

# Thinking about health care differently: nurse practitioners in primary health care as social entrepreneurs

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## ABSTRACT

**INTRODUCTION:** Challenges facing the primary health-care sector mean that policymakers and clinicians need to think and act differently to move forward. The principles of social entrepreneurship have been implemented successfully for improved health outcomes in other developed nations. There is a knowledge gap around whether nurse practitioners (NPs) in New Zealand primary health care (PHC) align with these principles.

**AIM:** To explore whether and how the innovative activities of primary care NPs can be described as socially entrepreneurial.

**METHODS:** A descriptive qualitative approach was used with data collected using semi-structured interviews with NPs working in primary care ( $n = 7$ ). Data were analysed using general inductive thematic analysis techniques.

**RESULTS:** Nurse practitioners interviewed worked in government-subsidised private general practice businesses. Two main themes emerged: (1) the nursing model of care aligned with social entrepreneurship; and (2) building social capital. NPs described a desire to see health care delivered differently and this aligned with acting as a social entrepreneur. Social capital emerged through the requirement to establish significant collaborative relationships.

**DISCUSSION:** It was found that NPs' work can be described as socially entrepreneurial. The holistic, person and community-centred model of NP care has an ultimate mission of improved health outcomes. Social capital is built through collaborative relationships with other health-care providers, individual service users and the community. However, the juxtaposition of the business model in primary care prevents NPs from initiating and leading sustainable change.

**KEYWORDS:** Nurse practitioner; social entrepreneur; innovation; primary health care; sustainable; health care delivery

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## Introduction

There is a recognised need to change the way we think and act in primary health care (PHC) to address the unequal and prominent burden of ill health for the people of New Zealand (NZ).<sup>1</sup> Health inequalities are attributed to both limited health service provision and disparities in the social determinants of health.<sup>2</sup> The Alma Ata Declaration (1978) asserts that PHC provides an equitable service to all people through

recognition of the wider determinants of health.<sup>3</sup>

The bio-psycho-social approach to health care has a population focus that includes disease prevention, health promotion, acute and chronic illness care. However, in NZ general practice, the main service model is more typically concerned with a bio-medical business model of health-care delivery.<sup>4</sup> Despite recent and promising developments towards more community-orientated services in rural areas (particularly

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## WHAT THIS GAP FILLS

**What is already known:** Principles of social entrepreneurship have been implemented successfully for improved health outcomes in services operating in Australia and the United Kingdom. The nursing model of care is well aligned with the principles of social entrepreneurship.

**What this study adds:** Nurse practitioners in New Zealand are in a position to lead sustainable change in primary health-care delivery through the application of social entrepreneurship principles. Education, policy and funding support of social entrepreneurship is a worthwhile area of further investigation to assist nurse practitioners with initiating and leading sustainable change in primary health care.

for Māori), the existing model has persisting difficulties in access to care and the inability to provide for health needs beyond current funded services.<sup>5</sup>

The New Zealand Health Strategy proposes innovation that addresses the broad social determinants of health as a way of achieving more equitable health outcomes for the most deprived populations.<sup>1</sup> Social entrepreneurship may be a sustainable innovative approach to address disparities. Rather than focusing on financial gain as the ultimate business goal, social entrepreneurship uses market-based strategies to bring about social benefit. The generation of money is a critical resource for the sustainability of the socially entrepreneurial venture,<sup>6</sup> and financial resources are reinvested to further the social mission.<sup>7</sup>

The building of social capital is an important principle of social entrepreneurship for driving the success of social ventures. Building social capital relates to partnering with and developing existing networks within the public, social and business sectors.<sup>8,9</sup> Building and strengthening social capital contributes holistically to positive outcomes within targeted communities; a key social entrepreneurship principle known as social benefit.<sup>10</sup>

For social entrepreneurs to be successful, the development of social capital must be embedded in supportive environments by government,

private and social sectors.<sup>11,12</sup> Development of trust between these sectors promotes networking and collaboration, which instils community confidence in the social entrepreneur's good intent, competence and openness.<sup>13</sup> In addition, collaboration is a way to share best practice, pool resources and demonstrate the success of socially entrepreneurial ventures, thereby gaining attention at the national policy level.<sup>13</sup> Building relationships and trust involves listening to, learning from, and participating in the community, thus creating social capital and sustainable social benefit.

