Nursing Developments in Primary Health Care 2001-2007

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ABSTRACT

This report outlines the development of primary health care (PHC) nursing in New Zealand since the introduction of The Primary Health Care Strategy in 2001 (Minister of Health, 2001). The report is part of the Evaluation of the Implementation and Intermediate Outcomes of the Primary Health Care Strategy undertaken between 2003 and 2008 by the Health Services Research Centre, Victoria University of Wellington, and CBG Health Research Limited, Auckland.

The report presents the findings relevant to practice nurses from interviews undertaken with a sample of PHO and general practice staff and other key stakeholder organisations in 2006, and from a survey conducted with general practice staff in 2007. Data from structured interviews with nurse leaders in 2006 is included as an extension to the evaluation. The data is analysed in relation to existing reports and evaluations impacting on PHC nursing, and in relation to national and international literature.

The Strategy represented a significant opportunity to develop the role of nurses working in PHC. Overall, data examined for this report indicated that since the introduction of the Strategy there has been substantial growth in the development of nursing roles and nurses’ capability in the PHO environment, especially in the management of chronic conditions and working with people in under-served and vulnerable groups.

Two factors have most influenced the expansion of the nurses’ roles. Firstly, where practices and PHOs have embraced the intentions of the Strategy to improve the health of the population, nurses’ roles have expanded, increasing access to services. Secondly, where nurses’ roles have expanded to provide better access to appropriate services, this has been as a result of additional funding for specific programmes – for example Care Plus, RICF, SIA, and the nursing innovations projects. This has resulted in more cost-effective services, greater acceptance by patients of nurses as first port of call, increased choice of provider for patients, freeing up of general practitioners’ time, and greater job satisfaction for the general practice teams.

Four main areas that require focus if PHC nurses are to further develop their roles and contribute to achieving the vision of the Strategy include the funding of PHC services, PHC nursing education at both undergraduate and postgraduate levels, leadership, mentoring and governance; and recruitment and retention.
ACKNOWLEDGEMENTS

This research would not have been possible without the generous financial support of our co-funders: the Health Research Council of New Zealand, the Ministry of Health (the Ministry), and the Accident Compensation Corporation. The Steering Group, which includes representatives from these funding organisations, oversees this project to ensure the research is timely and of a high quality, and that it will meet its aims. The support of the members of this group is gratefully acknowledged.

Thanks are especially due to all the many people who have so willingly given their time to participate in the research, whether through interviews, provision of quantitative data, or otherwise supporting our research efforts. The contributions of all who have been involved are much appreciated.

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# ABBREVIATIONS

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>ACC</td>
<td>Accident Compensation Corporation</td>
</tr>
<tr>
<td>CME</td>
<td>Continuing medical education</td>
</tr>
<tr>
<td>COPD</td>
<td>Chronic obstructive pulmonary disease</td>
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<tr>
<td>CSC</td>
<td>Community Services Card</td>
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<tr>
<td>CTA</td>
<td>Clinical Training Agency</td>
</tr>
<tr>
<td>DHB</td>
<td>District health board</td>
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<tr>
<td>DHBNZ</td>
<td>District Health Boards New Zealand</td>
</tr>
<tr>
<td>EAG</td>
<td>Expert Advisory Group on Primary Health Care Nursing</td>
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<tr>
<td>GP</td>
<td>General practitioner</td>
</tr>
<tr>
<td>HUHC</td>
<td>High Use Health Card</td>
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<tr>
<td>IPAC</td>
<td>Independent Practitioners Association Council Of New Zealand</td>
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<tr>
<td>NGO</td>
<td>Non-governmental organisation</td>
</tr>
<tr>
<td>NHS</td>
<td>National Health Service</td>
</tr>
<tr>
<td>NPAC-NZ</td>
<td>Nurse Practitioner Advisory Committee of New Zealand</td>
</tr>
<tr>
<td>NP</td>
<td>Nurse practitioner</td>
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<tr>
<td>NZMA</td>
<td>New Zealand Medical Association</td>
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<tr>
<td>NZNO</td>
<td>New Zealand Nurses Organisation</td>
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<tr>
<td>MECA</td>
<td>Multi-employer collective agreement</td>
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<tr>
<td>Ministry</td>
<td>Ministry of Health</td>
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<tr>
<td>MSO</td>
<td>Management service organisation</td>
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<tr>
<td>PDRP</td>
<td>Professional development recognition programme</td>
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<tr>
<td>PHC</td>
<td>Primary health care</td>
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<td>PHO</td>
<td>Primary health organisation</td>
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<tr>
<td>RICF</td>
<td>Reducing Inequalities Contingency Funding</td>
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<tr>
<td>SIA</td>
<td>Services to Improve Access</td>
</tr>
<tr>
<td>Strategy</td>
<td>Primary health care strategy</td>
</tr>
<tr>
<td>UK</td>
<td>United Kingdom</td>
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<tr>
<td>US</td>
<td>United States</td>
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EXECUTIVE SUMMARY

This report outlines the development of primary health care (PHC) nursing in New Zealand since the introduction of *The Primary Health Care Strategy* in 2001 (Minister of Health, 2001). The report is part of the *Evaluation of the Implementation and Intermediate Outcomes of the Primary Health Care Strategy* undertaken between 2003 and 2008 by the Health Services Research Centre, Victoria University of Wellington, and CBG Health Research Limited, Auckland.

