



# The training and education of nurse practitioners in Aotearoa New Zealand: Time for nationwide refresh

Te whakapiki i te whakangungu me te akoranga mō ngā mātanga tapuhi i Aotearoa: Kua tae ki te wā me whakahou mō te motu katoa

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## Citation

Adams, S., Oster, S., Davis, J. (2022). The training and education of nurse practitioners in Aotearoa New Zealand: Time for nationwide refresh [Editorial]. *Nursing Praxis in Aotearoa New Zealand*, 38(1), 1-4.

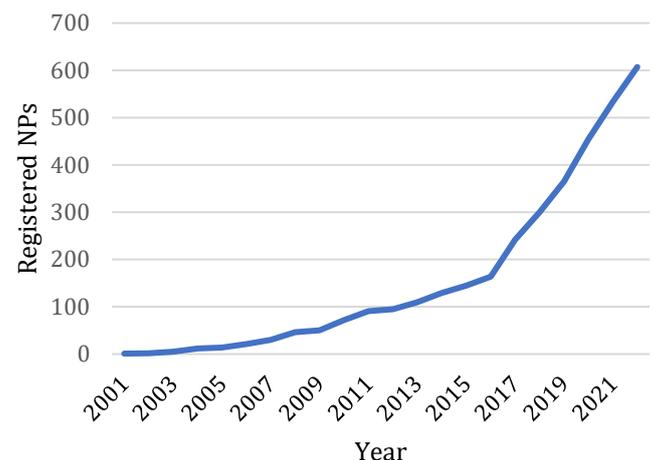
<https://doi.org/10.36951/27034542.2022.01>

## Introduction

Twenty years ago saw the first mātanga tapuhi/nurse practitioner (NP) registered in Aotearoa New Zealand; the launch of the Primary Health Care Strategy (King, 2001); and a white paper (Hughes & Carryer, 2002) describing the potential of a NP workforce to improve access to healthcare and equity of health outcomes. Since that time, we have witnessed concerted efforts by nurse leaders, educationalists, NPs, and colleagues across the health and disability sector to ensure the foundational educational, legislative, and regulatory requirements are in place to enable NPs to work to their full scope of practice as advanced practitioners and authorised prescribers (Nursing Council of New Zealand [NCNZ], n.d.). A NP's work is similar to a general practitioner in primary care or to a registrar in the hospital environment, with unequivocal evidence that health outcomes achieved by NPs are at least equivalent, indeed, oftentimes superior (Laurant et al., 2018; Martínez-González et al., 2014). But this only tells a part of the story. Nurse practitioners bring a nursing paradigm to their advanced role, which embraces an understanding of the socio-economic-cultural context of the lives of whānau, commitment to relational care, and the leadership to identify health needs and bridge gaps in service delivery (Browne & Tarlier, 2008; Carryer & Adams, 2017). Approximately 55% of NPs work in areas broadly

defined as primary health care (PHC), with perhaps 40% working in more traditional primary care and general practice settings.<sup>1</sup> As we enter the third decade of the NP workforce in Aotearoa New Zealand, with 607 NPs now registered with NCNZ (Figure 1), it is time to revisit current education and training and ensure we are holding true to the intent of the NP project.

**Figure 1:** Total number of NPs registered with NCNZ through to end February 2022 (note, usual end of year figures are to 31 March)



From the outset, the requirement for registration as a NP was a clinical master's degree, with specific courses on advanced pathophysiology, advanced health assessment and diagnostics, pharmacology,

<sup>1</sup> C. Lane, Ministry of Health, personal communication, March 15, 2022



and an advanced clinical practicum. Early NPs were pioneers. They were highly experienced nurses who were leaders in their clinical environment and often within their communities; and had the tenacity and mana to progress their career. They often had undertaken multiple clinical and postgraduate courses over many years and had a breadth and depth of knowledge that supported their shift into a NP role (Adams & Carryer, 2019; Gagan et al., 2014). The slow growth of NPs in the first 15 years was testament to the range and complexity of challenges and hurdles faced (Figure 1). But as the programme of education has been streamlined with a pathway that is easier to navigate (at least for some), are we now doing enough to create NPs as future leaders of our health services? Do we have a training and education system that delivers equity for the workforce as well as for the communities we serve?