Two examples of social enterprise are a PHC service in England and a mental health-care service in Australia. Both services fill a gap for people in an area of high deprivation where the traditional medical model has failed.<sup>14</sup> Their business objectives are to address determinants of ill-health such as unemployment, fuel-poverty, mental health and social isolation.<sup>7</sup> Social capital is built through connection with local consumers, general practitioners (GPs), psychiatrists, allied health professionals and collaboration with professional development associations, hospitals and employment and housing agencies.<sup>15</sup> Collaboration with appropriate services builds capacity and empowers clients, providing greater opportunities for a healthy life.<sup>16</sup> At the PHC service in England, a nurse practitioner (NP) is the clinical lead and 80% of patients are seen by the nursing team while doctors focus on patients with highly complex medical problems.<sup>14</sup> Outcomes include increased appointment availability, a saving of five pounds for every one pound spent and reduction in antidepressant prescribing.<sup>14</sup>

NPs in NZ are registered nurses who have completed a clinical master's degree and training to enable the provision of advanced care that includes diagnosis and treatment of health conditions.<sup>9</sup> NPs work autonomously as lead health-care providers for health-care consumers. Their work encompasses a population health focus in partnership with consumers and other clinicians, working collaboratively to improve health outcomes. In PHC, NPs can deliver the same health-care services as their GP colleagues.<sup>17</sup> At the time of writing, there were ~300 registered NPs in NZ, 170 of whom work in PHC settings.

The NPs in PHC are well positioned to enable social health outcomes beyond those achieved in a bio-medically orientated business model of primary care.<sup>18</sup> NPs work under a needs-based, patient-centred model of care for which there is evidence of improved population health outcomes,<sup>19</sup> and which is well aligned with principles of social entrepreneurship.<sup>20</sup> However, NPs have been underutilised in addressing population health issues, especially for the under-served.<sup>19,21,22</sup>

Social entrepreneurship provides a sustainable model of innovation from which NPs can lead health-care reforms.<sup>19,23,24</sup> The extent of PHC NPs' engagement in socially entrepreneurial activity in NZ is not yet known. This research explores ways that the innovative activities of PHC NPs can be described as socially entrepreneurial.

## Methods

Qualitative description was used to explore relationships between the innovative activities of NPs and principles of social entrepreneurship.<sup>25</sup> Qualitative description attempts to represent phenomena in their pure form<sup>26</sup> and was used because of the limited knowledge of NPs as being socially entrepreneurial and the complex nature of health care. Consistent with the literature on the qualitative description method of data collection, seven semi-structured, open-ended interviews were conducted.<sup>26,27</sup> Interviews were conducted by online conference call, of 45–60 min duration and were transcribed verbatim by the lead author. The interview schema was developed over a series of team meetings and with guidance from the literature, and piloted with a PHC nurse. Eight open-ended questions were used. One NP transcript was used from a prior study with permission of the researchers and participant.<sup>28</sup> The interview schema structure asked general questions with a framework of social entrepreneurship principles. Open-ended questions were used to promote dialogue about the way the NP improved patient outcomes, brought about change and influenced or drove innovation. Collaborative practice and business values were discussed with a final direct question on whether interviewees saw themselves as social entrepreneurs.

Purposive sampling through local networks led to a final sample that comprised seven NPs working in general practice. This number achieved data saturation and further participants were not sought. We analysed interview data using inductive thematic analysis<sup>29</sup> with a framework of social entrepreneurship, enabling description of the extent to which NPs in PHC can be described as socially entrepreneurial. NVivo™ version 11 (QRS International Pty Ltd, Doncaster, Vic, Australia) was used for the process of thematic coding. Ethics approval was granted through the relevant university ethics committee (SOA 16/28). Pseudonyms were assigned to participants to maintain anonymity.

## Results

The PHC settings for the NPs interviewed were private general practice businesses funded partially by the government. Participants experience working as a NP ranged from 9 months to 12 years. All were female. The PHC settings included a general practice independently owned by a NP, and NPs employed by urban and rural general practices. The demographic of people served by these businesses ranged from high to low socioeconomic, and from majority European to a broad diversity of cultures. Two NPs worked in a service targeting a high-needs, low socioeconomic population. The NPs served people from birth through to end-of-life care. Two major themes describe the NPs' practice: (i) a nursing model of care aligned with social entrepreneurship; and (ii) building social capital.

