

Places for nurse practitioners to flourish: Examining third sector primary care

AUTHOR

Jill Wilkinson

RN, PGCert TT, PhD

Senior Lecturer, School of Health and Social Services,

Massey University, Wellington, New Zealand.

j.wilkinson@massey.ac.nz

ABSTRACT

Objective

This paper examines and provides an example of the practice environments most likely to nurture nurse practitioner care delivery models and more fully realise the goals of the government's Primary Health Care Strategy.

Setting

Non-government third-sector primary care organisations flourished in New Zealand during a period of neoliberal reform in the 1990s. Because they tend to serve vulnerable populations on a non-profit basis, third sector organisations are not typical of owner-operator general practices, which have a for-profit business imperative.

Primary argument

Third sector primary care organisations are ideologically aligned to a core set of social justice values. They involve the community in management and governance structures, and the health professionals employed are salaried. High ratios of nurses to doctors are employed, and nurses work at an advanced level of practice with their patients. Decisions about the use of public funds are made with the community's health needs foremost. Significantly, nurses are able to advance and more fully contribute in ways that may not be so easily achieved amid share-holding practice owners.

Conclusion

The example of local investment in one third sector primary care provider illustrates that models of care other than the privately owned business model can better serve a high-needs and vulnerable population. With minimal structured and coordinated workforce development plans nationally, third sector organisations offer fertile ground in which nurse practitioners can flourish.

INTRODUCTION

In 2001 the New Zealand government introduced the Primary Health Care (PHC) Strategy, a new policy document that would restructure the publicly-funded primary care sector (Ministry of Health 2001). The Strategy was the first serious government attempt since the Social Security Act 1938 to address health disparities so evident in mortality statistics (Crampton et al 2000). The vision of the Strategy was for a different type of health service that would produce more equitable and long-term health outcomes in more cost-efficient ways (Ministry of Health 2001). Until this time, most general practitioners (GPs) operated on a small business, owner-operator, for-profit basis, funded by a mix of private co-payments and public money (Cumming et al 2005). The Strategy provided for the establishment of community trusts called Primary Health Organisations (PHOs) and were modelled on non-profit organisations operating in the third sector (King 2000).

The PHC Strategy brought a challenge to the traditional GP model of care delivery, with the expectation of more appropriate use of a multi-disciplinary workforce (Hill 2001). The Strategy has therefore been an important driver for the development of the nurse practitioner role. Nurse practitioners (NPs) are well-established in primary care in many countries, most notably the United States (on which the New Zealand model was developed), the United Kingdom and, more recently, Australia. However, the role has been slow to establish in New Zealand since its introduction in 2001. There are approximately 101 registered nurse practitioners who work across a variety of practice areas, 36 of whom work in primary care and only one or two in for-profit environments (Nursing Council of New Zealand 2012).

The aim of this paper is to highlight the characteristics of third sector primary care organisations and provide an example of the type of practice environment likely to nurture NP care delivery models. The paper starts with an overview of third sector organisation characteristics and how they came about in the context of primary care in New Zealand. Next are descriptions written by a GP and a NP about their experiences of working in third sector primary care organisations. Finally, an example is presented of an inner-city practice in New Zealand that has partnered with the local District Health Board to establish nurse practitioner positions in order to better serve a high-needs and vulnerable population.

DISCUSSION

Third sector organisations

The academic and research literature about third sector organisations suggests that a consistent definition with applicability across countries and contexts is contentious (Alcock and Kendall 2011). Broadly, third sector organisations are understood to be non-government and non-profit, making them distinct from both government and commercial enterprises. Non-distribution of profits to shareholders is a defining feature, as is a degree of volunteerism. They tend to function as gap-fillers in areas of state and market deficiencies, are growing in global significance, and bring an important balance to a mixed economy of government responsibilities and private business (Crampton et al 2001). Funding sources vary and are typically a mix of government funding, gifts and grants, and earned income. There is a wide spectrum of third sector activity; examples can be found in international aid, culture, recreation, social services, education, religion and health. Nearly 40 million people are employed in third sector organisations around the world, with the United States and Australia most heavily involved in health (Noya and Nativel 2003).