The report presents the findings relevant to practice nurses from interviews undertaken in 2006 with a purposeful sample of 20 PHOs (representing different types in terms of size, funding, Māori, and Pacific), general practice staff, and other key stakeholder organisations including seven DHBs. It also includes the findings from a survey conducted with general practice staff in 2007. In addition, data from structured interviews with nurse leaders in 2006 is included as an extension to the evaluation. The nurse leaders were drawn from a broad range of institutions, which included the Nursing Council of New Zealand, the Ministry of Health (the Ministry), district health boards (DHBs), PHOs, the New Zealand Nurses Organisation (NZNO), the College of Nurses Aotearoa, and academics involved in the teaching of PHC nursing programmes. Māori nurses, Pacific nurses and practice nurses were also included in the sample.

The data were analysed in relation to existing reports and evaluations impacting on PHC nursing, and in relation to national and international literature. The reports included evaluations of Care Plus, RICF, and the 11 PHC nursing innovation projects. The findings are discussed under three headings: capability, capacity and collaboration.

The Strategy represented a significant opportunity to develop the role of nurses working in PHC. Overall, data examined for this report indicated that since the introduction of the Strategy there has been substantial growth in the development of nursing roles and nurses’ capability in the PHO environment, especially in the management of chronic conditions and working with people in under-served and vulnerable groups.

Two factors have most influenced the expansion of the nurses’ roles. Firstly, where practices and PHOs have embraced the intentions of the Strategy to improve the health of the population, nurses’ roles have expanded and so have increased access to services. Secondly, where nurses’ roles have expanded, this has usually been as a result of additional funding streams – for example Care Plus, RICF, SIA, and the nursing innovations projects. This has resulted in more cost-effective services, greater acceptance by patients of nurses as their first port of call, increased choice of provider for patients, freeing up of general practitioners’ time, and greater job satisfaction for the general practice teams.

While nurses working for Māori providers reported they were already providing many of the services before the introduction of the Strategy, within the new environment they gained service contracts for mobile clinics and nurse-led initiatives.

Currently few nurse practitioners (NPs) are working in PHC but the role has the potential to enhance access to services and choice of provider, develop innovative ways of reaching communities, and meet health needs for under-served populations. NPs have extensive clinical and contextual knowledge of their specialty area that enables them to respond to the health needs of their communities and develop appropriate and cost-effective services. Inclusion of NPs with prescribing rights in PHC teams would
provide a very real advantage for enrollees and would increase the efficiency and effectiveness of practices.

Where there have been substantial developments in the practice nurses’ role, PHO managers and general practitioners (GPs) have encouraged their nurses to undertake new and innovative developments, have recognised that nurses add value to patient consultations, and have ensured that good leadership is provided in their practices. In addition the GPs have demonstrated effective teamwork, have had good staff retention, and have supported nurses in undertaking postgraduate education. The nurses who have expanded their practice have had positive attitudes about the opportunities for development, have been keen to respond to their communities’ needs, and have undertaken postgraduate education to enhance their skills and knowledge – often despite heavy workloads. Frequently these nurses have been employed in larger practices. Effective mentoring of nurses has been successful in involving them in governance at the PHO level.

The reported external barriers to nurses expanding their roles were the employer-employee relationship between GPs and practice nurses, GPs’ attitudes, lack of support and motivation from GPs, the current funding structures, poor remuneration, heavy workloads, lack of educational opportunities, lack of leadership, lack of physical resources, and patients not recognising the nurses as autonomous health professionals. Some nurses also reported a lack of self confidence, a belief that their current role is appropriate, and for some a lack of willingness to embrace change.

Both Care Plus and RICF have provided opportunities for nurses to expand their practice and offer innovative services to under-served populations and people with high needs as a way of reducing inequalities in health, but the ad-hoc nature of the programmes has limited their ability to enhance access to appropriate services for all those eligible in a way that is sustainable. It is imperative that the learning from these opportunities contributes to the development of new services and new ways of working.

Four main areas that require focus if PHC nurses are to further develop their roles and contribute to achieving the vision of the Strategy are: funding of PHC services; education at both undergraduate and postgraduate levels; leadership, mentoring and governance; and recruitment and retention.

Current funding models, which are tied to GPs, are not conducive to nurses working in innovative and expanded roles that would provide their communities with more effective care. Nor are they conducive to PHOs employing NPs, or for NPs to be contracted as providers, because they are not able to access funding for the services they deliver in an equitable way. One solution would be to provide practices with a single, baseline funding stream and the required clinical key-performance indicators and quality measures. This would then be supplemented by generous incentives for general practices and other providers who pursue the goals of the Strategy in terms of reducing inequalities in health and improving health outcomes.

The Strategy requires PHC nurses and doctors to provide population-based services as well as personal health services and this has meant a reorientation of practice nurses’ work. For many practice nurses this requires learning new knowledge and skills; and for those entering this specialty area it requires undertaking further education to acquire the core knowledge and skills necessary for practice.

Nurse leaders reported the need for leadership for PHC nurses at both the DHB and PHO level, mentoring for all levels of PHC nurses, and providing opportunities for the nurses to develop the skills necessary for taking an active role in governance at the practice, PHO and DHB levels.
Both recruitment and retention of practice nurses – especially experienced nurses and Māori and Pacific nurses – are key concerns. While 80% of the nurses in this study found practice nursing to be rewarding, there was considerable variation between practices in terms of retention. Some nurses and practices suggested the high turnover was due to nurses’ lack of control over the work environment, high stress, heavy workloads, lack of time for introducing new initiatives, inability to access resources, and lack of infrastructure (especially space). Yet other practices reported very stable workforces.

The 2005 MECA (multi-employer collective agreement) for DHB nurses resulted in a depleted PHC nursing workforce and led to the reduction and even cessation of some services. The recently agreed MECA for PHC nurses, while not providing pay parity with DHB nurses, should go some way towards resolving this issue.