### Nursing model of care aligned with social entrepreneurship

Social entrepreneurship involves filling gaps and meeting needs of people who are under-served by the current system. The NPs described a wish to see change in the way PHC was delivered to meet the needs of under-served people. They described a requirement to think broadly and adapt patient-centred innovation: '...we need to change the status quo, we need to make a change that suits them [the community] to do this' [NP4]. The NPs approach to health care emphasised health promotion intended to address the holistic needs of individuals and their community.

I tend to do a much more broad management... they tend to [give me] the more complex patients... I have slightly longer appointments, but I manage that stuff that can lead to a lot of presentations... with physical symptoms when in fact there are other things that are driving that... a lot of that is through education and empowerment and improving self-efficacy, health literacy, all those sorts of things that help them to look after themselves better and to feel more confident [NP2].

Working within a system structured in a way that endorsed a bio-medical business model of primary care was described as a challenge that must be overcome to deliver a nursing model of care. 'I might see a patient who I talk to about smoking cessation, their drinking... and there's so many other social problems that we talk about' [NP4]. The autonomous role of the NP was seen in itself as an innovative way of delivering care and provided an opportunity to deliver a different approach to care that aimed at social benefit for the community.

The NPs were asked to describe their employer organisation and then their personal approach to PHC business using a continuum from 1 for a business focused on purely social outcomes to 10 for a business focused purely on financial gain. There was general acknowledgment that financial income was essential to business sustainability. 'I think if you talk to the majority of my colleagues, including myself, we're kind of in the middle. So our heart would have us at 1, but our brain says 'but we have to have a sustainable business because otherwise we won't have a job'' [NP3]. Interviewees thought general practice business managers were highly financially driven. 'If you talk to the managers, they'll be very much close to the 10 because that's their driver, you know that's their job' [NP3]. However, NPs who worked under a model that emphasised maximisation of business income felt limited. Some examples were short time allocation for patient encounters, and the expectation of addressing only one issue per consultation.

Compassion for the people served and a desire to improve wellbeing for the population in a sustainable way was expressed. Financial gain was considered by the NPs as a critical means to

sustain PHC businesses and achieve the ultimate goal of improved outcomes for people served. Improved patient outcomes such as improved access to PHC and reduced presentations were highlighted. Although challenging to implement within the current PHC structure, sustainable improvement of equitable patient outcomes was thought to be possible if a highly collaborative approach between individuals, community and other related services was taken; 'I think inequalities will be successfully, hopefully, really addressed when people will really work in an integrated way...at the moment the integration is purely business' [NP6].

### Building social capital

A collaborative approach, embedded within a supportive environment, is important for building social capital consistent with social entrepreneurship principles.<sup>8,9,11,12</sup> Collaboration was seen by the NPs as a helpful way to understand what each discipline could contribute to the health-care journeys of patients. Integration through collaborative care helped fulfil the goal of delivering the most appropriate care to meet patients' health and wellbeing needs.

Collaboration was evident through the NPs building of trust within and between members of an integrated health-care team that included health professionals in primary and secondary sectors, as well as appropriate social services. Trust was described by one NP as 'the basis of a good working relationship' [NP5]. Trusting relationships with other service providers developed a supportive environment that promoted safe, efficient and appropriate services for patients. Through collaborative relationships, NPs were comfortable talking to other health professionals within and across health-care services about appropriate care for patients.

Collaboration with patients involved applying the nursing model of care by being relational, listening and having empathy – achieved through partnership, participation and consideration of the whole person. Collaboration with patients in this way was seen to embed confidence in the quality of received health care: '...working with individual patients, the plans of care, partner-

ship, follow-up, is key. And identifying their goals, and what they want to achieve is key to that' [NP3]. Rural NPs particularly described involvement in community activities such as a local community car service and providing free health checks at community events. Through such involvement, trust can develop between communities and NPs: '...we are real community partners...when they see that you're a part of community based activities, they're right behind you, and that works really well' [NP1].

To make a difference for the health of patients who do not fit the 'average', the NPs felt connection with patients was essential. Connection involved understanding the background and values of patients' cultural group, which could occur only when working in collaboration with the patient and their family. One NP described this approach as particularly important with the Māori population she served. She said that the current mainstream model of primary care delivery is not well suited to the needs of Māori and that collaborative care was essential for discovering the best way to help Māori on their journey to wellness.

