Releasing the potential of Nursing

Jenny Carryer RN, PhD, FCNA(NZ), MNZM

School of Nursing, College of Health, Massey University, New Zealand

Since the early 1940s, New Zealand's primary care policy has been notable for the shared control between government and general practitioners (GPs), largely because GPs have retained their independence in the private sector. Because governments have continued to support GPs' right to charge co-payments 'this has consistently positioned government as subsidizer rather than total funder of primary care'.[1] This means that general practices operate in a hybridized model attempting both to provide affordable care to their local communities while simultaneously sustaining the objectives of a viable business.

The Primary Health Care Strategy[2] was launched into a New Zealand (NZ) context that had a long history. It contained the notable statement that 'Primary health care nursing will be crucial to the implementation of the Strategy, and will therefore be best addressed at the national level' (p. 23). This statement engendered tremendous energy and enthusiasm among nurses and generated a flurry of developmental activity generously sponsored by the then Minister of Health, Annette King. Scholarships for education were released and some innovation models of practice were funded as we launched into what many of us imagined would be a brave new world.

In the years during the implementation of the primary healthcare strategy, I sat in numerous Ministry of Health meetings where discussion turned to the need for 'new ways of doing things'. The advent of capitation funding was promoted as the catalyst for new behaviours, new relationships and new forms of service to general practice clients. Along with funding for services to improve access, Care Plus funding and other sources, it was widely argued that there were no longer any barriers to nurses (and others) delivering direct services to clients as active participants in multidisciplinary teams. We were advised that the practice nurse subsidy was unbundled and included in the 60–70% of Government funding being paid to private general practice businesses. From now on, the best person to deliver whatever service a patient needed would be able to do so.

Nursing prepared its own strategy document entitled *Investing in Health*[3] in direct response to the original statement that primary healthcare nursing would be crucial to the success of the Strategy. One of the core goals to be achieved was the alignment of primary healthcare nursing services with community need, and there was clearly an ongoing struggle to achieve this. Crampton *et al.*[4] noted that nurses are relatively disempowered because of their status as employees of GPs, thus limiting their opportunity to construct new roles and 'who in general have remained hostage to the fortunes of their GP employers' (p. 236). Crampton *et al.* articulated my increasing awareness of nurses' frustration that they were still constrained in their ability to align their services and to have clinical autonomy. Largely, this was, and continues to be, manifested anecdotally in their GP employers noting that proposed services will not generate income for the practice and are therefore not possible. It became clear that the ongoing tension between public funding and private business ownership was not resolved by the Primary Health Care Strategy goals, which espoused a vison not actively underpinned or supported by operational levers.

Over the last 20 years, I have been engaged in research focusing on the experience of people with long-term conditions accessing general practice services; see for example, Carryer, *et al.*;[5] and Carryer and Adams.[6] This research has consistently revealed a disconnect between the fullest extent of people's needs and the way services are delivered. In 2016, the NZ Treasury issued a report noting the characteristics of children at greater risk of poor outcomes as adults, and suggesting the need for more focused early interventions.[7] In neither instance does the current system of service delivery seem able to respond to these needs, which go far beyond the acute response to presenting problems.

In summary, and as previously argued:

> 'After long years of health services framed by the culture of medicine, most countries report an

J PRIM HEALTH CARE
2017;9(3):197–199.
doi:10.1071/HC17063
Published online 25 September 2017

CORRESPONDENCE TO:
Jenny Carryer
School of Nursing, College of Health, Massey University, Private Bag 11-222, Palmerston North 4442, New Zealand
J.B.Carryer@massey.ac.nz

CSIRO Publishing
Journal Compilation © Royal New Zealand College of General Practitioners 2017
This is an open access article licensed under a Creative Commons Attribution-NonCommercial-NoDerivatives 4.0 International License

> epidemic of chronic disease, a resurgence of infectious diseases related to poverty, huge inequalities in access and outcomes, major expenditures occurring in the last year of life, and often insufficient investment in child and youth health.' (Kooienga and Carryer)[8]

As the years have rolled by, it has become ever more evident that a different approach to service delivery is urgently required. For nursing, the frustration is immense, as we have attempted to respond appropriately to predictions of the GP workforce crisis, the well-described tsunami of unmet need and concerns about the failure to seriously reduce disparities.

As a discipline, nursing has implemented the nurse practitioner role, begun to establish registered nurse prescribing, and established strongly clinical postgraduate education as the basis for these endeavours. Alongside preparing nurses who, at various levels, can pick up increased levels of service, we have vigorously guarded our focus on health education, health promotion, health literacy, cultural safety and partnership with people who are ultimately the best drivers of their own health and wellness, if enabled to do so.

