THE GENESIS OF ADVANCED NURSING PRACTICE IN NEW ZEALAND: POLICY, POLITICS AND EDUCATION

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Abstract

When New Zealand's first Nurse Practitioner was approved by the Nursing Council of New Zealand in December 2001, it was the centenary year of New Zealand nursing registration, but less than a decade after the commencement of New Zealand's first pre-registration nursing degrees. What were the conditions and forces in play that saw nursing achieve a new emphasis on advanced clinical education and practice, culminating in the development of an advanced, expanded scope of nursing practice? This contemporary historical study examines the professional and sectoral milieu of the 1990s and the turn of the 21st century, together with the policy initiatives undertaken to advance nursing in New Zealand during that period.

Key Words: Advanced nursing practice, Nurse Practitioner, nurse prescribing, policy.

Introduction

In the late 1990s, as an era of public sector reform settled, conditions were ripe for the development of the Nurse Practitioner (NP) in New Zealand. The Nursing Council of New Zealand (the Nursing Council), the statutory body governing the practice of nursing for the protection of the public, had confirmed the undergraduate degree in nursing as the requirement for entry-to-practice. A Ministerial Taskforce on Nursing (1998) had determined that there were systemic barriers to nursing's ability to deliver on its potential. While health had become "overtly politicised" from 1972 onwards (Dow, 1995, p. 214), the 1980s and 1990s brought an intense political focus to improve efficacy and efficiency in the health system (Finlayson, 1996). Nevertheless, in the late 1990s serious concerns persisted regarding delivery of primary health care, fragmentation of health services and the burden of chronic disease (Ministry of Health (MOH), 1996). In response to these issues, two successive Ministers of Health had demonstrated support for legislative and policy initiatives that could enable nurses to more effectively deliver primary health care

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and other specialist nursing services (Manchester, 1998; Minister outlines opportunities for nurses, 1997; MOH, 2002).

However, in spite of this favourable environment, the development of what was being termed "advanced nursing practice" was by no means assured. In particular, efforts to expand nursing jurisdiction into legitimated diagnosis and treatment, including prescribing, were met with anticipated inter-professional jurisdictional disputes. However, what was perhaps not well anticipated were the intra-professional conflicts.

Drawing on contemporary historical research (Jacobs, 2005), this article examines the professional and sectoral milieu of the late 1980s and 1990s. It explores the forces in play that enabled nursing to achieve a new emphasis on advanced clinical education and practice, culminating in New Zealand's Nurse Practitioner.

History provides evidence, counteracting what Michael King (1985) referred to as a "sandcastle culture" where "our many small constructions are completed, admired, and then washed away, unknown to those who follow …. Such a process – such cultural amnesia – handicaps us because it prevents building on sound precedents or harnessing experience already tested" (p. 186-187).

It is hoped that this exploration will assist nursing to recall, and build on the precedents and experiences gained in the late 1990s and turn of the 21st century.

Research approach

Drawing on semi-structured interviews/oral history, sociological, historical and political analysis methods, the research from which this article has been developed, sits within the late 20th century understanding of historical sociology (Green & Troup, 1999). Historical sociological studies focus on active processes over time, accounting for outcomes.

> For (historical sociologists) the world's past is not seen as a unified developmental story …. Instead it is understood that groups or organizations have chosen, or stumbled into, varying paths in the past. Earlier "choices" in turn, both limit and open up alternative possibilities for further change, leading toward no predetermined end. (Skocpol, 1984, p. 1-2)

The concept of "advanced nursing practice", as discussed in this article, refers to expanded and extended expert nursing practice, including nurse prescribing, supported by a Master's degree in nursing. New Zealand's advanced nursing practice development is part of an international movement involving more than forty countries, and as described by the International Council of Nurses (ICN), the Nurse Practitioner/Advanced Practice Nurse (NP/APN) is one who

> has acquired the expert knowledge base, complex decision-making skills and clinical competencies for expanded practice, the characteristics of which are shaped by the context and/or country in which s/he is credentialed to

> practice. A Master's degree is recommended for entry level. (ICN, 2003)

The characteristics of the NP/APN as discussed by the ICN include practice which encompasses advanced patient assessment and diagnostic reasoning skills, case management or own case load, regulatory mechanisms providing for diagnostic and prescriptive authority, and a formal system of licensure or credentialing.

