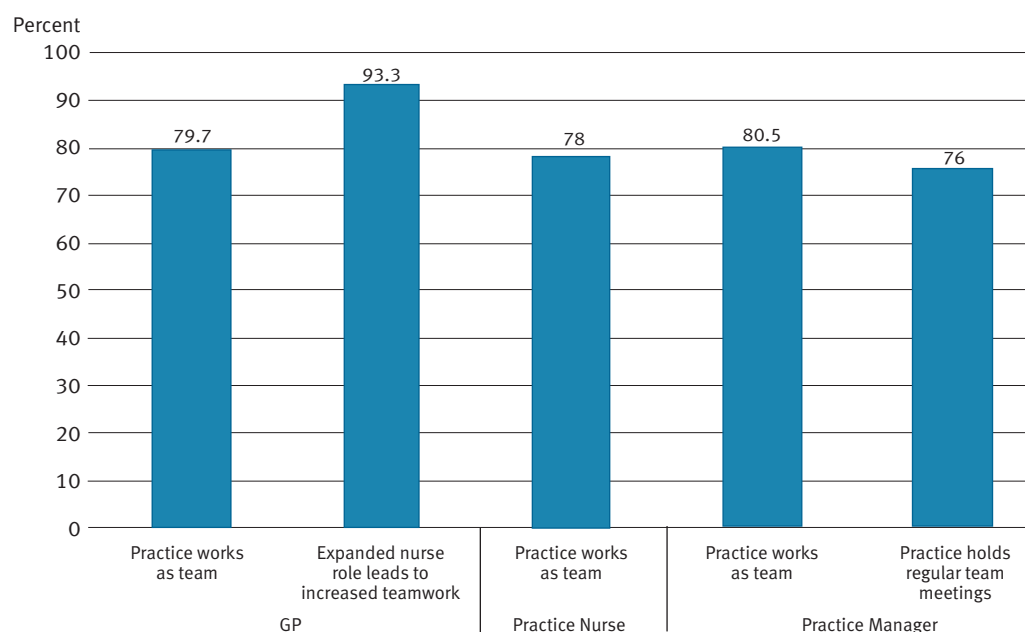
New funding such as SIA and health promotion had enabled PHOs to build links to non-government organisations (NGOs) such as the Cancer Society and the Heart Foundation.

The nurse leaders suggested new positions for practice nurses as ‘integration leaders’, facilitating collaboration between different nursing groups through working in shared projects.

‘I see a disconnection between practice nurses and other primary health care nurses and providers in the community. There is nervousness about “taking over roles”. I organise meet the other players evenings. . . all kinds of people are invited to connect and find out what others provide. . . it’s been successful.’ – Nurse leader

It was consistently reported by GPs, practice nurses and other staff that the practice operated as a team. However it appeared that GPs’ ideas of teamwork were variable and a survey of health care in seven countries (Schoen et al 2006) found that New Zealand demonstrated low levels of multidisciplinary teamwork in general practice. Respondents in this study identified several factors contributing to the slow development of teamwork within practices and collaboration with other PHC nurses and other health professionals. These included: patch protection issues between GPs, nurses and other professionals; GP attitudes towards nurses and nursing; nurses’ competence, confidence and willingness to embrace a fuller nursing role; workload and space.

Figure 6: Perspectives on teamwork



A strong theme emerging from the interviews was the impact of funding pathways on teamwork and relationships. In order to achieve the level of teamwork envisaged in the Strategy, some participants felt strongly that funding mechanisms would need to change. Business incentives were driving many GPs, who were focused on seeing patients to maintain their personal income. This was seen as a powerful incentive not to use nurses in expanded roles.

‘Those practices in the old model will not use their nurses. . . if you can get \$60 for a smear why have the nurse do it for \$10?’ – Manager, IPA-based PHO