Uptake of the Nurse Practitioner (NP) role in New Zealand has been painfully slow, with considerable wastage of investment and energy. According to Nursing Council data (2016), of the 9000 nurses holding a Master's degree, at least 4000 have completed a clinical Master's degree and are theoretically eligible to apply for a NP role. Alongside extensively publicised issues with general practice workforce and the unaffordability of general practice care for many, this resource remains untapped. Despite the considerable Government funding going into General Practice, and despite many calls for a transformation of the nature of service delivery, the very workforce poised to provide that new model of service for a fraction of the price continues to wait in the wings.

In the case of nurses and nurse practitioners, we are apparently producing a workforce that no-one seems seriously committed to using largely because of the barriers, conflicts and vested interests associated with a partly private and partly publically funded system of service delivery for primary care services. The net result is that the focus has remained very much on primary care as the narrow response to managing acute presenting problems rather than the intended focus on the broader and much-needed concept of primary health care.

Recently, the All Parliamentary Group on Global Health Report stated that in 2015, the nations of the world signed up to the ambitious goal of ensuring that everyone in the world should have access to health care – universal health coverage – and that nobody should be left behind.[9] This report notes that universal health coverage cannot possibly be achieved without strengthening nursing globally. It is stated in the report that this is partly about increasing the number of nurses, but also importantly about making sure that a nursing contribution is properly understood and nurses are enabled to work to their full potential.

The report argues that strengthening nursing will have the triple impact of improving health, promoting gender equality and supporting economic growth. It is noted that:

> 'Nurses around the world, however, have shared concerns about staffing problems, poor facilities and inadequate education, training and support. This can result in poor quality care. Moreover, nurses report that they are frequently not permitted to practice to the full extent of their competence; are unable to share their learning; and have too few opportunities to develop leadership, occupy leadership roles and influence wider policy.' (All-Party Parliamentary Group on Global Health)[9]

There is increasing recognition outside New Zealand that nursing, when released to its full potential, offers a new form of service delivery closely aligned to the goals of the old Primary Health Care Strategy and the newer refreshed Health Strategy.[10] Nurse Practitioners may well have taken on some of the tools and tasks of medicine, but they also hold closely to their basis in nursing and the need to teach, enable, strengthen and connect with people in a way that allows them, regardless of circumstance, to be the healthiest they can be. There are nurses in our small towns

and rural communities and our busy urban settings ready to step up if set free to do so.

It seems that a hybridised service model will continue to dominate the New Zealand primary care environment for the foreseeable future. Such a model serves to substantially trap and diminish the fullest potential use of nursing. Additionally, there is growing anecdotal evidence that the model meets none of its specified objectives of sustainability and affordability for patients and communities. If GP owners and public funders remain committed to such a model, then it is my view that nursing must be released from such constraints in order to deliver, in parallel, a service closely aligned with the very nature of community need we have now talked about for nearly 20 years.

References

1. Crampton P, Starfield B. A case for government ownership of primary care services in New Zealand: weighing the arguments. Int J Health Serv. 2004;34(4):709–27. doi:10.2190/FMJW-R4R9-C4R1-W8RJ
2. King A. The Primary Health Care Strategy. Wellington, NZ: Ministry of Health; 2001.
3. Expert Advisory Group on Primary Health Care Nursing. Investing in health: Whakatohutia te Oranga Tangata: a framework for activating primary health care nursing in New Zealand. Wellington, NZ: Ministry of Health; 2003.
4. Crampton P, Davis P, Lay-Yee R. Primary care teams: New Zealand's experience with community-governed non-profit primary care. Health Policy. 2005;72(2):233–43. doi:10.1016/j.healthpol.2004.08.003
5. Carryer J, Doolan-Noble F, Gauld R, Budge C. New Zealand patients' perceptions of chronic care delivery. J Integr Care. 2014;22(2):71–80. doi:10.1108/JICA-12-2013-0048
6. Carryer J, Adams S. Nurse practitioners as a solution to transformative and sustainable health services in primary health care: A qualitative exploratory study. Collegian. 2016. doi:10.1016/j.colegn.2016.12.001
7. Ball C, Crichton S, Templeton R, et al. Characteristics of children at greater risk of poor outcomes as adults. Analytical Paper 16/01. Wellington, NZ: NZ Treasury; 2016.
8. Kooienga SA, Carryer JB. Globalization and advancing primary health care nurse practitioner practice. J Nurse Pract. 2015;11(8):804–11. doi:10.1016/j.nurpra.2015.06.012
9. All-Party Parliamentary Group on Global Health. Triple Impact - how developing nursing will improve health, promote gender equality and support economic growth. London, UK: All-Party Parliamentary Group on Global Health; 2016. [cited 2017 June 20]. Available from: http://www.who.int/hrh/com-heeg/digital-APPG_triple-impact.pdf
10. Ministry of Health. New Zealand Health Strategy: future direction. Wellington, NZ: Ministry of Health; 2016. [cited 2016 December 10]. Available from: http://www.health.govt.nz/system/files/documents/publications/new-zealand-health-strategy-future-direction-apr16_1.pdf

COMPETING INTERESTS
The author declares no competing interests.