Title: Establishing nurse practitioners (NPs) in rural health in New Zealand: An institutional ethnography

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Abstract

The purpose of this ethnographic inquiry was to critically examine the establishment of nurse practitioner (NP) services in rural primary health care in New Zealand. NPs are a solution to meeting health care needs and reducing health inequalities. However, despite 15 years of a seemingly comprehensive legislative, educational, and policy framework to establish NPs as providers of health care, there are still few working rurally. Using institutional ethnography, this study explored the institutional processes and forces that socially organise and shape the implementation of NP services. The purpose was to explicate how it has taken so long to adopt NPs in rural health.

The institutional ethnography began by interviewing twelve NPs and four NP candidates from a range of rural health care settings across New Zealand. Using a process of mapping, particular areas of tension and disjuncture experienced by the participants were explored. This included the identification of texts and discourses which had a coordinating effect on relevant actions and interactions. To further explore the institutional ruling and organisation of rural NP employment and work, a second phase of interviewing took place with key informants in organisational positions.

The findings revealed firstly, that at the institutional, medical professional, and government policy level, doctors are still presumed to be the main provider of primary care. NPs worked extraordinarily hard to create a space to deliver services, despite doctor shortages, the rapid turnover of locum doctors, and high health need. Yet doctors who experienced working with NPs identified benefits to the service, their income and workload. Secondly, current neoliberal economic and health policy was mapped and identified as a significant barrier to adopting NPs. Multiple competing health providers, short-term contracting, and a focus on health outputs, all mitigated against establishing NP services in rural primary health care.
Introduction

The research presented in this paper is part of Sue Adams’ doctoral work that began in 2012 and is nearing completion. Jenny Carryer and Jill Wilkinson are Sue’s supervisors. The purpose of the research was to critically examine the establishment of nurse practitioner (NP) services in rural primary health care in New Zealand.

The evidence is now unequivocal that NPs in primary health care provide at least equivalent care to general practitioners (GPs) and family physicians. Additionally, NPs have successfully delivered services to deprived, marginalised, indigenous, and rural populations (DiCenzo et al., 2010; Everett, Schumacher, Wright, & Smith, 2009; Holt, Zabler, & Baisch, 2014; Horrocks, Anderson, & Salisbury, 2002; Martínez-González et al., 2014; Swan, Ferguson, Chang, Larson, & Smaldone, 2015). Globally, governments and health systems are facing ongoing escalation of health care costs due to the epidemic of long term conditions, ageing populations, growing numbers of people with disability, and displaced populations (Ahonen, Benavides, & Benach, 2007; Marmot & Bell, 2012; World Health Organization, 2014). New Zealand is no different, with a concern that health inequalities between rich and poor, and between Māori (the indigenous people), Pacific people, and the majority, who are white people of European origin, is rising (Matheson & Loring, 2011). The prevailing acute care biomedical model is not addressing health inequalities nor long term conditions, and a new model of care is required (Carryer, Doolan-Noble, Gauld, & Budge, 2014; Commission on Social Determinants of Health, 2008). It has been argued that nurses should be at the forefront of the evolution of healthcare and NPs are an essential workforce of the future (Institute of Medicine, 2011).

New Zealand has a diverse, multi-cultural population of 4.7 million and rising. Many people (approximately 24%) live either rurally, or in small towns at some distance from main urban centres (Statistics New Zealand, 2006). Primary health care services are provided rurally, in the main through general practices, primary health organisations (PHOs), health trusts, including Māori health providers, and district health boards (DHBs). Diagnostics and secondary services are limited through distance. Despite the ongoing struggle to recruit and retain GPs rurally, the GP owned and led practice model dominates and is favoured by government policy. As a result, rural New Zealand relies heavily on an overseas doctor
locum workforce. Approximately 25% of all general practices had one vacancy at any one time in the past five years [Personal Communication, Acting CEO, NZ Locums, 2016].

Waiting in the wings is a potential NP workforce. The NP project in New Zealand began in earnest in 1998 with the first NP registered in 2001. NPs are all educationally prepared to clinical masters level through a Nursing Council of New Zealand approved programme. As the regulatory authority, the Nursing Council is accountable for the registration of NPs. Since 2014 NPs are now authorised prescribers, in the same way as doctors. By March 2016, there were 164 practising NPs, with an estimated third of those working in primary health care. Given the educational, regulatory and legislative framework in place, the progress to firmly embed the NP workforce, particularly in primary health care has been slow.