Nurses’ role in governance

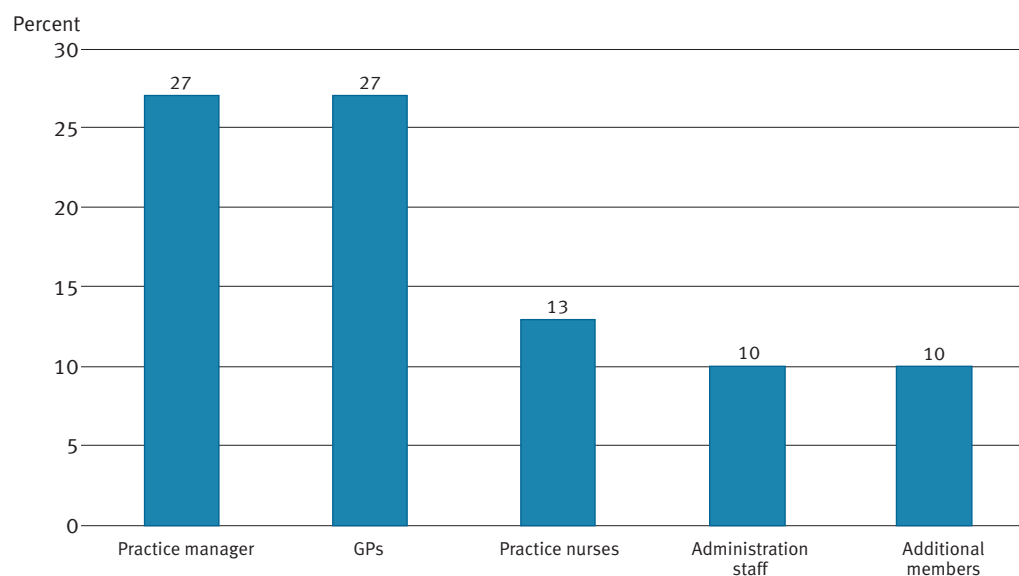
Few PHC nurses were thought to be participating at a governance level within DHBs, PHOs, NGOs, and other health provider organisations, despite this being an expectation of the Strategy. Where nurses were members of governance groups, the position was often considered ‘token’.

‘Nurses might be on groups but don’t articulate their views or [aren’t] asked for their views – they’re just there for some politically correct reason. That’s where we need to provide nurses with some skills around governance and helping them to be more assertive in these types of roles.’ – Nurse leader

The need for nurses to contribute to governance was strongly advocated by the nurse leaders. This, they believed, would avoid nurses having organisational changes imposed on them by doctors and managers. They suggested developing skills in strategic planning, policy development and assertiveness would assist nurses to become more effective contributors. While Directors of Nursing were generally considered to not have much experience in PHC, they were recognised as having requisite skills in leadership. They could therefore have greater involvement in mentoring PHC nurses for governance.

Some practice nurse board representative interviewees generally expressed satisfaction with the way PHO boards were working and reported respectful relationships with other board members. Other boards were said to be GP-dominated where the employer–employee relationship was seen to perpetuate the power differential.

Figure 7: Who sits on your practice management committee?



Building collaboration

Some interviewees reported that PHOs and/or DHBs could play a greater role in developing teamwork within practices. Others suggested that charging for nurse visits would help recognise the value of nurses and help promote them as more equal members of the practice. Some PHOs were keen to pursue salaried models. Other participants expressed the view that capitation does not provide incentives to work as a team.

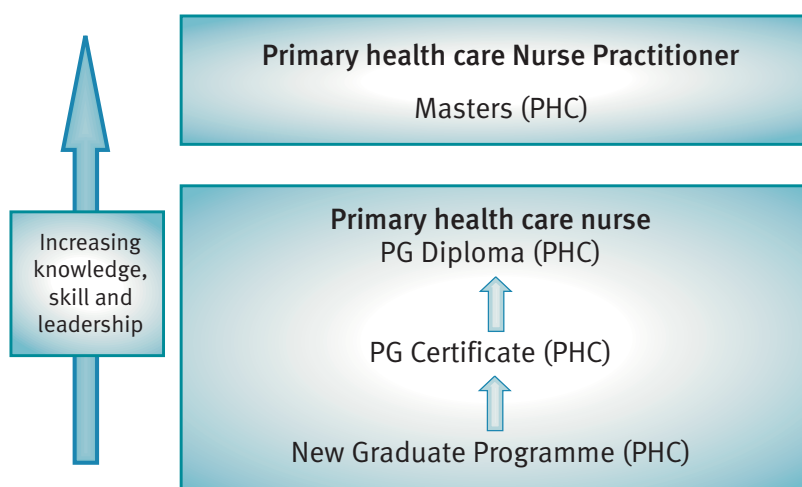
One contributing barrier to teamwork between nursing services was the physical and operational dislocation of PHC nursing services, in DHBs. It was felt services such as district and public health nursing, diabetes care and paediatric outreach would be better placed within the community.