The establishment of an environment that encourages innovation, attracts and retains appropriately skilled nurses, and is focused on achieving the vision of the Strategy has implications for both policy and practice. This research has identified four key areas for these: funding; education; leadership, mentorship and governance; and recruitment and retention.
Implications for Policy and Practice

**Funding** – To increase nursing capability and capacity:
- Offer incentives for PHOs to establish NP positions.
- Enable NPs to access PHC funding.
- Adopt a single baseline-funding stream with incentives.
- Avoid ad-hoc short-term funding streams.
- Amend ACC contracts to fully fund PHC nurses to provide comprehensive services to ACC patients.

**Education** – To improve capability:
- Advocate for all PHC nurses to have a PHC postgraduate qualification as part of developing necessary knowledge and skills.
- Continue scholarships and funding for postgraduate education.
- Promote quality of clinical placements for undergraduate students.

**Leadership, mentorship and governance** – To embed increased capability and capacity:
- Appoint directors of PHC nursing in DHBs to provide leadership.
- Appoint nurse leaders in PHOs.
- Establish mentoring programmes within PHOs and DHBs.
- Include and mentor PHC nurses in governance roles within DHBs and PHOs at strategic levels.
- Introduce PDRPs for all PHC nurses.
- Develop and implement nursing-sensitive patient outcome indicators.

**Recruitment and retention** - To improve capacity:
- Instigate a national advertising campaign to increase:
  - awareness of PHC nursing as a career choice
  - PHC nurses as providers of health care.
- Target Māori students through schools, workplaces and hui.
- Target Pacific students through schools, workplaces, churches, and fono.
- Provide incentives to establish NP positions.
1 INTRODUCTION

The purpose of this document is to report on the development of primary health care (PHC) nursing in New Zealand since the introduction of The Primary Health Care Strategy in 2001 (Minister of Health, 2001). The report is part of the Evaluation of the implementation and intermediate outcomes of the primary health care strategy undertaken between 2003 and 2008 by the Health Services Research Centre, Victoria University of Wellington, and CBG Health Research Limited, Auckland. The report focuses on material relevant to the role of nurses and is drawn from the second-phase interviews undertaken in 2006 with key stakeholders involved in the delivery of PHC, as well as the results of surveys conducted in 2007 with practice nurses, GPs, practice managers and PHO board members. The report also draws on data from interviews conducted with nurse leaders in 2006. The data are analysed in relation to existing reports and evaluations impacting on PHC nursing, and in relation to national and international literature.

PHC nurses work in a wide range of settings and roles including practice nursing, district nursing, public health nursing, occupational health, family planning, and sexual health (Ministry of Health, 2003). This report, however, focuses only on nurses, mainly practice nurses, who work in PHO settings, since the PHO is the key structure targeted by the Strategy (Minister of Health, 2001). Future investigations into PHC nursing that include the diversity of PHC settings would provide a more comprehensive illustration of the roles of PHC nurses.

1.1 Primary Health Care Nursing

As mentioned above, the term “primary health care nursing” in New Zealand encompasses a wide range of nursing roles in a variety of different community settings. A survey of nurses who identified as working in settings thought to be associated with PHC was conducted in 2001, prior to the introduction of PHOs (Ministry of Health, 2003). A potential sample of 7,763 PHC nurses was identified from the annual workplace survey that accompanies Annual Practising Certificate (APC) applications. Of these, 3,562 nurses responded (46%). The survey results identified 13 distinct “work types” that fall under the umbrella of PHC nursing, with each nurse reporting on average that they worked in two types of work. For example, a practice nurse or public health nurse might also report working in well child, child health, or mental health nursing – as might a rural health nurse.
Table 1: Work Type of Primary Health Care and Community Nurses, 2001 (n = 3,562)

<table>
<thead>
<tr>
<th>Work Type</th>
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<tbody>
<tr>
<td>Practice nursing</td>
<td>21.1</td>
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<tr>
<td>District nursing</td>
<td>7.7</td>
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<tr>
<td>Public health nursing</td>
<td>4.7</td>
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<tr>
<td>Well child or child health nursing</td>
<td>9.6</td>
</tr>
<tr>
<td>Māori health nursing</td>
<td>3.2</td>
</tr>
<tr>
<td>Pacific health nursing</td>
<td>1.3</td>
</tr>
<tr>
<td>Mental health nursing</td>
<td>7.5</td>
</tr>
<tr>
<td>Family planning / sexual health nursing</td>
<td>5.6</td>
</tr>
<tr>
<td>Rural health nursing</td>
<td>3.4</td>
</tr>
<tr>
<td>Health education / health promotion</td>
<td>13.1</td>
</tr>
<tr>
<td>Management of PHC or community services</td>
<td>3.8</td>
</tr>
<tr>
<td>Occupational health nursing</td>
<td>2.8</td>
</tr>
<tr>
<td>Specialist PHC or community nursing</td>
<td>12.0</td>
</tr>
<tr>
<td>Other</td>
<td>4.0</td>
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</table>

Source: Ministry of Health, 2003, p. 6

Data from the 2004 annual workforce survey suggest that approximately 16% of nurses (5,551) were involved in the work types indicative of PHC (New Zealand Health Information Service, 2006).

The potential and actual sample sizes from 2001 is not an accurate representation of the PHC nursing workforce at that time, as it is not clear from the 2001 report how the initial 7,763 nurses were identified or whether some of the non-respondents did not respond because they disagreed with the researcher’s assessment of their work type. Thus no rigorous comparison can be made between the numbers of pre- and post-Strategy nurses and their work types.