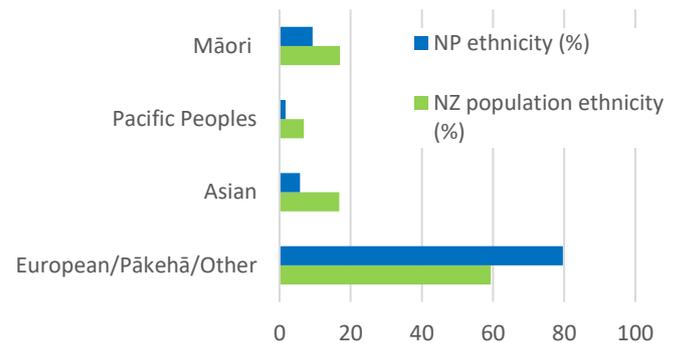
### Ethnicity

Māori NPs (9.3%) and Pacific NPs (1.7%) are a scarce resource and grossly underrepresented when compared to the ethnicity of the Aotearoa New Zealand population (Figure 2). Nearly 80% of all NPs are European/Pākehā. These figures are shameful for a country that has been promoting equity since the Primary Health Care Strategy in 2001 (King, 2021). Indeed, if we were truly committed to the endeavour of health equity and Te Tiriti o Waitangi (Te Tiriti), Māori NPs (and, indeed Pacific NPs) would be overrepresented in the figures (Chalmers, 2020). Work is currently underway with a growing cohort of Māori RNs at various stages of their pathway, and we expect this to provide valuable insights into the frameworks required to support their successful registration and work as NPs.

### Access to funding

The allocation of funding by the district health boards (DHBs) for postgraduate nursing education is inequitable and lacks strategic workforce planning. The funding is received from the Health Workforce Directorate (previously Health Workforce New Zealand) with the director of nursing (DoN) of the DHB managing the application process and allocation employed directly by the DHB are often at a

**Figure 2:** The ethnicity of the NP workforce compared to the overall population of Aotearoa at end February 2022 as a percentage



Note: Prioritised ethnicity data has been used. Sources: Ministry of Health; NCNZ, 2022<sup>2</sup>

disadvantage, such as those working in aged residential care, primary care, Māori and iwi health providers, Pacific providers, and other community health services (Adams et al., 2020). For example, a Māori nurse with a postgraduate diploma who works with a Māori health provider is commencing her final preparation for NP registration, yet to date has fully self-funded her education with no knowledge of her eligibility for Health Workforce funding. Of 55 nurses (responding to a survey) on the NPTP over the past two years, 19 have self-funded two or more courses and two had not heard about the national funding.<sup>3</sup> As described elsewhere (Adams & Carryer, 2019; Gagan et al., 2014) the establishment of NPs across the country is ad hoc and variable (Figures 3) signalling a lack of national workforce policy and variable interest and acknowledgement of the value of the NP role.

### The nurse practitioner training programme (NPTP)

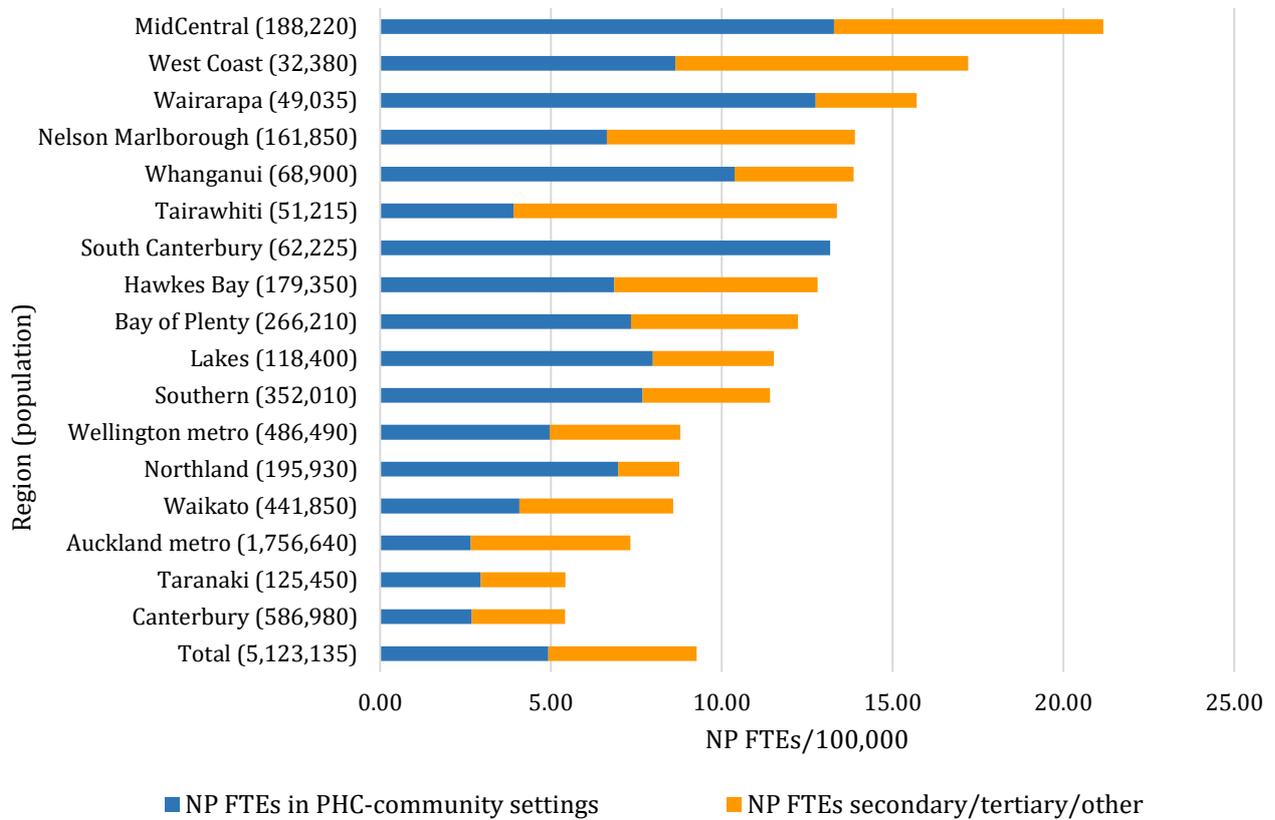
To better support the final clinical practicum year and registration of NPs, the Health Workforce Directorate funded a pilot NPTP in 2016 between the University of Auckland and Massey University for 20 NP trainees per year. Instead of applying through the DoNs at the DHBs, nurses who were ready (academically and clinically) to be NPs at the end of the practicum year, could directly apply to the universities. The pilot was positively evaluated by Malatest (2018) and precipitated a substantive growth in NP numbers (Figure 1). In 2021, the