Core values common to the third sector include those of justice, equity, democracy, accountability, user engagement, and responsiveness to user feedback. There is invariably a commitment to the most marginalised in society (Taylor and Warburton 2003). When applied to a primary care context, these values and characteristics translate to an emphasis on social rather than commercial objectives. The community

is involved in management and governance structures, and the health professionals employed are salaried (Crampton 1999). These characteristics are not typical of owner-operator type general practices, which operate on commercial objectives and are managed by share-holding partners (Kumar 2004).

Third sector primary care has tended to develop in countries with significant barriers to access, especially for vulnerable populations (Crampton, Woodward, and Dowell 2001; Tennant et al 2006). In New Zealand, a variety of community-oriented third sector primary care centres began to flourish with the support of state funding during the neoliberal reforms of the 1990s. In particular, Maori, who are disproportionately represented in areas of high deprivation (see Ajwani et al 2003), sought greater autonomy over health care services and established tribally-based primary care initiatives in many sites around the country. The Ministry of Health was active in their support of these initiatives due to what Crampton et al (2001, p.12) describe as the 'sustained failure of the state and private sector to provide freely accessible services for low-income populations, rural communities and Maori populations'. Consistent with neoliberal practices, state support and finance for the development of tribally-based primary care services encouraged Maori communities to take responsibility for health care problems and attended to the neoliberal concern about special-interest group capture by facilitating entry of this new competitor to the health care market. Crampton (1999, p.15) viewed these third sector, tribally-based Maori health initiatives as 'one of the principal successes' of the reforms.

Primary health care in New Zealand

The health sector underwent further reform with a change of government in 1999. Under the New Zealand Public Health and Disability Act 2000, administrative responsibility for public health services is held by twenty geographically defined District Health Boards (DHBs). The boards each receive population-based funding for the provision of health and disability services inclusive of primary and secondary/tertiary level care in their area. The strategic direction of the sector has been set by the overarching New Zealand Health Strategy (Ministry of Health 2000) as well as a number of targeted strategies for specific areas, an example of which is the Primary Health Care Strategy (2001). Primary health care as defined in the Strategy refers to the Alma Ata Declaration (World Health Organization 1978) and embraces the wider determinants of health.

Structurally, the PHC Strategy provided for the establishment of non-profit community trusts called Primary Health Organisations, which were funded by DHBs for the provision of services that met local needs. Although modelled on the existing third sector services described, in reality, the collective groupings of privately owned general medical practices known as Independent Practitioner Associations simply re-branded as PHOs and employed a broader range of health professionals (Cumming et al 2005; Simon 2005). They took charge of governance, and in many cases, continued to operate competitively as private businesses (Morrissey 2003). The Strategy was viewed by many small scale proprietary businesses as an imposition on practice that would increase costs without increasing revenues (Crampton et al 2005).

PHOs are funded by a capitation system based on the number and ethnicity of people enrolled with the member GPs. The significance of capitation funding to nurses and nurse practitioners is 'the incentive for providers to use health professionals in different, more appropriate ways, as funding is not contingent upon doctors carrying out particular tasks' (Crampton 1999, p. 22).

The expected effect of the capitation incentive was for practice nurses to expand into more challenging roles. However, a recent New Zealand study by Hefford et al (2010) assessed the impact on practice profitability of nurse–doctor clinical task substitution and found profitability improved only in practices that charge similar co-payments for both nurse and doctor consultations. Third sector practices tend to have a policy of charging the same (low) fee regardless of provider, which in Hefford et al's financial modelling improves overall profitability and also expands the scope of nursing practice. The same cannot be said of for-profit practices,

where there is considerable fee disparity between nurse and doctor consultations, making it more worthwhile to the practice for a patient to see a doctor than a nurse (Hefford et al 2010). Third sector organisations not only provide environments supportive of advanced nursing roles, but the policy of charging the same fee regardless of provider is a financial incentive to make better use of nurses' skills.