'...when they [patients] come into the general practice, they bring a whole lot of cultures with them. They bring their ethnic background, they bring their different family dynamics... they bring their culture of wellness and illness... They then come into our centre which is another culture again and they go up against me and my own ethnic background, my own beliefs, my own thinking about what is wrong with them and why it is wrong...' [NP7].

## Discussion

This study set out to describe socially entrepreneurial behaviour among PHC NPs in NZ. While the notion of social entrepreneurship is an emerging field of interest in health care, research on social entrepreneurship in PHC is limited.<sup>19,21,30</sup> We found the NPs in this research work under principles that are well aligned with social entrepreneurship. Social entrepreneurs are strongly focused on a mission that creates and sustains social value.<sup>31</sup>

Population-based strategies to improve health outcomes through increased access and reduced inequalities have been identified as central to the role of NPs.<sup>32</sup> To fulfil their role, the NPs endeavoured to provide appropriate and accessible PHC services for the population they served. Improved health outcomes were made possible through a person-centred service, with particular concern expressed about the inadequacies of the traditional bio-medical model for meeting the needs of under-served populations. In NZ, it is common for PHC NPs to work in rural and under-served communities.<sup>33</sup> The autonomy provided by the NP role was seen as an innovative opportunity to apply their model of care to meet the specific needs of their community.

The NPs described their service as improving health outcomes for their community through increased access and reduced service presentations. While these outcomes do not describe direct health improvement for the community, they could be indicators of a healthier population. For example, provision of effective and timely PHC helps to avoid premature death from cardiovascular disease, cancer and respiratory illness.<sup>5</sup>

The NPs' approach to improved outcomes can be understood under social entrepreneurship principles. The evidence is clear that the creation of social value within health systems leads to improved health outcomes.<sup>7,14,34</sup> The NPs talked about their work within PHC business as focused on social value creation and they had little or no commercial or financial motivation. It was clear that they felt most satisfied within their setting when the community members they served were provided with an equitable and high-quality service. Their ideal business could be described as suited to a model of social enterprise where the objective is sustainable social improvement rather than financial return.<sup>24</sup>

Evidence of building social capital was seen in the way the NPs worked collaboratively with other professionals. Collaboration built trust between other health professionals and the community. Building social capital in populations that have been marginalised by health systems, which are not structured to cater appropriately to their



needs, is suggested as a tool for empowerment of that population.<sup>16</sup> Empowerment gives control of health and wellbeing back to under-served populations, and when facilitated by health professionals, can address broader health issues.<sup>4</sup>

While the business ideal of the NPs might have aligned with a model of social enterprise, the business environments for most of the NPs were largely fiscally focused. The ability to fulfil a social mission under a nursing model was restricted by the need to accommodate business managers focused on financial efficiency. Under-valuing the nursing approach by employers who are organised in a traditional bio-medical business model has previously been observed in the literature.<sup>35</sup>

There was a sense that complete focus on a central social mission was neither possible nor realistic. Recognising the importance of financial sustainability, the NPs said that they distanced themselves from management of the financial side of business in order to maintain their focus on patient care. A perceived lack of interest and skill in the day-to-day operations of a PHC business is a disabling factor to PHC NP social entrepreneurship.<sup>36</sup> It has been observed that NPs who want to be social entrepreneurs must receive 'necessary education and knowledge related to clinic management'.<sup>36</sup>

Limitations to this study include the small sample size and the possibility that as all study participants were female, they may have different entrepreneurship experiences than males.<sup>37</sup> Consistent with the epistemological underpinnings of qualitative research, the findings of this study are not generalisable to all PHC NPs or wider health professions. The scope of this research was limited to NPs as being socially entrepreneurial. This research forms a platform from which further research might extend to other PHC professionals. Additionally, further research would be useful to investigate social entrepreneurship principles as a guide for NZ health system policy.

## Conclusion

This study found that NP work can be described as socially entrepreneurial. The holistic, person

and community-centred model of NP care has an ultimate mission of improved health outcomes. Social capital is built through collaborative relationships with other health-care providers, individual service users and the community. However, the juxtaposition of the business model in primary care may prevent NPs from initiating and leading sustainable change. Education, policy and funding support of social entrepreneurship appears to be a worthwhile area for further investigation for sustainable and equitable delivery of PHC in NZ.

