The future of practice nursing

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There has been much discussion and debate amongst primary health care providers and funders about the potential and actual services provided by primary health nurses in response to the Primary Health Care (PHC) Strategy. Because practice nurses (PNs) are the largest group of primary health care (PHC) nurses (MOH 2003),[1] their profiles and role opportunities have been somewhat more visible in this debate, particularly as much of the controversy and change during the implementation of the strategy has centred on general practice. To ensure excellence and responsiveness of primary health care nursing service delivery, and to allow practice nursing to reach its full potential within the primary health care sector, there must be a change in the fundamental structure of how these services are governed, funded, managed and delivered. In this paper I will describe and discuss the main themes that cause barriers and that may present opportunities for PNs to fulfil their potential in the future.

Current issues

The Ministry of Health's (MOH's) *Ministerial Taskforce on Nursing* report[2] identified barriers to expanding nursing practice, stating among them *'the lack of consistent national standards to demonstrate nurses' level of practice and specialty knowledge'*. In particular, barriers to practice nursing achieving autonomous nursing services are articulated, acknowledging attitudinal as well as physical and financial barriers[2] that continue today. The report also encouraged the primary care organisations *'to make more effective use of practice nurses, including direct access to nurses by patients and including nurses within management structures.'*[2]

The PHC Strategy[3] argues that nurses are 'crucial' to its successful implementation. Yet the funding and employment structures enabling nursing to respond to the challenges have not eventuated. Neither the MOH, nor the Primary Health Organisations (PHOs) have addressed the means by which the goals of the Strategy could be achieved by nurses. The document *'Investing in Health'*,[4] written by the PHC nursing expert advisory group to the MOH, articulated how nurse leaders in New Zealand sought to provide a blueprint to activate the nursing workforce in the PHC sector. The document outlines a number of possible means by which primary health care nursing could contribute to improved health outcomes of New Zealanders, and how to utilise effectively the current and future nursing workforce to achieve this. To date there has been little progress nationally to implement the recommendations made in the document, activity has tended to be ad hoc and inconsistent, and it has focused locally around different models of nursing service delivery.

Funding

Funding of nursing services in general practice continues to be a source of contention and debate amongst nurse providers, their employers and the funders of health care services. Lack of funding has continued to limit the expansion of nursing services in general practice[2,5] because capitation and other funding streams into general practice re-

main linked to enrolled service users (ESUs) through general practitioners. The Ministry has recommended strongly against tagging components of PHO funding for different health professional groups. They have indicated that they perceive the capitation payments, services to improve access (SIA) and health promotion (HP) funding as 'flexible' funding for the PHO to best deliver services to the enrolled population.[6] Because nursing services continue to be constrained by population health funding that is inextricably linked to general practitioners, clients do not have the opportunity to perceive and utilise nurses as potential key providers of primary health care services.

Attitudes

It has been acknowledged that general practices are private businesses and thus carry significant financial risk in this new PHC environment.[1] This means that GPs are understandably reluctant to relinquish control over services provided within the practice. PNs have been employees of GPs for many years, thus it is difficult for many GPs and PNs to separate the employee/employer status from the professional status. This separation must be facilitated to allow the growth of clinical autonomy of PNs as they attempt to expand their current nursing services and meet the challenges put forward by the PHC Strategy. It is also perceived erroneously by some GPs that they are liable for nurses' professional practice. All nurses are accountable for their own practice. GPs, as employers of practice nurses, are only responsible vicariously[7] in situations where there is failure to provide safe working environments and to support safe practice. If not managed well, this misconception may cause anxieties amongst GPs, creating a barrier to expanding nursing services.

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Tomorrow's practice nurses

In my future, practice nurses will be more mobile, e.g. enabled to provide services in patients' homes; more educated, e.g. most will have postgraduate level education; and better remunerated. However, before any discussion on what or how services may be provided, it is necessary to examine the professional practice environment that will sustain future practice nursing activities.

To date there has been little public debate about the power base that practice nurses must work under and manage every day. It appears, for reasons many and varied, that it is too difficult for all, particularly the GPs and PNs, to address the issue of power and professional practice autonomy in a constructive and mutually respectful way that could bring about necessary positive change.

True autonomy, in this author's view, is having the power, knowledge and authority to control nursing practice in clinical situations, to be able to work in an environment that is free from rules and regulations that have little to do with nursing practice and to take responsibility for one's practice. For example, having a general practice structure and funding that enables PNs to re-appoint patients for follow-up with one nurse consistently to ensure continuity of care. Having appointment times that are more reflective of the time needed to meet complex patients' needs, e.g 30 minutes for a well woman check rather than 10 or 15. Or funding that recognises nurses' clinical value so that the patient is not required to wait extra time to have a GP check a wound just to gain extra funding dollars from funding streams such as ACC or, in some cases, because the GP wishes to have clinical oversight.