The 1990s: Setting a context

Nursing development in the 1990s occurred in the wake of radical socio-economic and public sector reform.

> If called upon to explain the comprehensive transformation of New Zealand between the 1960s and the 1990s, the word, "1984" would occur to many. In that year, the reforming Labour government was elected. It proceeded to comprehensively restructure the New Zealand state and economy, in the direction known as "New Right", "neo-liberal", or "free-market". Its policies were continued ... by the fourth National government of 1990-1999. (Dow, 1995, p. 214)

Seven months after its December 1990 election, the incoming National government advised its intentions to radically reform New Zealand's health care system. Elected Area Health Boards were immediately disestablished, and the next few years saw the creation of a plethora of agencies designed to separate government funding agencies from provider arms, and to create competition among public, private for-profit, and private non-profit providers of services (Gauld, 2001; Scott, 1990). Nursing leadership in hospitals and area health boards was dismantled. The positions of Chief Nurse or Director of Nursing in area health boards were disestablished, and replaced by advisory roles. The voice of clinical nursing struggled to be heard.

In spite of nursing education being sited within the tertiary education sector, opportunities for further nursing education were limited. In 1991, entry-to-practice requirements had yet to be established as an undergraduate degree, and the development of clinical practice had been stunted by a lack of coherent, accessible post-registration educational pathways.

In the charged environment of the late 1980s and early 1990s, the range of professional objectives of the New Zealand Nurses' Association (NZNA) largely became overtaken by its "industrial" concerns (Hine, 1997; Stodart, 1991; Ten years of our time: A review of nursing in the 1980s, 1989). The State Sector Act (1988), which ushered in the reforms of the public sector, required NZNA to register as a union. By 1993 the organisation representing nurses in the private sector, the Nurses' Union, had amalgamated with NZNA forming the New Zealand Nurses' Organisation (NZNO). By the mid-1990s NZNO considered that it should become a "nursing/midwifery and allied health workers' organisation representing as many health workers as possible" (Viewpoint: One health union, 1994/5, p. 16).

Refocusing on clinical practice

As early as 1991, the Minister of Health, Simon Upton explicitly signalled government's view of the potential for nursing to expand its practice. In a lengthy editorial in *Kai Tiaki* Upton (1991/1992) noted,

> Nurses are key players in the health system, but over the years have struggled to overcome being perceived and treated as "hand-maidens" to doctors ... . The reforms ... will ... open the way to many more opportunities and innovative approaches across the health system ... I think nurses should be looking carefully at these opportunities ... . Primary care is an area which I believe deserves far more attention ... there should also be more options for nurses working in the community. I realise there are legislative barriers to nurses carrying out some procedures, and this is something I am looking at – with your input ... . In some countries nurses see and examine patients, make diagnoses and referrals and write prescriptions alongside doctors. Nurses bring a unique focus which is complementary to the medical model. (p. 2-3)

In that same year, NZNA (1991) released *A Proposal for Career Development for Nurses in Clinical Practice*. It noted,

> The 1990s herald change for the nursing profession in New Zealand. Time honoured structures have all but disappeared, and new issues and challenges confront nurses ... . This severance from traditional forms provides the opportunity for professional nursing to ... re-focus unequivocally on clinical practice ... . (p. 1)

The NZNA proposal described five levels of nursing practice based on experience, education, complexity of practice role and setting, and clinical leadership. Clinical career ladders were progressively introduced throughout the country during the 1990s, however they were greeted with limited and distracted enthusiasm as a new round of reforms swept the country.