## References

1. Ministry of Health. New Zealand Health Strategy: Future direction. Wellington: Ministry of Health; 2016.
2. International Council of Nurses. Nurses' role in achieving the sustainable development goals. Geneva: International Council of Nurses; 2017. [cited 2017 May 10]. Available from: [https://www.icnvoicetolead.com/wp-content/uploads/2017/04/ICN\\_AVoiceToLead\\_guidancePack-9.pdf](https://www.icnvoicetolead.com/wp-content/uploads/2017/04/ICN_AVoiceToLead_guidancePack-9.pdf)
3. World Health Organization. The declaration of Alma-Ata. Geneva: World Health Organisation; 1978.
4. Carrier J, Dignam D, Horsburgh M, et al. Locating nursing in primary health care: a report for the national health committee. Wellington: Ministry of Health; 1999. [cited 2017 July 17]. Available from: <http://www.moh.govt.nz/notebook/nbbooks.nsf/0/DCA9D6A0BA49FD97CC256AF600755342?OpenDocument>
5. Downes A. From theory to practice: the promise of primary care in New Zealand. Wellington, New Zealand: Fulbright New Zealand; 2017. [accessed 2017 July 30]. Available from: <http://www.fulbright.org.nz/publications/from-theory-to-practice-the-promise-of-primary-care-in-new-zealand/>
6. Dacin PA, Dacin MT, Matear M. Social entrepreneurship: why we don't need a new theory and how we move forward from here. *Acad Manage Perspect*. 2010;24(3):37–57.
7. Roy MJ, Donaldson C, Baker R, Kay A. Social enterprise: new pathways to health and well-being? *J Public Health Policy*. 2013;34(1):55–68. doi:10.1057/jphp.2012.61
8. Hoogendoorn B, Pennings E, Thurik R. What do we know about social entrepreneurship? An analysis of empirical research. ERIM Report Series Reference No. ERS-2009-044-ORG. Available from: <https://ssrn.com/abstract=1462018>; 2010.
9. Phan PHC, Kickul JR, Bacq S, Nordqvist M, editors. Theory and empirical research in social entrepreneurship. Cheltenham, England: Edward Elgar Publishing; 2014.
10. Miller TL, Grimes MG, McMullen JS, Vogus TJ. Venturing for others with heart and head: how compassion encourages social entrepreneurship. *Acad Manage Rev*. 2012;37(4):616–40. doi:10.5465/amr.2010.0456
11. Catford J. Social entrepreneurs are vital for health promotion - but they need supportive environments too. *Health Promot Int*. 1998;13(2):95–7. doi:10.1093/heapro/13.2.95
12. Mair J, Ignasi M. Social entrepreneurship research: a source of explanation, prediction and delight. *J World Bus*. 2006;41(1):36–44. doi:10.1016/j.jwb.2005.09.002
13. Heinze KL, Banaszak-Holl J, Babiak K. Social entrepreneurship in communities. *Nonprofit Manag Leadersh*. 2016;26(3):313–30. doi:10.1002/nml.21198