The workforce categories offered to nurses in the annual survey are broader than those in the PHC survey of 2001, so accurate comparison of work setting and work type are not possible. The accurate capture of data pertaining to work setting and type in the PHC sector is vital for the measurement of workforce efficacy and recruitment/retention trends.

1.2 The Primary Health Care Strategy

1.2.1 Policy Context

*The Primary Health Care Strategy* was seen as a “key first step” towards achieving the objectives of the Government’s health strategy (Minister of Health, 2001, p. iii). Along with other national policy documents, it sets out the Government’s directions for changes to the way PHC services are provided to ensure “the best health and independence for populations” (Minister of Health, 2001, p. 4).

The overarching policy document, *The New Zealand Health Strategy*, signalled a focus on PHC as central to improving the health of New Zealanders (Minister of Health, 2000). Its principles emphasised
reducing inequalities in health, improving access to health care, collaboration by all sectors, acknowledging the special relationship between Māori and the Crown, and active involvement with consumers (Minister of Health, 2000). PHC was identified as central to achieving the goals and objectives of the Strategy (Minister of Health, 2001).

*He Korowai Oranga – Māori Health Strategy* reinforced the Government’s commitment to the principles of the Treaty of Waitangi (Minister of Health & Associate Minister of Health, 2002). It highlighted the importance for Māori of the “collective” – working with people in a social context – as well as with individuals. *He Korowai Oranga* emphasises a need for accessible and culturally appropriate mainstream services as well as affirming Māori holistic models of wellness and the desire of Māori to manage their own services (Minister of Health & Associate Minister of Health, 2002).

*The Pacific Health and Disability Action Plan* recognised the need for active participation and leadership by the Pacific community (Minister of Health, 2002). It prioritised developing a Pacific workforce plan, mainstream services supporting the development of a Pacific health workforce, addressing mental health workforce issues, and developing the necessary workforce to support Pacific PHOs (Minister of Health, 2002).

*The Health of Older People Strategy* focused on developing an integrated approach to health and disability support services for older people using a holistic, person-centred approach that promoted wellness (Associate Minister of Health, 2002). The strategy focused on including older people as participants in decision-making at individual, community, and broader policy and service development levels (Associate Minister of Health, 2002).

*Youth Health: A guide to action* proposed the active participation of youth in the PHC sector, and the development of youth-friendly PHC services (Ministry of Health, 2002b). This strategy was particularly focused on the prevention and early recognition of risk-taking behaviour by young people and on the need to respond appropriately and quickly to their needs.

*Te Tāhuhu: Improving Mental Health 2005-2015: The Second New Zealand Mental Health and Addiction Plan* identified primary mental health care and mental health promotion and prevention among its ten leading challenges (Minister of Health, 2005). This strategy called for the PHC workforce to increase capability so that mental health needs were accurately assessed in PHC settings and met within the PHC setting whenever possible.

### 1.2.2 The Strategy

The introduction of the Strategy provided a new direction for PHC, with a greater emphasis on population health, community involvement, health promotion and illness prevention through the establishment of PHOs.

PHOs were to be established to provide a set of essential PHC services at the local level to enrolled populations. Although not responsible for providing all health services, PHOs would be a “central point of contact” for community and secondary care providers, co-ordinating care for their enrolled populations. There was an expectation that PHOs would extend their services outside the traditional boundaries of general practice and that the right mix of services would allow most new problems to be successfully dealt with at the primary level (Minister of Health, 2001). As at July 2006 there were 81
PHOs covering 3.9 million people – just over 95% of the estimated total population of New Zealand (Ministry of Health, 2006a).

In contrast to the pre-existing focus on GP-led practices, the Strategy signalled the need for access to a broad range of health professionals. The new population-based funding model would provide for flexibility in the types of practitioners providing the care, opening the way for nurses and other health professionals to provide the most appropriate health services in each situation according to their expertise.

The Strategy also represented a significant opportunity to improve primary health services for people with mental illness and addictions, particularly through prevention and early intervention, workforce development, and building effective linkages with secondary mental health services (Minister of Health, 2005).

1.2.3 Implications of the Strategy for PHC Nurses

The implications of the Strategy for nurses’ roles were significant. Not only were PHC nurses stated to be “crucial” to its implementation (Minister of Health, 2001), but the Strategy’s population focus and greater range of intended services clearly implied a greater need for skilled and knowledgeable nurses. This required clarification of roles and responsibilities, knowledge and skills, career frameworks, and appropriate employment arrangements (Minister of Health, 2001).

A number of key themes for nursing development arose from the Strategy:

1. Development of the PHC nursing workforce

PHC nurses would need to be well educated, and to have a strong career framework and leadership structure. They would share core knowledge and a skill set as well as developing advanced skills in specialised areas, potentially taking on expanded roles with greater autonomy and responsibility. They would have significant input into, and influence on, decisions relevant to their practice.

2. A focus on health promotion and early intervention

The nurses would need the resources and expertise to refocus their work more towards population-based disease prevention, appropriate screening, opportunistic health education, and early interventions. A population-based approach requires health professionals to take a broader approach to health care, recognising the need to prevent and manage disease and to promote health for their local populations rather than just treat those who appear in the waiting room.