Working in third sector primary care

The experience of a general practitioner who is employed in a third-sector primary care practice is described in the following excerpt from an article published in *New Zealand Doctor*:

I am a salaried employee of my workplace, along with 30 other staff from varied disciplines. The practice is an incorporated society and the community owns it... I do not carry the business risk. Neither do I profit from it... My income is independent of how many patients I see (apart from the obvious need for the practice to be viable). I relate to my workmates as equals not as employer-employee, and I think this is a significant contribution to being able to work as a multidisciplinary team. Teamwork is different when one person holds the ultimate control. I am in no way critical of my medical colleagues in privately owned practice. ... I do, however, disagree with the opinion that the only way to achieve quality primary care is by strengthening the doctor-centred, privately owned business at the expense of other models of care (Coppell 2006).

The GP's comments begin with a description of the workplace in which they are employed, and its characteristics match those of the third sector organisations previously described. That is, there are a variety of health professionals who are salaried employees, it is owned by the community and, as an incorporated society, may not associate for pecuniary gain (Incorporated Societies Act 1908). Without personal liability for business profitability, this GP maintains better care is achieved for patients because firstly, there is more time to spend with them and secondly, relationships with colleagues are not hindered by an employer-employee relationship, so teamwork is better.

Because they are already ideologically aligned with the Primary Health Care Strategy, there is little need for third sector organisations to re-arrange how they work. Decisions about the use of public funds are made with the community's health needs foremost, avoiding any one professional group profiting at the expense of the community, and distributing the power of decision-making among the team members. Power, of course, remains present, but is distributed in less obvious ways and allows nurses to advance and more fully contribute in ways that may not be so easily achieved amid share-holding practice owners. Coppell (2006) points out that the traditional model is not the only way to achieve quality primary care.

In another third sector primary care organisation, a nurse practitioner shares a similar experience to that of the GP. The following is an excerpt from a contribution to an informal email discussion group written by Paula Renouf, with a subject line of 'Nurses doing primary care'.¹

I have just had a wonderful year and a half working as a child and youth NP in a large busy primary care practice in South Auckland. Here's how it worked in a nutshell: a great experience (clinically). **The GPs, CHWs [child health workers], nurses and families can all see the benefits of my role/paradigm of practice, combo of solid primary care medicine with all the NP extras! Dx [diagnostic] testing?** No problem. **Prescribing?** Not an issue except for dealing with delay in independent access to full formulary – February 06. **Relationship with community pharmacists/hospital consultants for admissions?** Dynamic, helpful

¹ The original post was made to the College of Nurses Aotearoa discussion board. Minor formatting changes have been made to improve clarity. Permission to use the text was granted by the author.

and fun. **Competition with GPs?** Not even a concept in anyone's mind and I certainly have great respect for these superb GPs' skills and training medically... **Families thinking they are getting a 'less qualified' practitioner?** Not an issue, they love someone whose fundamental philosophy is to empower and strengthen, get them to find the solutions etc. but who can independently manage their conditions too. **Teamwork with medical staff?** Superb, regular peer group meetings, bidirectional referring/easy consultation. **Teamwork with practice nurses?** Good too (our roles are like the GP/NP role, complementary, a lot of cross over, but different) (July, 2006).

Renouf gives an account of the freedom in her practice and working relationships with colleagues and families (using words such as wonderful, great, dynamic, fun, love, empower, superb). She lists the contentious issues often encountered by nurse practitioners (highlighted in bold), addressing them in turn, and seems delighted to report she has not experienced difficulty in these areas. Importantly, her place of work is a tribally-based provider that operates on a non-profit basis and services the health needs of a 'maximally deprived' population. In this environment, she is positioned as a valued team member offering a paradigm of practice that is fundamentally empowering to clients and families. Clearly her practice pushes the boundaries of both nursing and medical discourses as she is legally empowered to engage in practices that are outside the normal purview of a nurse.