Shared governance

Shared governance is an accountability-based approach to relationships and teams in an organisation.[8] It's about having the people closest to the issues involved in the decision and policy making process – in this case clinical nursing decisions about patient care. Research from Magnet Hospital development in the United States has indicated that nurses in a shared governance system work more efficiently, effectively and are retained for longer. Although there is as yet little evidence relating to the effects of shared governance on the professional practice in general, the cost-benefit impact, and value of shared governance with regard to advancing patient care outcomes,[8] there is no doubt that this model has made a difference in the past three decades to secondary care nursing service delivery in the States.[9]

A shift from the current hierarchical model used in most New Zealand general practices to a shared governance model will require recognising equity of professional roles, ownership of responsibilities by all staff, accountability for one's practice and commitment to a partnership philosophy by all participants. It is also likely to mean improved job satisfaction, higher organisational effectiveness through improved communication and anecdotally better patient satisfaction and health outcomes.

At a practice level, the philosophy, commitment and structure of the organisation would need to be focused towards true sharing of governance. This would mean that PNs would expect to be and would accept the responsibility for being integral to long-term goal setting for the practice and successful achievement of those goals. Having the knowledge available to them to

make clinical decisions at the point of service, they would know enough about the funding structure and implications of adjusting clinical service delivery that these decisions would benefit or, at the very least, not jeopardise the general practice business.

Some practices believe that they already function under this model and perhaps they do. But often when speaking to PNs within these 'enlightened' practices one finds that their clinical services are still very much monitored and restricted by the practice business needs, and comments about being 'allowed' to make clinical changes is still the norm. This may be a reflection of a lack of sufficient education or the inability of the PNs to assume the responsibility of professionalism and self-governance.

Implementing shared governance is likened to 'pinning jelly to a wall' by a leading authority from the United States.[10] A clear understanding of the model, support from mentors and long range planning will help decrease the possibility of negative outcomes and facilitate the acceptance and feeling of capability that will be required by all stakeholders to progress this model. But once shared governance is achieved the ability of the PNs to provide an appropriate and truly responsive nursing service will be enhanced immensely.

A patient-centred service

There is no doubt that experienced and well-educated PNs are capable of a much greater contribution to the delivery of primary health care and many GPs are eager to utilise the PNs more effectively. Primary health care nurses practising in remote/rural areas of New Zealand are a good example that, if given the opportunity, nurses can and will adjust their practice to not only relieve doctors of considerable workload, but also generate new business opportunities for medical practices.

In my future, PNs being enabled and empowered by the shared governance model adopted in the practice, will work more closely alongside other primary health nurses and providers in the primary health care sector, providing a patient-centred service that guides the patient through the maze of primary and secondary health services they encounter. This may include utilising the PNs skills in chronic disease management and their holistic focus to provide a case management service for the patient within this integrated primary health team.

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The inclusion of other providers, for example Plunket or district nurses, into the general practice team, by means of contracting for example, seems a sensible solution to the risk of service delivery fragmentation and service overlap where patients may fall through the gaps. At the very least the primary health care team must have a communication strategy that ensures a seamless service is possible, whether or not they are all in the same physical location.

Employment models for practice nurses

Although some of the current employment models for PNs are deterring innovative and responsive nursing service delivery, due to the constraints of the private business model or the lack of understanding or willingness to change of the employer, who is in many cases the general practitioner, other models have proved successful in providing comprehensive patient health care and health promotion programmes. For example, in the USA, the National Nursing Centers Consortium has attracted federal grants and funding to continue their work in communities across America.[11] In New Zealand a partnership pilot project in Aranui, implementing a nurse-led clinic alongside general practitioners and introducing a mobile nursing service, is evolving into a mobile community nursing role with emphasis on nurse care management.[12]

Other options for the future employment of PNs in New Zealand may be a Primary Heath Organisation (PHO) as an employer, as some PHOs in New Zealand have already implemented, or indeed the District Health Boards (DHBs), who already employ the majority of New Zealand's nursing workforce and who have been given the responsibility to oversee the primary health care sector. It will be imperative, whatever model is adopted, that the collaborative relationship, professional trust and respect between the PNs and GPs is established and maintained, so that the services provided are mutually complementary and not competitive. One size does not fit all but it is obvious that, as stated above, to be able to effectively govern one's own professional practice and provide a service that will answer the needs of a community and the requirements of the Primary Health Care Strategy, the PN may need to seek alternative employment models.

Conclusion

If PNs are to reach the potential that is already articulated in government documents[2,1,3] there must be fundamental changes in the attitudes of all stakeholders and in the structures and funding that affects current nursing service delivery. Governance is about power, control, influence and authority.[13] To have an autonomous and effective practice nursing service, the power

base must shift from the current hierarchical employer/employee focus to one of shared governance, regardless of whether the employment status changes. If PNs are enabled to take professional responsibility for their clinical decisions, enhance their employment relationships and environment and improve their job satisfaction, general practice businesses will ultimately benefit.

It is the responsibility of nurses to assist with effecting change towards providing a seamless patient-centred health care service within a multidisciplinary team. To do this they must accept the responsibility of professionalism and autonomy and engage and collaborate with other stakeholders to begin or complete the changes to enhance the proven successful model of organised general practice.

Competing interests

None declared.

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