3. Collaboration in service delivery and governance

The Strategy emphasises the collaborative and multidisciplinary nature of service delivery which is required to meet people’s needs. Nurses would work as part of an integrated team alongside GPs and other key PHC professionals in equitable relationships. In addition, nurses and nurse leaders would coordinate care with other health and non-health agencies. The Strategy also stresses collaboration in governance of PHOs.
4. Providing services targeted to populations

Nurses would assist PHOs to collect information about enrolled populations, identify health needs, and tailor services accordingly. They would develop nursing service models that address physical access barriers, cultural barriers, life-stage barriers, and hard-to-reach populations.

The Strategy therefore represented an opportunity for nurses working in PHC to improve their education and take on expanded roles with greater autonomy and responsibility. To achieve this vision for PHC nursing, three key areas of focus are needed: increasing the capability of PHC nurses (skill, experience and qualifications), their capacity (the size and demographic extent of the PHC nursing workforce, environmental opportunities, and barriers), and their collaboration with other members of the PHC team and other health providers.
2 LITERATURE REVIEW

A review of New Zealand and international literature was conducted on published articles, reports, theses, evaluations, and grey literature relevant to the development of PHC nursing since 2000. Material for this review was accessed using electronic bibliographic databases and websites of a range of New Zealand agencies. Theses and dissertations were accessed via university libraries.

The international literature was limited to articles published from the United Kingdom (UK), United States (US), Canada and Australia since 2000.

2.1 Primary Health Care Nursing before the Strategy

The climate in PHC nursing in New Zealand in the 1990s has been variously described as “market driven”, “output-focused” and “fragmented”, leading to increasing specificity and specialisation. Prior to the introduction of the Strategy the focus of PHC was on treating individuals, with doctors the principal providers (Carryer, Dignam, Horsburgh, Hughes, & Martin, 1999). Issues for nurses included “poor identification of disciplinary skills, confusion over accountability, inequitable workloads, vested interests, role ambiguity, status differentials and struggles with authority and power” (Carryer et al., 1999, p. 1).

Two surveys provide a useful snapshot of PHC nursing immediately prior to the release of the Strategy. In 2001, a workforce survey of nurses working in PHC in New Zealand identified the two main employer groups of PHC nurses as GPs (32%) and DHBs (32%). Only 2.5% of PHC nurses worked for Māori providers and 1% worked for Pacific providers (Ministry of Health, 2003). This survey reported the following key issues: capacity, especially the paucity of Māori and Pacific nurses and leaders; lack of a career pathway; high workloads and lack of relief staff, which restricts time for collaboration and education; and lack of funding for introducing new programmes (Ministry of Health, 2003).

The 2001/2002 New Zealand National Medical Care Survey found that practice nurses had limited graduate or postgraduate qualifications and were not working in an expanded role or utilising a broad range of skills (Kent, Horsburgh, Lay-Yee, Davis, & Pearson, 2005). Their roles were primarily focused on traditional nursing tasks. These data are consistent with international studies (Kent et al., 2005).

2.2 Developments in Nursing since the Strategy

Since the release of the Strategy there have been changes in the broader nursing workforce environment in addition to the PHC-specific initiatives that have been introduced.

In 2003, a Ministry-appointed Expert Advisory Group developed a framework of five goals for aligning PHC nursing with the Strategy: aligning with community needs; developing innovative models; participating in governance and leadership; ongoing education; and career development (Expert Advisory Group on Primary Health Care Nursing, 2003).

Recently, there has been an increase in the networks available to PHC nurses. In 2003, the NZNO Primary Health Care Nurses Advisory Council was established to provide leadership and strategic
direction for PHC nursing. In addition, an email network for PHC nurses was set up through the Primary Health Nursing Network Group of the College of Nurses Aotearoa.

A new multi-employer collective agreement (MECA) early in 2007 increased pay rates for experienced practice nurses, and was considered to be a “huge step forward” towards pay parity with hospital nurses (NZNO, 2007). Additionally, various initiatives by PHOs and DHBs have attempted to deal with PHC nursing recruitment issues. While it is difficult to quantify the extent of these initiatives, they include, for example, marae-based and church-based recruitment strategies, new programmes for graduates and first year of PHC practice, and collaborative initiatives to train more Māori PHC nurses (Counties Manukau District Health Board, 2004; Midcentral District Health Board, 2005).

A number of developments since the Strategy are working to facilitate greater education for PHC nurses. The Health Practitioners Competency Assurance Act (2003) requires registered nurses to maintain their currency by undertaking ongoing education. Ministry-funded scholarships for postgraduate courses in PHC nursing have been available since 2003 – as have scholarships for postgraduate education for rural nurses, including Master’s degree completion for those intending to pursue NP accreditation. Clinical Training Agency (CTA) funding was shifted to DHBs in 2007, providing them with an opportunity to purchase postgraduate education for their PHC nurses as well as their hospital nurses ("Nurse specialists," 2006).

The Ministry outlined an expectation that NPs would be ideally placed to provide many of the programmes and services needed to achieve the objectives of the Strategy (Ministry of Health, 2002a). Currently 15 of the 47 registered NPs are working in PHC as their primary role (DHBNZ, 2008). While considerable barriers remain to the establishment of the NP role in PHC, initiatives such as the Ministry and DHBNZ Nurse Practitioner Employment and Facilitation Programme established in 2007 are a step forward.

Several funding streams from the Ministry have enabled the trialling and establishment of expanded and innovative PHC nursing services. In 2002, Reducing Inequalities Contingency Funding (RICF) was allocated to 35 PHC projects, many of which involved nursing outreach services (CBG, 2007); and in 2003 the Ministry allocated funding to support 11 innovative developments in PHC nursing (Primary Health Care Nurse Innovation Evaluation Team, 2006). In 2004 the Care Plus programme was first offered to PHOs to target people with chronic health needs, and in many practices this became a nurse-led service (CBG, 2006). Funding through SIA has also led to many nursing initiatives.