Arising from these reforms, a Clinical Training Agency (CTA) was established in 1994/5 to fund post-entry health professional education. The funds allocated to the CTA were primarily constituted from historical funding for medical student training. At the time of its establishment, no funding for post-registration nursing education was provided by CTA. In 1994, Frances Hughes, then a Director of Mental Health at Capital and Coast Crown Health Enterprise, made a case for a clinically-based, post-registration programme in mental health nursing, and subsequently achieved funding for the first post-registration nursing programme financed by the CTA (Interview with F. Hughes, Aug 22, 2002).

Concerned by the potential for further *ad hoc* clinical, post-registration nursing programmes being funded, Hughes and colleague Jill White (then Professor of Nursing and Midwifery at Victoria University), initiated dialogue with the Nursing Council about the

need for an education framework including specialty and advanced practice programmes. It was their view that such a framework would be a means to develop advanced nursing practice.

Judy Kilpatrick was appointed to the Nursing Council in 1996, and elected Chairperson at the first meeting she attended in May of that year. It was during 1996 that their work on developing standards for post-registration nursing education began. In December 1996, the first draft of this framework, which differentiated specialist and advanced nursing practice, was completed. Following extensive consultation, the Nursing Council published its *Framework, guidelines and competencies for post-registration nursing education,* in 1998.

Concurrent with the development of the above *Framework*, leaders in professional nursing organisations were also exploring the development of advanced nursing practice. Nurse Executives of New Zealand (NENZ) is an organisation of Directors of Nursing/the most senior nurse/s in District Health Boards/major health provider organisations, and the senior nurse from each, the Department of Corrections, Ministry of Defence, Department of Occupational Safety & Health, and MOH. In January 1998 NENZ convened a meeting with representatives from key organisations – NZNO, the College of Nurses Aotearoa (NZ) [CNA(NZ)], Nurse Education in the Tertiary Sector (NETS) (the Heads of Schools of Nursing), and the Nursing Council – to discuss the role and preparation for a NP in New Zealand. In exploring the desired role of a NP it was generally agreed that this practitioner would be

> Able to differentially diagnose, manage the whole patient, undertake risk management ...reflect on practice ... involved in health promotion, expert front-line care. The outcome for clients should be better patient outcome and quality of life ... and ... probably 1000 (would be) required in the next two years. (Report meeting with NENZ re: NP role, Friday Jan 30, 1998, S. H. Jacobs, personal papers)

NENZ subsequently published their proposal, *Developing and supporting advanced practice roles: Clinical nurse specialist, nurse practitioner* in April 1998.

Nurse-prescribing

Earlier, in 1994, a discussion paper on the possible extension of prescribing rights to nurses and other health professionals had been commissioned by the MOH. Its author, Professor John Shaw commented,

> In 1992 ... Government considered a paper on occupational regulation of the core health professions ... . One of the issues covered in that paper was that of extending prescribing rights for nurses ... . Extending prescribing rights to nurses could increase efficiency by providing access to health care which might otherwise be unavailable; potentially reducing pharmaceutical costs as nurses tend to use other therapeutic approaches before drugs, (the recent experience from expanding

> prescribing rights to midwives has demonstrated this effect). (Shaw, 1994, p. 8-9)

Frances Hughes, who had been appointed as a nursing advisor in the MOH in 1996, was asked to chair groups to consider the extension of prescribing rights to nurses. She noted,

> There was always a great deal of support from both administrations ... . I don't think the Ministry particularly was – because it was taking on the doctors ... . What is significant about the prescribing work is that there was an absolutely overt means of embedding nurse-prescribing into advanced practice, and this is one of the key drivers that linked the two together ... . No one set out in the Government or the previous National Government to have a policy about the NP. (Interview with F. Hughes, Oct 22, 2002)

Subsequently, a working party to explore matters relating to safety and quality in extending prescribing rights was convened, and its report (MOH, 1997) was published November 1997. Shortly after this, on May 12, 1998 (International Nurses Day), the Minister announced his intention to introduce legislation to enable the extension of prescribing rights to nurses and other health professionals. Two areas of nursing practice had been selected for policy work for the introduction of limited nurse prescribing. These were child family health and aged care. Frances Hughes, who had been appointed Chief Nurse Advisor, MOH in 1997, noted, "We were making suggestions from the Ministry to the Government, because Council had not dealt with nurse-prescribing. It literally was the Minister's choice" (Interview, Oct 22, 2002).