There is increasing evidence that NPs are working in a way that is improving health outcomes for primary health care patients (Martínez-González et al., 2014; Swan et al., 2015). NPs are able to work combining their nursing model of practice, strongly underpinned by social justice and the concepts of primary health care, with biomedical diagnosis and prescribing – the best of both worlds (Browne & Tarlier, 2008; Carryer & Adams, in press). The research presented in this paper took the position that NPs are a viable solution to meeting health care needs of primary health care and rural populations, and reducing health inequalities (Carryer & Yarwood, 2015).

Approach to the Inquiry

Institutional ethnography (IE) was used as the approach to research (Smith, 2005). The central commitment of an IE is “discovering ‘how things are actually put together’, ‘how things work’” (Smith, 2006, p. 1). The everyday lives of individuals in a local situation are textually coordinated by the institutional ruling relations. By exploring the individual’s experiences and activities, the researcher is able to map and analyse how the ruling relations are organising what happens to people in their local setting. The ruling relations, in this research, are created by various regulatory, legislative, and professional bodies, and by health and educational organisations, historical texts, and discourses. An earlier paper by the authors (Adams, Carryer, & Wilkinson, 2015) gave an overview to IE and introduced the doctoral research.
Hence, for this research the starting point was be interviewing nurses and NPs to explore their experiences and actions to both become a NP and then to gain employment delivering NP services in rural populations. From the interviews tensions or disjunctures were interviewed. In IE, disjunctures indicate a point of entry to further explore the ruling relations. From this point data analysis identifies and further explores texts that were in some way organising the NPs’ experiences, and in turn this would lead to revealing some of those institutional ruling relations that were delaying the establishment of the NP workforce. The research questions could be phrased as follows:

- What is happening organisationally and institutionally that is making it a struggle for nurses to become NPs and deliver NP services in rural primary health care?
- How do the nurses and NPs engage with the ruling relations in order to achieve their goal of becoming rural NPs?

Twelve NPs and four NP candidates (interns or trainees) were interviewed from rural areas across New Zealand, and a further group interview with four additional NPs was conducted. Further interviews took place with a range of other informants, including general practitioners, practice managers, district health board nurse leaders, and others representing specific organisations.

Findings & Discussion

1. The contested space of primary health care

“But that’s GP owners. That’s the paradigm. That’s what we’re up against.”

[Participant 14]

The general practice that this NP candidate was employed at had recently changed ownership from having a small collective of GPs willing to support her NP candidacy, to a new GP owner who did not recognise the value a NP would bring to the practice. The NP found this disheartening and was unsure of the reason for this – perhaps it was money, perhaps it was the personality of the new GP. She did not know.
A NP who had been providing rural NP services for some time was asked to provide locum cover at a district health board managed general practice. She said she went to meet the GPs beforehand:

“They were very nice face to face, and then they told the managers that if I went to work there, they would all leave.” [Participant 5]

A few years later, perhaps due to her positive reputation, she returned as a locum, and had since undertaken several locums at the practice.

At a small rural clinic managed daily by a NP and a registered nurse (RN), with the GP visiting just once a week, the NP described the difficulties she faced referring patients onto specialists. With some she had excellent relationships, but others refused to accept her referrals:

“Some of the stuff I’m sending through they [the specialists] are saying no to; they won’t see; [the patient] needs to be referred by a doctor. That is concerning me, because I’ve had a couple of patients who have needed to be seen. They have had serious things.” [Participant 8]

The resulting time and effort the NP then spent to ensure the patients received the care required was frustrating and unnecessary.

The above examples are disjunctures. They identify points of tension between what the NP expected should happen and what actually did happen. From these disjunctures, textual analysis was undertaken beginning from those local experiences up and through the ruling relations. One such avenue of analysis began from exploring NZ Doctor, a publication widely read across general practices, and at district health board and governmental levels. From reviewing articles and news items published regarding NPs, it was evident that there were a group of vocal GPs who regularly challenged the incumbent NP workforce. For example:

“Most NPs/wannabe NPs I have worked with in a community setting were dangerous. They didn’t know, and yet thought they knew it all. Grasp far exceeded reach. Prescribing just scared me, insight little. Experience of prescribing safely for
years before independent practice non existent. [sic]” (Docherty, 2014, see comment by 'Coalface')

‘Coalface’ remained anonymous. Given the very few NPs working primary health care it is evident that this GP could not possibly be speaking from experience. There is absolutely no evidence to support that NPs in New Zealand or internationally are unsafe prescribers.