2.2.1 Capability

The first report from this research project (Cumming, Raymont, Gribben, Horsburgh, & Kent, 2005) reported on developments in PHC between October 2003 and October 2004. Cumming et al. found the Strategy had provided opportunities to expand the role of practice nurses within traditional general practice, but that the extent of the development varied widely between individual practices and was largely determined by the preferences of the GPs as employers. GPs with a high workload were more likely to assign tasks to their nurses. Barriers to the expansion of the practice nurse role included some GPs’ and nurses’ preference for the traditional hierarchical structure, the absence of a separate practice-nurse funding stream, and direct employment of practice nurses by GPs. Many nurses reported that the public needed to be educated to accept nurses as first point of contact where appropriate (Cumming et al., 2005).
Effective nursing initiatives identified in the report include home visiting, home-based care, youth health clinics, community outreach nurse-led clinics with multidisciplinary back-up, and NP-led services (Cumming et al., 2005). The need for increased education and training to provide the new services has also been identified (Denny, Balhorn, Lawrence, & Cosgriff, 2005; Nelson, Fowler, Cumming, Peterson, & Phillips, 2003).

Horsburgh, Smith and Kivell (2002) described a paediatric home-based nursing service that bridges primary and secondary care in South Auckland. The service is described as reflecting the Strategy's intentions with its nurse-led provision of community-based care, attention to cultural issues, and multidisciplinary teamwork.

The Kaupapa nursing service at Te Puna Hauora is an example of the integration of Māori and mainstream services (Lyford & Cook, 2005). It acts as an interface between primary and secondary care, with services such as mental health, district nursing, specialist nursing teams providing health promotion for diabetes and cardiology patients, and post-discharge care.

Nelson et al. (2003) contend that the PHO environment provides the opportunity for nurses to play an increased role in mental health. They highlight an example of a practice nurse who is a key player in a Newtown mental health programme that runs outreach clinics and follow-up consultations. Practice nurses are also fulfilling co-ordination and advisory roles in mental health (Nelson et al., 2003; Rodenburg, Bos, O'Malley, McGeorge, Love, & Dowell, 2004).

In November 2004, 42 PHOs were funded by the Ministry to establish primary mental health initiatives. These were evaluated by Tony Dowell and his research team at the Department of Primary Healthcare and General Practice at the University of Otago, Wellington. In 2007 they reported on their evaluation of 20 of the initiatives. These included various models of care, not all of which included nurses; but where they did, the new initiatives provided opportunities for nurses to establish new roles and expand their services. In addition, nurses were often involved in co-ordination roles for people with a wide range of mental health problems (Dowell, Garrett, Collings, McBain, McKinlay, & Stanley, 2007) However the evaluators noted that, because of the older average age of practice nurses, most had registered as general and obstetric nurses with no experience or education in mental health. Since the 1980s all undergraduate nursing programmes have included mental health education, resulting in nurses receiving comprehensive registration.

A study of one PHO found that practice nurses were mainly working in generalist roles focused primarily on traditional nursing tasks, although some nurses were involved in cervical screening, nurse clinics, and home visits (Horsburgh, Kent & Coster, 2005). Overall, many nurses considered that they were underutilised in terms of experience and skills. Fifty per cent of the nurses reported having an autonomous role, and many reported a more hands-on role with patients since joining the PHO. Increased responsibilities and educational opportunities were also reported along with increased workloads, including more administration (Horsburgh et al., 2005).

Some researchers have suggested that funding streams linking practice enrollees to GPs inhibits the growth of clinical autonomy and expanded roles for practice nurses (Carryer, 2007; McKinlay, 2006). Greenslade (2004) argued that the direct employment of practice nurses by GPs creates a number of difficulties – for PHOs’ standards setting; the employee/employer relationship for nurses; the need for practice nurses to negotiate release time for education; the implementation of PHO-wide programmes; and the dependence on GP support for implementing new programmes (Greenslade, 2004). Others
argue there is a disincentive to develop nurse-led services where rates for nurses are lower than those offered to GPs for the same service, such as ACC payments (CBG, 2006).

A current Ministry/DHB funding formulae review aims to measure the effectiveness of funding formulae against the objectives of the Strategy (Ministry of Health, 2006a).

As mentioned above, to date only 15 of the 47 registered NPs are working in PHC (DHBNZ, 2008) and not all are integrated into PHC teams. In one example where this has happened successfully, the NP provided comprehensive well-child and teen-care programmes, and independently managed common acute and chronic conditions in a high-need setting (Renouf, 2007). This NP has been involved in DHB and nationwide child-health initiatives, school-based health initiatives, women’s sexual and reproductive health initiatives, and expert working groups in youth health. A NP working in Whānau Ora in an independent practice reported working in equal partnership with medical colleagues and managing independent outreach clinics in remote rural settings (Murray, 2006). Another NP has established a well-women’s clinic in a PHO, focusing on breast health awareness, sexual health, contraception, education, and cervical screening ("Mobile service,", 2005)

**Education and Career Development**

The first report from this research project (Cumming et al., 2005) identified that, in order to improve the attractiveness of PHC nursing and to develop capability in line with the Strategy, the following issues needed to be addressed: development of a career pathway; financial incentives to up-skill; standard introduction to practice nursing courses and mentoring; reduction of practical barriers to education; and nationally accredited standards for practice nurses.