<sup>2</sup> C. Lane, Ministry of Health, personal communication, March 15, 2022; N. Huntington, NCNZ, personal communication, March 24, 2022

<sup>3</sup> S. Adams, unpublished survey data collected from NPTP cohorts of 2021 and 2022, March 16, 2022



**Figure 3:** Total number of NP FTEs (full time equivalents) per 100,000 population for NPs recorded as working in primary health care and community settings; and those in secondary and tertiary services and other settings. (End March 2021 data<sup>1</sup>)



Note: There is considerable variation in population size of the DHBs ranging from West Coast at 32,385 to the Auckland DHBs with over 1.7 million. Health workforce data is unable to accurately separate all DHB regions. A small change in NP numbers can therefore significantly change the ratio of NP/capita for those smaller DHBs.

Ministry of Health opted to extend the programme, following a competitive process, and funded a national NPTP to be run in partnership between the University of Auckland, Victoria University of Wellington, and the University of Otago. The programme prioritises Māori and Pacific workforce, rural, primary health care, mental health and addiction, aged care, and NP services delivering to priority populations. The NPTP is funded to train 50 NPs per year, a figure that is less than two thirds of the required places to meet workforce demands. The NPTP provides 500 hours of advanced supervised and supernumerary practice (less than the international benchmark yet 200 hours more than NCNZ requires), NP academic mentorship, a secondary placement of 80 hours under NP supervision, and preparation for final assessment by NCNZ immediately following the completion of the practicum. With eight tertiary education providers delivering a NP training, Aotearoa New Zealand now has a two-tiered system of funding and education.

Given the levels of accountability that NPs have as autonomous experienced clinicians who are authorised prescribers, we question whether the system we have now is good enough for futureproofing this extremely valuable and growing workforce.

### Where to from here?

The NPTP is just one, though essential, component of the training and education of a NP. As one of us stated: “You can’t drop a nurse into a one-year practicum and just expect that a NP will appear at the end of the year.” Work is required before and after the NPTP. The early NPs had a resilience and tenacity that stood them in good stead for becoming a NP. However, times are changing (and thank goodness for it) where the NP journey is mostly better supported than it once was; where employers have an understanding of how a NP might work; where trainees can access NPs for mentorship; and where consistent standards of education are being set. Yet



those current trainees still express considerable angst and stress through the process. We argue that the following are critical for the ongoing development and establishment of NPs across the health sector.

1. A review of the NP competencies alongside a review of the educational components to ensure the NP workforce has the depth and breadth to enact the NP scope of practice and promote health equity.
2. Support through the NP pathway – both education and clinical practice – to ensure registered nurses (RNs), together with their employers and leaders, are adequately prepared and ready to undertake the NPTP (see NPNZ website). Given the inequities that abound in our system, a particular focus on the support of Māori, and Pacific is required to ensure Te Tiriti is enacted.
3. Nationally consistent and appropriately funded NPTP accessible to all NP trainees which includes 500 hours of supervised clinical practice, NP academic mentoring, and experience of working alongside a NP in practice.
4. Support during the first year of practice as a novice NP to include ongoing peer support and mentoring, and access to ongoing professional development.
5. A national workforce plan that focuses on the development of the NP workforce to meet health needs of communities and promote health equity.

With the impending health reforms, we hope that the NP workforce receives the recognition and necessary action to embed NP services across the country. As a CEO of a primary health organisation once said: “Every community deserves a NP.”

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**Acknowledgements:** Chris Lane, Ministry of Health; and Nyk Huntington, NCNZ, for support with providing data.