Through the looking glass: the perspective of a nurse and practice manager-owned general practice

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How we started

Two years ago, the general practitioner (GP) who employed us decided to close the practice. After much consideration, the clinic was purchased by three registered nurses, one enrolled nurse and the practice manager. We took over private ownership on 1 May 2015.

Challenges

A few months after taking ownership, we were asked by a GP colleague 'where do you see this practice heading in the future and where do you want to be?'. At that stage, we had no concrete plans as we were treading water and trying to establish stability within the practice. After 2 years of owning the practice, we are in a better position to consider that very question.

We find it an ongoing challenge to provide the levels of health care we wish to deliver and remain financially viable under the current primary healthcare funding model. Funding streams that we have no control over determine how a clinic operates, rather than patients' needs. For example, our Primary Health Organization (PHO) falls under the Very Low Cost Access funding framework (VLCA). While this enables patients to receive health care at reduced cost, it also encourages more consultations than expected. So, this means that patients present earlier when there is an exacerbation of chronic illness, but they also have a lower threshold to present in general, such as with early cold-type symptoms. Increased presentations mean increased pressure on an already stretched rural health service.

The practice is also able to treat acute presentations such as dehydration, exacerbations of asthma and issues with constipation, but there is no specific funding available to provide these services via the existing finding streams. We are aware that other regions have access to acute demand funding through some PHOs. However, despite requesting a similar type of finding to our area so we can provide this level of acute services to patients and reduce demand on our Emergency Department, this is currently not available.

Despite this, managing acute presentations is an important facet of care continuity that is increasingly difficult to provide while there is no payment to the business for such services. While we are helping our patients stay out of secondary services, there is a significant loss of practice income through non-funded human and physical resources, and as healthcare professionals, first and foremost, we can find it difficult to remember we still need to remain a viable business.

Often patients are discharged from hospital with advice to see their local general practice for ongoing wound care or dressings. This advice appears to be made without appreciating that following it will generate frequent clinic visits with associated inconvenience and cost to patients in time and transport, and costs to the practice. We have to charge for our time (at least minimally), yet many patients find such visits an additional financial burden they cannot afford.

These factors may mean it is difficult for patients to attend appointments as often as required. Patients are therefore referred back to district nurses, employed by the very District Health Board (DHB) that referred them to primary care in the first place. If funding were made available directly to the practice to provide home-based nursing and support services, it would eliminate much of the 'back and forth' and allow the practice to maintain its 'continuous' relationship with the patients.

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The future

Although the above concepts are not new, we see a growing need for doctors, nurse practitioners and up-skilled practice nurses to move out of physical practices and into their communities to work with specific population groups such as the elderly and infirm, and with a more holistic approach, using IT-based programmes and support; for example, home visits to Mr and Mrs Elderly to give B12 injections, take blood pressures, measure weight and provide repeat scripts, which would be sent electronically to the pharmacy who could then home deliver them. Home visits also enable health professionals to see what the home environment is like and gain an insight in to their patients' worlds. Advice on health management or medication could be requested at the time of visit from the most appropriate clinicians via mobile technologies such as Skype, text messaging or FaceTime.

The current model of care expects all patients, regardless of whether they use wheelchairs or frames, drive, or care for dependents, to visit a clinic at a particular time on a particular day. The system demands they come to the service, rather than the service go to them. Current funding models are unable to support this important and much needed patient-focused system change.

The bulk of our funding is allocated by the DHB via the PHO through capitation payments, meeting Ministry of Health targets and chronic care payments. The funding is spent on health promotion, keeping people well and out of secondary services. While capitation remains relatively predicable, the system of target reward payments is inconsistent. If a practice reaches a 'target' but another practice within the PHO does not, the performance payment is withheld to all. This is frustrating for practices who successfully meet these targets. Is this the best way to allocate funding?

Despite various targets set to improve population health, there continues to be increasing population trends in obesity and diabetes, which are more evident in poorer communities, further increasing health inequalities. These trends are also coupled with increased admission rates to secondary care.

Every PHO and every practice has differing needs to other areas and practices. We would prefer to see a bulk funding approach, which would mean practices are better able to cater for their individually enrolled populations. This would allow for greater creativity in how each practice delivers primary health services, specifically tailored to the identified need of their enrolled population.

In the past, GPs were the central figures in general practices, but permanent or long-term GPs are increasingly difficult to attract to rural areas. Nurses, whether they be nurse practitioners or practice nurses, are replacing doctors as the stable workforce in these areas, and increasingly becoming owners of medical practices. We believe this trend will inevitably see more practices becoming solely nurse-owned.

Currently in our practice, we are very fortunate to have working for us some very experienced GPs, all of whom are very supportive and keen to help. We enjoy the diversity that comes from our GP colleagues from other countries and from other areas of New Zealand. As well as GP support, we also look forward in the future to benefit from the diversity that nurse practitioners bring to the collaborative team approach in providing quality health care to our patient population – regardless of how the funding is allocated!

COMPETING INTERESTS
The authors declare no competing interests.