The potential for nurse practitioners in these environments (and other environments also), however, is limited by inflexible funding mechanisms and minimal structured and coordinated workforce implementation plans for nurse practitioners, despite the role's existence for over a decade (Carrier et al 2011). Until these barriers are addressed nationally, it falls to the health and disability market to determine employment or self-employment opportunities and for prospective NPs to pioneer new positions by garnering employer sponsorship, matching their particular area of expertise with health service goals.

An example of a community-owned, non-profit general practice that is providing opportunities for nurse practitioners is Te Aro Health Centre, a small inner-city health clinic that provides low-cost, high-quality, accessible health care for people who have low incomes and a high number of barriers to accessing health care services. The health centre is overseen by a community trust board comprising voluntary community representatives. Doctors, nurses and administration staff are paid a salary and in addition to DHB and PHO funding, some projects are funded by charitable organisations. Teamwork is evident in the way the work is managed, and egalitarian ideals are articulated by the staff.

It is in this environment that a joint project between the health centre and the local District Health Board began. The DHB's District Strategic Plan 2006–2012 identifies key priority areas for workforce development in primary care and for family-based/primary care nurse practitioners. Although the DHB is responsible for funding all public health and disability services in the region, the national funding formula for capitation funding of the health centre's very high-needs population is insufficient to meet the clinic's running costs, so new ways to provide services are of particular interest.

The joint project involved a credentialed family nurse practitioner from the United States working at the health centre in a NP candidate position under the sponsorship of the DHB. Although she has considerable experience working with vulnerable populations as a NP, her role at the health centre was in a candidate position until she obtained a New Zealand practising certificate in October 2011. At the time the health centre was well positioned to provide the supportive clinical environment that would lead to New Zealand registration as a NP, and in return, the clinic would benefit from her extensive expertise. During her tenure as a NP candidate, another NZ registered NP was appointed as the clinic's leader, sharing her time between clinical and managerial responsibilities.

With two NPs on staff the health centre became a nurse-led clinic. All patients are assessed by a registered nurse (RN) in the first instance using a holistic nursing model of assessment and then referred to the most appropriately prepared professional in the team. That person, be it a RN, a mental health nurse, a NP or a GP, is responsible for assessing, planning, implementing and evaluating the effectiveness of interventions initiated. The expertise of others in the team and the wider health community are called on when and as needed. Diagnostic tests, prescriptions and referrals to specialists are arranged and followed-up on by NPs or GPs. The advantage of a nurse-led model is that the financial viability of the health centre is maintained when the available professional resource is maximised, and for the patient, when their level of need is matched to the expertise available at the clinic. Trend data on patient outcomes appears to be improving under this model and there are plans to formally evaluate this nurse-led approach to care in the coming year.

CONCLUSION

An expectation of the PHC Strategy (2001) was that nurses at all levels would expand into more challenging roles. With minimal structured and coordinated workforce development plans, the number of NPs working in primary care settings has remained low. The experiences of a general practitioner and a nurse practitioner each working in third sector organisations illustrate the non-profit philosophy of their primary care practice environments, which led to an openness to alternative models of care provision that are supportive of advanced practice roles for nurses.

The need to find new ways to provide services for Te Aro Health Centre fitted well with the workforce development plans of the local DHB. Supporting a NP candidate into a role that would best utilise her skills was a good fit with the strategic plan, as was the appointment of another NP as the clinic leader. Aside from the capacity to initially fund the role themselves, the third sector characteristics of the health centre overcame many of the barriers to employing nurse practitioners. With minimal structured and coordinated workforce development plans in place nationally, third sector organisations offer fertile ground in which nurse practitioners can flourish.