Following the publication of a study (Pirret, Neville, & La Grow, 2015) showing that no statistically significant difference was found between the diagnostic reasoning of NPs and medical registrars, Jon Wilcox, a GP and regular anti-NP commentator stated:

“This study is a bit of a sham really. Any good triage nurse working at an A&M clinic would also get the same results as ‘a Registrar’ or a ‘GP’ or a ‘whatever’ in this particular study” (Cameron, 2014, see comment by Jon Wilcox)

The denigration of research is made without any adequate critique.

At this point, it is important to note that there have been many GPs who have supported the development of NPs, and that there are a growing number of GPs who are increasingly accepting, and indeed advocating for NPs. What is interesting, however, is that at the medical professional organisational level, the resistance continues.

In 2015 the Nursing Council announced its decision on the new scope of practice following extensive consultation. Of particular contention for the medical profession was the statement that NPs would provide health care services including the “diagnosis and management of health consumers with common and complex health conditions” [Italics for emphasis] (Nursing Council of New Zealand, 2015). The Chair of the New Zealand Medical Association stated:

“Nurse practitioners are an important part of the healthcare team, but they cannot substitute for a fully trained doctor, particularly where the diagnosis of complex medical conditions is concerned.” [The expanded scope and newly developed competencies could] “inadvertently undermine the Nursing Council’s primary role under statute to protect the safety of the public”. (Lee, 2015, quoting Stephen Child)
Textual analysis revealed that the wording Child used had been taken from a letter written by his predecessor, Mark Peterson, to the Nursing Council. Peterson’s letter referred to and directly used phrases from the Canadian Medical Association’s (CMA) position statement on *Achieving patient-centered collaborative care* (CMA, 2008), and the American Academy of Family Physicians (AAFP) (2012) paper on *Primary care in the 21st century*, subtitled *Ensuring a quality, physician-led team for every patient* (American Academy of Family Physicians, 2012). In both these documents there is a recognition that the NPs are an important member of the health care team, however, in both it is emphatically stated that only physicians can lead teams and manage patients with complex health conditions. Yet evidence provided through systematic reviews, using positivist biomedical research methods, that support the ability for NPs to provide at least equivalent care are discounted.

2. Establishing NP services within a neoliberal health policy environment

One NP candidate described her “frustration and disappointment” at the various U-turns in policy and employment situation that prevented her from becoming a NP. Over a three year period she moved from one job to the next, with each manager promising to support her to become a NP in their organisation. Yet each time a change of policy or manager, for reasons often unknown to her, stopped her progress. A second NP described various efforts to develop services to meet the needs of deprived rural, again with predominantly Māori communities. Both NPs were committed to providing services to reduce health inequalities. It seemed that competing contractual arrangements, competition between providers, and the changing stance of general managers stopped the implementation of NP services.

Neoliberalism has been criticised for disenfranchising marginalised populations, increasing health inequalities and the burden of long term conditions, and being bad for our health (Camargo Plazas, Cameron, & Smith, 2012; Coburn, 2004; Mooney, 2012). The introduction of general managerialism and the creation of competitive health care markets were intended to improve efficiencies, reduce health care costs, and promote innovation (Coburn, 2000). In the primary health care sector in New Zealand non-governmental not-for-profit organisations compete for contracts to deliver health services often in the same space as privately owned general practices. Contracts are mostly annual, and organisations are required to report quarterly and meet health targets. Longer term health planning to
promote population health is often thwarted within this free-market context, and the
development of integrated population primary health care has not been realised (Cumming,
2016). Frequent policy changes, including to contracts and funding, has resulted in
organisations responding reactively rather than proactively, leading perhaps to missed
opportunities to fully utilise the NP workforce. Yet it is precisely in this sector where NPs
could ‘flourish’ (Wilkinson, 2012).

In summary, NPs have the potential to promote social justice by working with local
communities to provide services that embrace a nursing model of health that aspires to
meet the goals of national governments and the World Health Organisation (Carryer &
Adams, in press). New Zealand now has in place a robust educational, regulatory, and
legislative framework that would facilitate the implementation of a NP workforce across the
country in primary health care and with rural populations. While the numbers of NPs
working in practice is growing, it is slower than is ideal to meet the population health needs.
The ruling relations are changing, and the opportunity for NPs is gaining momentum.

Discussion Questions

- How do we develop and promote NP services within a neoliberal policy framework
  and refocus on social justice?
- How do we make more visible the work of NPs to both local communities and
  politicians?

References

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