Following the Minister's announcement, it became evident that the profession was divided by multiple discourses relating to prescribing. Some nurses suggested that nurse-prescribing was a sly move by policy-makers to institute "cheap doctoring", or at the very least, it was a practice that would "taint" the essence of nursing (Beekman & Patterson, 2003; Making us cheap doctors, 1992; Stodart, 1992). Other nurses saw nurse prescribing as advantageous to patients, but could not see themselves expanding their practice in this way.

Additionally, the complexity of extending limited or circumscribed prescribing rights was probably not well understood by nurses. Shaw's (1994) discussion paper noted,

> In all submissions, the range of prescribable items requested by nurses was small and directly related to their scope of practice ... . While this approach is sensible, it does provide some major administrative difficulties. Because the range and scope of nursing practice is so varied, each individual group of nurses will have different requirements. The provision of 30 or 40 separate "nurse formularies" is neither logical nor desirable. (p. 56)

However, some nurses made a case for prescribing across a much wider context, including limited prescribing

for all registered nurses. Hughes' observation suggests the political realities for extending prescribing at that time:

> I had people ringing up and saying, "That's not the way to go. We should go the way of the midwives." I thought, it's nothing like the midwives. We have 33,000 registered nurses. We will lose the war (Interview with Hughes, Oct 22, 2002).

The "war" was the inevitable conflict with the medical profession. Registered midwives had been granted prescribing rights in the Nurses Amendment Act 1990. However, as noted in the Shaw paper, while midwives have an "unlimited list" of drugs, they prescribe only within their scope of practice; that is prenatal, intrapartum, and postnatal care. Furthermore, midwives constitute a small group, estimated at 2030 active midwives in 1999 (Nursing Council of New Zealand (NCNZ), 2000, p.16). With the Minister now advocating "nurse-prescribing, extended roles ... shifting of professional boundaries" between nurses and physicians (Minister outlines opportunities for nurses, 1997), it could be anticipated that these moves would not be widely embraced by physicians. Indeed, in a two-page editorial, Anton Wiles, Chairman of the New Zealand Medical Association (NZMA), created the spectre of patient endangerment due to nurse-prescribing (Wiles, 1998a). As Shaw noted, there would be "turf battles", and the "knee-jerk response will be 'Over our dead bodies' " (MacLennan, 2000, p. 10).

Ministerial Taskforce on Nursing

On February 23, 1998, the Minister of Health, Bill English, established a Ministerial Taskforce on Nursing "to recommend strategies to remove the barriers which currently prevent registered nurses from contributing to a more responsive, innovative, effective, efficient, accessible and collaborative health care service for New Zealanders" (Ministerial Taskforce on Nursing, 1998, p. 8). In launching the Taskforce, the Minister noted,

> nurses were concerned about historical, prescriptive rules and regulations around how nurses worked and other barriers which prevented them from fulfilling their potential ... . The profession sought my support to establish such a taskforce and I was, in fact, thinking along fairly similar lines. (O'Connor, 1998, p. 10)

Jenny Carryer, Executive Director of the CNA(NZ) recalled how she went to see the Minister in November 1997.

> I drew up a ... case around the major barriers that were impeding the development of nursing, and pointed out how they were interlocked, and ... were high level ... . To resolve them we needed to understand them better and have a strategic plan, ... bring(ing) together all the nursing organisations and a funded Ministerial taskforce ... . I think he ... was frustrated by the ... recycled nature of the problems in delivering health care, and I think he thought that resourcing

> and spending some energy on nursing would pay dividends. (Interview with J. Carryer, Jul 22, 2002)

Following its establishment in February 1998, the Taskforce conducted extensive consultation, receiving individual and group submissions; carried out a number of consultative gatherings with Maori; and conducted a series of ten focus group meetings throughout New Zealand (Ministerial Taskforce on Nursing, 1998, p. 9-11). When, in May, the Minister announced the government's intention to extend prescribing rights to nurses, it would seem the Minister was adding impetus to what would be one of the Taskforce's eventual recommendations.