The lack of a clear career pathway has long been an issue for PHC nurses both in New Zealand (DHBNZ Nursing and Midwifery Workforce Strategy Group, 2006) and internationally (Gibson & Heartfield, 2005; Woodward, 2006). Further, poor development of professional development recognition programmes (PDRPs) has impeded the development of career pathways in PHC nationally (DHBNZ Nursing and Midwifery Workforce Strategy Group, 2006).

In response, the New Zealand Nurses Organisation (NZNO) developed a PDRP in 2005. It can be used by PHOs to implement an appropriate career structure, as a guide for the development of knowledge and skills and career progression, and as a mechanism for nurses to demonstrate their ongoing competence. PDRPs are being implemented in some PHOs: for example, four PHOs and NGOs have recently joined Waitemata DHB's PDRP (Cassie, 2006, 2007; "Waitemata PDRP," 2007).

In 2003, the Expert Advisory Group on Primary Health Care Nursing criticised several aspects of nursing education. It claimed there was ad-hoc and inconsistent programme development, poor clinical placement experiences for undergraduates, informal and ad-hoc orientation to practice, and a lack of mentoring for new graduates (Expert Advisory Group on Primary Health Care Nursing, 2003). The group proposed a postgraduate education model based on a defined core body of PHC nursing knowledge with optional papers relevant to each nurse’s practice area (Expert Advisory Group on Primary Health Care Nursing, 2003). In the same year, the Health Practitioners Competency Assurance Act 2003 established a requirement for registered nurses to document their practice and provide evidence of ongoing education.
A number of postgraduate courses in PHC nursing have been established since the introduction of the Strategy, and a range of initiatives has been developed to help nurses access postgraduate education and training. Initiatives include a central bureau of nurses to provide relief for nurses attending training by Counties Manukau District Health Board, and a NorthTec project aimed at motivating and supporting nurses on PHC placements through text-messaging (Mackay, 2007).

The educational needs of nurses have been recognised by some DHBs and PHOs in their workforce development strategies (Graham-Smith, 2006; Midcentral District Health Board, 2005). These include: funding for ongoing education; release time; liaison with education providers to establish PHC courses; graduate internship programmes; high-quality PHC placements for new graduates; professional development sessions; and mentoring (Graham-Smith, 2006; Midcentral District Health Board, 2005). Practice nurses have responded positively to this support (Cuminium et al., 2005; Horsburgh et al., 2005).

2.2.2 Capacity

Despite the Government’s expectation that the future of health services will increasingly be in primary and community settings, PHC nurses make up only a small proportion of the overall nursing workforce (Minister of Health, 2001). The annual Nursing Council workforce questionnaire in 2004 found 16% of nurses and midwives identified as working in PHC. This included practice nurses, district nurses, public health nurses, and nurses in occupational health, family planning, and sexual health (New Zealand Health Information Service, 2006). The most recent PHC nursing workforce survey, undertaken in 2001, found the PHC workforce was older than the general nursing workforce (Ministry of Health, 2003) and more than half worked part-time. Only 7% were Māori and approximately 1% Pacific and 1% Asian.

The majority of practice nurses (64.2%) work with self-employed GPs (Mel Pande, Stenson, Webber, Fretter, Fox, & Turner, 2006) and only a small proportion of nurses are employed directly by PHOs.

Recruitment and Retention

A recent survey of NZNO members found that more than 60% of PHC nurses reported their workplace had difficulty recruiting new staff, and that over half of the respondents had considered leaving their jobs in the preceding six months (NZNO, 2006a). Twenty-five percent of PHC workplaces were reported as having vacancies, with this rising to 60% for Māori and Pacific providers. Pay parity with hospital-based nurses was listed as the top priority for PHC nurses by 95% of respondents (NZNO, 2006b).

The DHB Nursing and Midwifery Workforce Strategy Group (2006) highlighted the need for recruitment to PHC, noting that growing demand for population-based approaches would require specific skills in health promotion and health education. It also identified the need to develop the Māori nursing workforce (DHBNZ Nursing and Midwifery Workforce Strategy Group, 2006). In response one DHB has reported implementing marae-based and church-based recruitment strategies and new graduate schemes to target Māori nurses. In addition, a collaborative initiative between a Māori PHO, Manukau Institute of Technology, the Ministry of Social Development, and Work and Income aims to train at least 100 Māori nurses over the next decade to work in PHC in that region (Manukau Institute of Technology, 2007). Te Puna Hauora provides a year-long pre-entry kaupapa health professional programme to prepare students for study (Lyford & Cook, 2005).

A number of Māori providers have developed initiatives to encourage Māori into nursing and to further develop Māori nurses’ knowledge and skills. Ngāti Porou Hauora Incorporated provides scholarships for
Māori to enter nursing and also sponsors nurses to attend postgraduate courses (Abel, Gibson, Ehau, & Tipene Leach, 2005).

### 2.2.3 Collaboration

In 2006, the US-based Commonwealth Fund surveyed primary health physicians in seven countries. This included 503 interviews with New Zealand GPs. It found that routine use of multidisciplinary teams in New Zealand fell far below that of the UK, Germany and the Netherlands but was similar to that of Australia, Canada and the US. Routine use of non-physicians to help manage patients with multiple chronic diseases in New Zealand was above average, but below that of Germany and the UK (Schoen, Osborn, Trang Huynh, Doty, Peugh & Zapert, 2006).

The Palliative Care Project in MidCentral District Health Board is an example of a multidisciplinary team where practice nurses co-ordinate care across a number of health care providers, including general practice, hospice services, the PHO, the DHB District Nursing Service, the Cancer Society, and Māori health providers (Stewart, Allan, Keane, Marshall, Ayling and Luxford, 2006). The providers suggest that this co-ordination role has led to more effective communication and greater collaboration between providers, and to better patient choice (Stewart et al., 2006).