Recommendations

The following are suggested strategies to overcome constraints to effective and innovative practice in order for the goals of the Strategy to be fully realised.

- Because PHC is a specialty area of practice it is important that new graduates and other nurses moving into the area complete at least a Postgraduate Certificate in PHC Nursing. It is suggested new graduates undertake the Clinical Training Agency (CTA)/DHB funded Nursing Entry to Practice Programme in their first year following graduation as part of this. Core PHC knowledge the nurses require includes: understanding population health and health determinants, equity issues, community assessment and community empowerment, health promotion, collaborative action and working with diverse groups. Core knowledge should also include mental health and chronic care management.
- Continuation of current scholarships such as those awarded by the Ministry of Health or CTA rural primary health nurse funding would encourage more nurses to develop their clinical and knowledge capability.
- It would be a real advantage for all nurses pursuing nurse practitioner accreditation to be mentored through the final stages of their Masters programmes, during the development of their portfolios for submission to the Nursing Council, and through the accreditation process. Providing ongoing education related to setting up a new business would also benefit nurse practitioners once the necessary changes have been made to the funding formula to enable them to obtain funding for their patients/clients.

Figure 8: Education and career pathway model



The above model provides both an education and career pathway for PHC nurses. It demonstrates the two scopes of practice, PHC registered nurse and PHC nurse practitioner, and the levels of education required for advancing practice within the specialty of PHC nursing practice.

- Nurse leaders suggested there was a real need for up-to-date data on the PHC nursing workforce and nurses' educational needs.
- The practice nurses and nurse leaders supported the recommendation from CBG Health Research that PHOs should develop nurse home-visiting programmes for Care Plus enrollees to increase efficiency. Inclusion of nurse practitioners with prescribing rights in PHC teams would provide a very real advantage for enrollees and increase efficiency and effectiveness for practices.

- Nurses will require further education, training and ongoing support in the area of mental health.
- School-based nurses and occupational health nurses would benefit from closer links with PHOs and multidisciplinary PHC teams.
- Access to appropriate services in the community would be enhanced if current ACC contracts were amended to fully fund PHC nurses to provide comprehensive care to ACC clients.
- It may be necessary to find other incentives for nurses who have not taken advantage of scholarships and support for further education. It is crucial that practice nurses and other PHC nurses, as well as GPs, recognise their responsibilities to provide appropriate services for their communities. Nurse leaders suggested the introduction of standardised clinical performance indicators measuring the quality of care provided would be one way to ensure effective care.
- Building capacity and capability in the Māori and Pacific nursing workforce is vitally important for offering culturally appropriate and acceptable health services as the numbers of Māori and Pacific in the population grow. Appropriate mentors are needed and it was suggested that recruitment focus on schools, churches, marae and fono. The many Māori and Pacific nurses who are working outside the health sector could be encouraged to undertake re-entry to practice programmes.
- A national media marketing campaign and a texting campaign to high school students' mobiles could promote interest in PHC nursing as a career and reach a broader section of the public.
- Exposure to PHC knowledge and practice in undergraduate programmes should be extended. PHOs and education providers need to work together to ensure general practices and other PHC providers can provide undergraduates with good quality clinical placements.
- It is imperative that nurse practitioners' roles are established in PHC. PHOs may need incentives to establish the roles as part of the broader PHO team.
- GP attitudes seemed to be the most important variable with regard to teamwork and the need to develop incentives for GPs to pursue the goals of the Strategy.
- DHB PHC managers, as well as PHO managers, reported that community-based PHC nursing services need to be focused within PHOs and practices.
- The nurse leaders reported that within DHBs and PHOs there should be senior leadership roles for PHC nurses.
- Nurses often need mentoring to develop skills in strategic planning, policy development and assertiveness to play a more effective part in these organisations.

New funding model

- In many practices where GPs deal with patients directly in order to access maximum funding, there is no incentive to have their nurses work autonomously. One solution would be to provide practices with a single, baseline funding stream and require clinical key performance indicators and quality measures. This would then be supplemented by generous incentives for general practices and other providers who pursue the goals of the Strategy.
- Avoiding ad hoc funding for short-term projects (such as RICF) and additional optional services (such as Care Plus) would promote integration of programmes and sustainability for recipients, who are often from high-risk groups.
- It is imperative that nurse practitioners are able to access funding within the PHOs so that they can work as independent members of the multidisciplinary teams.

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