The report of the Taskforce outlined thirty-seven recommendations. These addressed issues relating to the need for the expansion of the scope of nursing practice; barriers to funding of post-registration and postgraduate nursing education; support for nursing research at the national level; the loss of a nursing voice in senior level health management and policy arenas; broad workforce issues; and concerns of particular import to Maori. At the time it was the hostile withdrawal of NZNO from the process that captured attention.

NZNO and advanced nursing practice

The preface to the *Report of the Ministerial Taskforce on Nursing* (1998) underscored the fracture within the profession.

> Unfortunately, in spite of considerable effort and weeks of discussion, we were unable to find consensus with the New Zealand Nurses' Organisation (NZNO). The NZNO has been part of the Taskforce for the last five months ... . Many changes were made to drafts of this report to accommodate the concerns of NZNO. The outstanding issues, as far as we can determine, relate primarily to the status and role of NZNO rather than to the Taskforce's terms of reference or to patient outcomes ... . It is with regret that we must present this report without the support of NZNO. (p. 5)

In the August 1998 editorial of *Kai Tiaki*, written by NZNO Chief Executive, and member of the Taskforce, Brenda Wilson, a number of reasons for NZNO's withdrawal were delineated (Wilson, 1998). The editorial noted NZNO's disagreement with the Taskforce's recommendation for masters-level education for advanced and specialist roles, arguing that years of experience was a valid determinant of advanced practice. In this stance, NZNO's executive ignored the organisation's 1991 document on clinical practice development, and its earlier wisdom on the complementary value of experience, education and clinical leadership.

However, perhaps the major issue for NZNO's executive was the Taskforce's recommendation for the Nursing Council to regulate advanced practice. NZNO seemed not to appreciate that the Nursing Council was the only neutral and legitimate body to carry out credentialing of advanced NPs.

The NZMA seized the opportunity created by a profession divided to wade in alongside NZNO, in an attempt to discredit the Taskforce report. In an *NZMA Newsletter* editorial titled "Two Professions Share Misgivings", Anton Wiles asked, "Can you imagine how much confidence doctors would have in a Report from a Ministerially appointed Taskforce on Medicine, if the NZMA rejected it?" (Wiles, 1998b, pp. 1-2). The misgivings cited by Wiles related to the potential loss of doctors' near-exclusive jurisdiction. These included fears that nurses might gain capitation funding as suggested in a Health Funding Authority draft plan. Wiles also found it concerning that

> The Taskforce wants nurses to have more than prescribing rights – e.g. access to laboratory and diagnostic tests, specialist referral and ACC payments. Furthermore, it endorses Ministry proposals for ... a system of specialist and vocational registration for nurses, similar to that of the medical profession. (Wiles, 1998b, p. 1)

Struggling in the changing tide, NZNO leadership undermined the relevance of the Taskforce report, and polarised the profession.

Not infrequently, persons "new to the scene" can bring a different perspective. Shortly after the publication of the *Report of the Ministerial Taskforce on Nursing*, Ketana Saxon, Chair of the NZNO national student unit during 1994/95, and a registered nurse of only two years experience, wrote in *Kai Tiaki*:

> In regard to the taskforce report and subsequent debate, ... the majority of nurses still work in clinical settings where the ability to translate nursing vision into practice is severely restricted ... . In such a climate, is it unreasonable to suspect that the move to encourage nurses to take on aspects of doctors' work could yet be another cost-cutting exercise? At the same time it is worrying to hear nurses ... dismiss aspects of the taskforce recommendations, which have the potential to empower and enhance nursing roles, as the ideas of an "elitist" group. (Saxon, 1998, p. 19)

The 1990s had brought unprecedented and difficult challenges to NZNO. But by 2000, détente had developed. NZNO's position statement on advanced nursing practice stated, "Being an expert-by-experience in a specialty is not on its own sufficient for advanced nursing practice" (NZNO, 2000). It went on to note the relevance of postgraduate study, and the appropriateness of the regulation of advanced nurse practitioners by the Nursing Council. It cited the Ministerial Taskforce Report in its bibliography.

