EDITORIAL

Myths, cautions, and solutions: Nurse practitioners in primary health care in Aotearoa New Zealand

Ngā paki, ngā whakatūpato me ngā rongoā: Ngā tapuhi mahi i roto i te taurimatanga hauora tuatahi i Aotearoa

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Aotearoa New Zealand is set to reach 500 registered nurse practitioners (NPs) by the end of 2020. Just over half of these work in settings which can be broadly defined as delivering primary health care (PHC)[1] services to a wide range of population groups and communities. Local providers employing NPs or contracting for their services extol their value, yet the recognition that NPs can deliver comprehensive and meaningful PHC services remains lacking at policy, planning, and funding levels of the health sector.

The health sector awaits the final report of the New Zealand Health and Disability Service Review (HDSR), chaired by Heather Simpson, and due to be delivered to the Minister of Health at the end of March 2020. The Interim Report (HDSR, 2019) addressed the failure of the sector to implement widely the vision of the Primary Health Care Strategy (King, 2001), particularly regarding equity and access. The Interim Report stated that if the "system is to be more equitable and more sustainable, [then] significant change was required" (HDSR, 2019, p. 3). Two key areas for change included strategies to ensure the future workforce reflects the community it serves with the necessary skills to effectively operate different models of care; and health services planned with more meaningful engagement and improved connections (HDSR, 2019). With the Report affirming the goals and direction of the PHC Strategy, we should expect nursing and NPs to be central to the future of the PHC sector.

Over the last five years the numbers of NPs registering each year has accelerated, and while it may be too soon to claim to have reached the "tipping point'', we most certainly can claim that NPs are here to stay, are sought after by employers, and offer great potential for improving the health outcomes of people in Aotearoa. The first 15 years of the NP project in Aotearoa required extraordinary tenacity and commitment by individual Registered Nurses (RNs), NPs, nurse leaders, the Nursing Council of New Zealand (NCNZ), tertiary education institutes, local providers, and other champions, to overcome a vast array of barriers and hurdles (Adams & Carryer, 2019). Their efforts and persistent work have seen Aotearoa develop a robust legislative, regulatory, and educational framework, which is the envy of many countries.

Yet, despite the successful implementation of NP services in various settings in Aotearoa, myths and misunderstandings about NPs remain across many levels of the health sector.

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[1] Primary health care is defined in line with the World Health Organization's Declaration of Astana (2018) and includes promotive, preventive, curative, rehabilitative services and palliative care.

There is ongoing misunderstanding about the far-reaching scope of NP practice[2]. Nurse practitioners are additionally educated to practice at a standard equal to both medical colleagues in general practice, and those who hold registrar positions in secondary services, having the same prescriptive authority. They assess, order diagnostic tests, diagnose, treat, prescribe, and refer, as does a general practitioner (GP). Further legislative changes enacted through the omnibus Bill (Health Practitioners (Replacement of Statutory References to Medical Practitioners) Bill, 2015) covered eight other pieces of legislation and replaced "medical practitioner" with terminology to also include other health practitioners[3].

There is ongoing ignorance about the capacity of NPs to generate income in PHC settings. Nurse practitioners can claim general medical services (GMS) funding; they can enrol their own patients and claim capitation funding; they can own their own practices or buy into an established practice; employ staff; and issue standing orders. They can work within, for example a Māori, or Pacific provider organisation, and deliver general practice services; or be contracted to deliver services for aged residential care facilities. There is no requirement for NPs to work with GPs, either virtually or directly. They are independent and autonomous practitioners and fully accountable for their own practice under the Health Practitioners Competence Assurance Act (2003). The concern expressed by some medical practitioners that they are accountable for the practice of NPs is a fallacy. Here it is necessary to caution against NPs being used as "substitutes" for GPs. For example, a GP shortage led to an NP being pulled away from their outreach work with Māori whānau to provide core primary medical services; and some NPs are required to work within a narrow biomedical specialty rather than practising from the broad, holistic remit that underpins NP preparation. These examples will not yield the health gain possible through NP work. More people are living with long-term conditions and co-morbidities; the population is ageing; more people are experiencing mental health and addiction issues; and we are failing to protect the health and wellbeing of our most vulnerable groups. Health inequalities for Māori, and Pacific persist at unacceptably high rates. The enduring and dominant model of GP-led primary care based within an acute biomedical-pharmaceutical model of care has fallen short of improving health outcomes for many of these population groups, including the rural population. The Interim Report of the HDSR (2019) stated that:

> *Continuing with the current model of care, based largely on a Western medical model, employing more and more medically qualified staff focused on treating illness, rather than promoting wellness, will not only be ineffective in achieving the equitable outcomes we desire, it will not be sustainable. (p. 2).*

The World Health Organization's (WHO) Declaration of Astana in 2018 has reiterated the necessity of strengthening PHC, increase the capacity of the workforce, and improve access. Further the WHO stated:

> *We find it ethically, politically, socially and economically unacceptable that inequity in health and disparities in health outcomes persist. (WHO, 2018, para III).*

Instead, we require a model of care that is culturally embedded; improves access to health services for individuals, whānau, and communities; promotes social justice focusing on reducing disparities; and works seamlessly across health, social service, justice,

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2 For full NP Scope of Practice see https://www.nursingcouncil.org.nz/Public/Nursing/Scopes_of_practice/Nurse_practitioner/NCNZ/nursing-section/Nurse_practitioner.aspx?hkey=1493d86e-e4a5-45a5-8104-64607cf103c6

3 The Health Practitioners (Replacement of Statutory References to Medical Practitioners) Bill (2015) has enabled NPs to, for example, issue certificates for the cause of death; certify proof of sickness or injury; supervise designated prescribers; prepare individual rehabilitation plans through the Accident and Compensation Corporation (ACC); carry out medical examinations ordered by the Court for victims of abuse; and complete applications for assessment under the Mental Health (Compulsory Assessment and Treatment) Act 1992.

corrections, and education sectors. The NP workforce offers the opportunity to deliver comprehensive and meaningful PHC services embracing a nursing paradigm of care, grounded in social justice, with a biomedical-pharmaceutical approach (Browne & Tarlier, 2008). Indeed, NPs "offer the exact transformation in care that the WHO seeks" (Carryer & Adams, 2017, p. 526). However, maintaining a philosophy of delivering PHC services to improve health outcomes and reduce health inequalities is a considerable challenge in our current neoliberal health policy and funding climate. Providers and NPs delivering services at a local level are confronted with a contracting and reporting environment set within the context of an expansive hierarchical health bureaucracy that limits their time and ability to deliver multidisciplinary, collaborative care. While it is laudable that NPs' work has been recognised as filling health workforce gaps, Aotearoa is in danger of missing the true value of NPs.

The international evidence of NPs delivering at least equivalent outcomes to GPs is unequivocal (for example, Laurant et al., 2018). Perhaps more interestingly, there are various parameters for which NPs are delivering improved health outcomes, relating to mortality rates, physiological measures, and patient satisfaction with increased health literacy. We can theorise the likely reasons for these outcomes, such as bridging biomedicine with nursing, focusing on engagement and relationships, and delivering culturally safe services. However, research is now required to explore the "value-add" of NP work, particularly to meet the needs of our Māori, Pacific, vulnerable, and rural communities. With the recommendations of the HDSR released in March 2020, we must actively engage in dialogue with providers, PHOs, DHBs, and the Ministry of Health, to ensure the sector knows that NPs offer the transformational change required to deliver comprehensive and meaningful PHC services.

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