REFERENCES

- Ajwani, S., Blakely, T., Robson, B., Tobias, M., and Bonne, M. 2003. *Decades of disparity: Ethnic mortality trends in New Zealand, 1980-1999*. Ministry of Health & University of Otago: Wellington.
- Alcock, P., and Kendall, J. 2011. Constituting the third sector: Processes of decontestation and contention under the UK Labour governments in England *Voluntas: International Journal of Voluntary & Nonprofit Organizations*, 22 (1):DOI: 10.1007/s11266-010-9178-9.
- Capital & Coast District Health Board. 2006 - 2012. *District Strategic Plan*. <http://www.ccdhb.org.nz/aboutus/dsp/FINAL%20DSP%20ALL%20v2.pdf> (accessed 25.5.12).
- Carrier, J., Boddy, J., and Budge, C. 2011. Rural nurse to nurse practitioner: An ad hoc process. *Journal of Primary Health Care*, 3(1):23-28.
- Coppell, V. 2006. The same but then different. Viewpoint. *New Zealand Doctor*, January 25:4.
- Crampton, P. 1999. *Third sector primary health care: A report prepared for the National Health Committee*. Wellington: National Health Committee.
- Crampton, P., Davis, P., and Lay-Yee, R. 2005. Primary care teams: New Zealand's experience with community-governed non-profit primary care. *Health Policy*, 72(2):233 - 243.
- Crampton, P., Salmond, C., Blakely, T., and Howden-Chapman, P. 2000. Socioeconomic inequalities in health: How big is the problem and what can be done? *Pacific Health Dialog*, 7(1):94 - 98.
- Crampton, P., Woodward, A., and Dowell, A. 2001. The role of the third sector in providing primary care services: Theoretical and policy issues. *Social Policy Journal of New Zealand*, December(17):1-21.
- Cumming, J., Raymont, A., Gribben, B., Horsburgh, M., Kent, B., McDonald, J., Mays, N., and Smith, J. 2005. *Evaluation of the implementation and intermediate outcomes of the Primary Health Care Strategy: First report*. Health Services Research Centre, Victoria University of Wellington: Wellington.
- Hefford, M., Cumming, J., Finlayson, M., Raymont, A., Love, T., and van Essen, E. 2010. *Practice nurse cost benefit analysis: Report to the Ministry of Health*. Ministry of Health: Wellington.
- Hill, S. 2001. Tariana Turia enrages diehard ProCare boss. Conference report. *New Zealand Doctor*, October 24:16.

- Incorporated Societies Act. 1908. New Zealand Government: Wellington.
- King, A. 2000. *The future shape of primary health care: A discussion document*. Wellington: Ministry of Health.
- Kumar, R. 2004. Getting your slice of capitation pie. *New Zealand Doctor*, September 8:33-34.
- Ministry of Health. 2000. *New Zealand health strategy*. <http://www.health.govt.nz/publication/new-zealand-health-strategy> (accessed 25.5.12).
- Ministry of Health. 2001. *Primary health care strategy*. <http://www.health.govt.nz/publication/primary-health-care-strategy> (accessed 20.04.10).
- Morrissey, B. 2003. Bridging ethos gap between IPA and PHO. Viewpoint. *New Zealand Doctor*, November 19:12.
- New Zealand Public Health and Disability Act. 2000. New Zealand Government: Wellington.
- Noya, A., and Nativel, C., (eds). 2003. *The non-profit sector in a changing economy*. OECD: Paris
- Nursing Council of New Zealand. 2012. *Nurse practitioner numbers* <http://www.nursingcouncil.org.nz/index.cfm/1,41,html/Nurse-Practitioner> (accessed 25.5.12).
- Simon, J. 2005. The health of our health sector is an illusion. Viewpoint. *New Zealand Doctor*, March 9:14-15.
- Taylor, M., and Warburton, D. 2003. Legitimacy and the role of UK third sector organizations in the policy process. *Voluntas: International Journal of Voluntary & Nonprofit Organizations*, 14(3):321-338.
- Tennant, M., Sanders, J., O'Brien, M., and Castle, C. 2006. Defining the nonprofit sector: New Zealand. *Working papers of the John Hopkins comparative nonprofit sector project*. The Johns Hopkins Center for Civil Society Studies: Baltimore.
- World Health Organization. 1978. *The declaration of Alma-Ata*. http://www.who.int/hpr/NPH/docs/declaration_almaata.pdf (accessed 25.5.12).