The New Zealand Nurse Practitioner

In March 2001, the Nursing Council published *The Nurse Practitioner™: Responding to health needs in New Zealand*. In introducing the document, they noted,

> In 1998 the Ministerial Taskforce on Nursing supported the development of a Nurse Practitioner™ role and

> recommended that the Minister of Health direct the Nursing Council to develop and validate specialist competencies that linked to nationally consistent titles ... . This document provides details of the Nursing Council's framework for the regulation of Nurse Practitioners™ ... . It combines and updates previous documents ... regarding the Nurse Practitioner™ and nurse prescribing. (p. 9)

At this time the Nursing Council trademarked the term, Nurse Practitioner. "The title Nurse Practitioner will be protected by the Nursing Council and will only be able to be used by those who succeed in meeting Council requirements" (NCNZ, 2001, p. 10). The use of trade marking conveyed the significance and exclusivity of the title, and interestingly, it also conveyed the language of the market. In 2004, arising from the Health Practitioners Competency Assurance Act (2003), the Nursing Council designated four scopes of practice, described under the titles: Nurse Assistant, Enrolled Nurse, Registered Nurse, and Nurse Practitioner. Subsequent to this, trade marking of the term Nurse Practitioner was no longer necessary. At the end of 2001, the centenary year of New Zealand nursing registration, Deborah Harris became New Zealand's first NP.

Summary

The reforms of the late 1980s and early 1990s signalled opportunities for nursing to expand its jurisdiction, creating greater capacity for the profession to address population health concerns. However it was not until the late 1990s that New Zealand achieved its system of undergraduate pre-registration nursing education and a foundation for growing postgraduate development and advanced practice. In order for the opportunities foreshown in the health reforms to be realised, it required nursing leadership across a range of organisations to couple strategies and solutions to the persistent problems of health inequalities, fragmentation of health services and the burden of chronic diseases.

Jenny Carryer, Executive Director of the CNA(NZ), Frances Hughes, Chief Nurse Advisor in the MOH, and Judy Kilpatrick, Chair of the Nursing Council were able to drive significant change. Drawing on the international advanced nursing practice momentum, these leaders, together with others in NENZ, the Nursing Council, CNA(NZ), NETS and the MOH created the policy impetus to enable a new emphasis on postgraduate clinical education and practice, and the development of the New Zealand NP.

However, the era of extensive and radical public sector reform had decimated familiar clinical leadership structures and contributed to a counter-current of mistrust and cynicism. In this environment, New Zealand's oldest, largest nursing organisation, NZNO struggled to focus, and instead saw its mission to become a super-union, representing as many health workers as possible. Opportunities to collaborate with other nursing organisations such as CNA(NZ), the Nursing Council, and

NENZ were eschewed. Fortunately, co-operation to achieve the NP superseded intra-professional conflict.

Conclusion

Forty years earlier in the United States, nurses there drew on similar social and political conditions to develop the NP. Reflecting on this, Loretta Ford, co-founder of the first NP programme noted, "The NP movement is one of the finest demonstrations of how nurses exploited the trends in the larger health care system to advance their own professional agenda and to realise their great potential to serve society"(Bigbee, 1996, p. 18). In a further forty years from now, will New Zealand nurses voice similar reflections?

History enables us to build on what has gone before. It is hoped that this exploration of the development of the New Zealand NP will counter-act the potential for King's "sandcastle culture" in nursing – and that this study will contribute to our future efforts in demonstrating collective leadership across the range of health and social policy arenas.

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