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Investing in health

Jennifer Carryer[A,*]

For full list of author affiliations and declarations see end of paper

*Correspondence to:
Jennifer Carryer
School of Nursing, Massey University, PB 11-222, Palmerston North, New Zealand
Email: J.B.Carryer@massey.ac.nz

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There is a long-standing global call for a paradigm shift in the way health is perceived and addressed through service provision and related investment.[1] Improving the primary health care focus challenges our prioritisation of funding toward diagnosis and treatment, our reliance on escalating technology usage, and our tendency towards prolongation of life at all costs. The flip side of such focus is limited attention and investment in the many factors known to protect and support health at a community level. The problem with such long standing calls is that we seem to have become collectively deaf to their importance in much the same way we seem able to largely ignore the climate crisis.

The central focus of nursing has always been to privilege the contexts of health at both individual and community level through a social justice lens.[2] Nevertheless, the overarching structures and focus of health service delivery pull too many nurses into roles more closely aligned with assistance and compliance with a medicalised and business focus. The Primary Health Care (PHC) Strategy[3] was greeted with energy, enthusiasm and excitement by nurses. There was a strong sense that our time had come and a flurry of activity ensued around analysis of employment structures, development of education, implementation of the Nurse Practitioner (NP) role and a general sense of renewal. Nursing developed a clear strategic plan to ensure our capacity to support implementation of the Strategy.[4]

The aims of the current reforms are remarkably similar to the aims of the primary health strategy.[3] Nursing excitement has been noticeably absent this time. The silence could be attributed to cynicism and despair but more positively it could be attributed to the gulf between actual and ideal having reduced to some small extent. In 2001 nursing was reeling from the contract and competitive culture of the 1990s.[5–7] The commodification and compartmentalising of nursing roles, the paucity of funded post graduate education and lack of visible leadership in the PHC sector resulting from the 1990s meant there was a great deal to do.

In 2022, the situation is both considerably improved yet unchanged in other ways. There is no doubt that the more appropriate utilisation of nurses in General Practice has increased enormously. Registered nurses have stepped up, embraced prescribing, taken up significant responsibility for managing long term conditions[8,9] and regularly see patients independently in clinic settings. Currently advertisements for NP positions significantly outstrip the supply (despite there now being nearly 650 NPs in New Zealand) and the number of candidates for training positions also exceeds available funded places.

One significant problem has been our inability to independently pull the levers required to activate our carefully thought through strategic goals. This is particularly evident in our dealings with Health Workforce New Zealand as it was named, and the new incarnations of this entity as now deployed within Te Whatu Ora. We have spent years working with, providing submissions to and advising health workforce staff and leadership. Consistently our advice is ignored or challenged thus ensuring significant waste of time, energy and opportunity. We anticipated the current workforce crisis and could well be filling many more of the unfilled advertisements for Nurse Practitioner roles, growing a Māori nurse workforce appropriate to the population demographics and ensuring the transition of graduates directly into primary health positions if our early advice had been heeded. Nursing services are not delivered in a vacuum and are also strongly influenced by employment, funding and other issues of design and infrastructure.

It is sobering to consider that there has been no careful analysis as to why the laudable goals of the PHC strategy were not achieved and a strong sense of déjà vu accompanies the repetition of such goals underpinning the current reforms. There are challenges ahead

to consider including continuing a much-needed shift away from the medicalised focus on primary care towards a community-based focus on primary health care and making genuine attempts to acknowledge socio-economic determinants, foster health literacy, increase equity and make wellness available to all rather than a privileged few. Matheson *et al.*[10] have noted the disappointing attention to primary health care in the current reforms. They report the lack of dedicated funding and limited engagement of appropriate leadership and warn that 'the new entities are in danger of repeating old mistakes' (p. 2).

Much energy and attention is directed towards current and emerging models of general practice as the sole locus of primary care[11,12] and there are clearly no easy ways to move out of the current hybrid model of private business and public funding.[13,14] The current model is considered by business owners to be inadequately funded and under resourced with escalating workforce shortages and high levels of stress. There is an urgent need to challenge an overarching model that, despite variations, continues to deliver services in much the same way it always has.

This has implications for nursing. I have always argued that the employment of practice nurses by general practitioners is a limitation on the full development of nursing services as it largely confines them within a first contact medical services model and also constrains the formation of truly functional teams with individual member autonomy.[15,16] At the same time the disconnect between general practice and other community-based entities such as NGOs means there is fragmentation between nurses in various community-based roles whose employment remains connected to structures and contracts rather than people and communities. Nurses, as for other health professionals, thrive on building therapeutic relationships and express concern at the increasing loss of continuity of care in emergent models of general practice.[17] Currently energy is also being directed towards establishing a plethora of new roles to bolster existing services within the current model. This too has implications for continuity of care as people are divided into disease entitles or functional differences.[18]

When PHOs were first mooted nursing envisaged the development of real primary health care nursing wherein practice nurses, district nurses, public health nurses, aged care services and others became part of a seamless service from nursing following people across artificial service and employment boundaries. This remains a dream oddly aligned to the reform rhetoric but less closely aligned to the changes emerging under the current reform process.

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Author affiliation
[A]School of Nursing, Massey University, PB 11-222, Palmerston North, New Zealand.