14. Robinson F. The rise of social enterprise in primary healthcare. *Practice Nurse*. 2010;39(6):9–12. <http://www.practicenurse.co.uk/>
15. Raeburn T, Hungerford C, Sayers J, et al. Leading a recovery-oriented social enterprise. *Issues Ment Health Nurs*. 2015;36(5):362–9. doi:10.3109/01612840.2015.1011760
16. Domínguez S, Arford T. It is all about who you know: social capital and health in low-income communities. *Health Sociol Rev*. 2010;19(1):114–29. doi:10.5172/hesr.2010.19.1.114
17. Ministry of Health. Health practitioners (replacement of statutory references to medical practitioners). Wellington: Ministry of Health; 2015. [cited 2017 July 15]. Available from: <https://www.health.govt.nz/about-ministry/legislation-and-regulation/regulatory-impact-statements/health-practitioners-replacement-statutory-references-medical-practitioners>
18. Nursing Council of New Zealand. Competencies for the nurse practitioner scope of practice. Wellington: Nursing Council of New Zealand; 2017. [cited 2017 August 30]. Available from: <http://www.nursingcouncil.org.nz/Nurses/Scopes-of-practice/Nurse-practitioner>
19. Wilson A, Whitaker N, Whitford D. Rising to the challenge of health care reform with entrepreneurial and intrapreneurial nursing initiatives. *Online J Issues Nurs*. 2012;17(2):5.
20. Gilliss CL. The nurse as social entrepreneur: revisiting our roots and raising our voices. *Nurs Outlook*. 2011;59(5):256–7. doi:10.1016/j.outlook.2011.07.003
21. Darbyshire P. An idea whose time has come: nursing entrepreneurialism. *Whitireia Nurs & Health J*. 2014;(21):9–14. <https://www.whitireia.ac.nz/about-us/publications/whitireia-nursing-and-health-journal/>
22. Wilkinson J. Places for nurse practitioners to flourish: examining third sector primary care. *Aust J Adv Nurs*. 2012;29(4):36–42.
23. Gilmartin MJ. Principles and practices of social entrepreneurship for nursing. *J Nurs Educ*. 2013;52(11):641–4. doi:10.3928/01484834-20131014-03
24. Cheater FM. Improving primary and community health services through nurse-led social enterprise. *Qual Prim Care*. 2010;18(1):5–7.
25. Sandelowski M. Focus on research methods: what-ever happened to qualitative description? *Res Nurs Health*. 2000;23(4):334–40. doi:10.1002/1098-240X(200008)23:4<334::AID-NUR9>3.0.CO;2-G
26. Kim H, Sefcik JS, Bradway C. Characteristics of qualitative descriptive studies: a systematic review. *Res Nurs Health*. 2017;40(1):23–42. doi:10.1002/nur.21768
27. Lambert VA, Lambert CE. Qualitative descriptive research: an acceptable design. *Pac Rim Int J Nurs Res Thail*. 2012;16(4):255–6. Available from: <https://www.tci-thaijo.org/index.php/PRIJNR/index>
28. Brewer J. Thinking about primary care differently: nurse practitioners as innovators. Bachelor of Business Studies (Hons), research report. Auckland, New Zealand: School of Management, Massey University; 2016.
29. Braun V, Clarke V. Using thematic analysis in psychology. *Qual Res Psychol*. 2006;3(2):77–101. doi:10.1191/1478088706qp0630a
30. Martin WM, Mazzeo J, Lemon B. Teaching public health professionals entrepreneurship: an integrated approach. *J Enterp Cult*. 2016;24(02):193–207. doi:10.1142/S0218495816500084
31. Frederick HH, Kuratko DF, O'Connor A. Entrepreneurship: theory/process/practice. [Non-fiction electronic document]. South Melbourne: Cengage Learning Australia; 2016. [cited 2017 March 5]. Available from: <https://cengage.com.au/product/title/entrepreneurship-theory-processpractice/isbn/9780170352550>
32. Carryer J, Adams S. Nurse practitioners as a solution to transformative and sustainable health services in primary health care: a qualitative exploratory study. *Collegian*. 2017;24:525–31. doi:10.1016/j.colegn.2016.12.001
33. Ministry of Health. Nurse practitioners in New Zealand. Wellington: Ministry of Health; 2017. [cited 2017 October 27]. Available from: <http://www.health.govt.nz/system/files/documents/pages/nurse-practitioners-in-new-zealand.pdf>
34. Altman M. Nursing social entrepreneurship leads to positive change. *Nurs Manage*. 2016;47(7):28–32. doi:10.1097/01.NUMA.0000484476.21855.50
35. Wall S. Nursing entrepreneurship: motivators, strategies and possibilities for professional advancement and health system change. *Nurs Leadersh*. 2013;26(2):29–40. doi:10.12927/cjnl.2013.23450
36. Sharp DB, Monsivais D. Decreasing barriers for nurse practitioners social entrepreneurship. *J Am Assoc Nurse Pract*. 2014;26(10):562–6. doi:10.1002/2327-6924.12126
37. Marlow S, McAdam M. Gender and entrepreneurship: advancing debate and challenging myths; exploring the mystery of the under-performing female entrepreneur. *Int J Entrepren Behav Res*. 2013;19(1):114–24. doi:10.1108/13552551311299288

**COMPETING INTERESTS**  
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