For many Māori providers, the new direction of the Strategy mirrored existing approaches to care (Abel et al., 2005). Ngāti Porou Hauora Incorporated was already providing mobile nursing services and major health education/promotion programmes in the late 1990s. Currently, it provides an holistic health service based on multidisciplinary teams made up of practice nurses, GPs, kaiawhina (community health workers), and a broader range of health professionals (Abel et al., 2005).

A study of practice nurses at HealthWEST PHO in West Auckland found most nurses felt they were supported by a team but the nature of the GP/practice-nurse relationships varied, as did attendance at team meetings (Horsburgh et al., 2005).

Evidence of highly functional professional relationships between GPs and nurses was reported in one study (Pullon, 2006). Collaboration is enhanced, claimed Pullon, by doctors and nurses having confidence in their own professional skills and by understanding and valuing the roles and skills of other team members (Pullon, 2006; Ross, 2001). There is an increased interest in the benefits of PHC interdisciplinary education at postgraduate level as a means of promoting greater understanding of roles (Expert Advisory Group on Primary Health Care Nursing, 2003). However, these programmes are yet to achieve accreditation by the Nursing Council (College of Nurses & NZNO Strategy Group, 2007).

Pullon suggested further that organisational and funding structures which actively foster effective collaboration are required for building teamwork in PHC. Ross (2001) claimed that fee-for-service funding for GPs, the practice nurse subsidy, and the employment of practice nurses by GPs have all been found to contribute to difficulties in developing collaborative teamwork. Ross also suggested that one way to partially alleviate funding barriers would be for all PHC providers to be salaried. Gray (2005) suggested the salary model at the Newtown Union Health Service results in greater task-sharing and an emphasis on teamwork.

PHC nurses involved in the delivery of chronic care programmes have called for greater consistency in the delivery and support of these programmes nationwide (Cassie, 2006). The nurses reported increased job satisfaction, but they complained of a lack of nationally consistent resources (including IT resources),
poor workforce development for nurses, lack of co-ordination of Care Plus (discussed below in Section 2.3.1) with other chronic care programmes, and lack of national analysis of clinical outcomes and successful delivery models.

There has been a significant development in networks for PHC nurses in recent years. Both the NZNO and the College of Nurses Aotearoa have contributed to this. The NZNO Primary Health Care Nurses Advisory Council was established in 2003 to provide leadership and strategic direction for nurses within the NZNO. It has facilitated three PHC conferences and encouraged the establishment of network groups to bring together nurses working in PHC (Minto & Hansen, 2005). In addition, the Primary Health Nursing Network Group of the College of Nurses Aotearoa has developed an email network for PHC nurses to enable information sharing and discussions of professional issues (Minto & Hansen, 2005).

A survey of PHO nurses undertaken in 2004 reported that some PHO nurses, especially those in smaller practices, felt isolated from other nurses within their PHOs. They also believed PHC nursing was fragmented, with organisational divisions separating groups of nurses working in the community (Cumming et al., 2005).

### 2.3 Review of Evaluations of Primary Health Care Initiatives

Since 2002, the Ministry has provided additional PHC-provider funding to improve the management of people with chronic conditions, to develop innovative services and improve access so that health inequalities will be reduced, and to support nurses in their development of new and innovative services that align with the intentions of the Strategy. Funding is available through Care Plus, RICF, SIA, and nursing innovation projects. These funding streams have facilitated the development of new models of PHC nursing and enabled the further development of existing models. Evaluations of these initiatives have highlighted facilitators and barriers to the development of PHC nursing in New Zealand, along with the implications these have for people receiving the services.¹

#### 2.3.1 Care Plus

Care Plus is a national initiative that targets people “with high health needs due to chronic conditions, acute medical or mental health needs or terminal illness” (CBG, 2006, p. 1). It aims “to improve chronic care management, reduce inequalities, improve primary health care teamwork and reduce the cost of services for high need primary health care users” (CBG, 2006, p. 5). Eligible patients receive expanded, low-cost services which aim to provide more effective management of chronic health conditions as well as support in making lifestyle changes.

Care Plus was first offered in 2004, and 80% of PHOs were delivering Care Plus in some or all of their practices by April 2006 (CBG, 2006). Half of the practices surveyed by the Care Plus evaluators (CBG) reported that the programme was driven by nurses or was an exclusively nursing service. Most agreed this worked well, particularly where nurses had been fully involved and actively supported by the PHOs and general practices. Nurses reported that they experienced increased job satisfaction, their skills were more fully utilised, and their profile with patients increased. However, there was significant variation in the way Care Plus was implemented, because of the PHOs’ different levels of resources and differing attitudes towards Care Plus. Overall Care Plus worked best when “linked to existing chronic care programmes” (CBG, 2006, p. 50).

¹ An evaluation of the SIA funding is not available.
The evaluation was undertaken too soon after the introduction of Care Plus to be able to assess the impact on health outcomes for the enrollees, but CBG reported enrollees’ hospital admissions increased by 40% in the first year (CBG, 2006). It was suggested that this may be due to closer monitoring through more frequent consultations. CBG also reported that there was no evidence of improved prescribing quality and suggested that nurses should be given prescribing rights to enable more effective delivery of chronic care services (CBG, 2006).

Care Plus was aimed at the 5% of the New Zealand population with two or more chronic conditions; however, the implementation relies on PHOs and general practices agreeing to offer the services to their populations. The delivery of Care Plus was shown to be inequitable, with many eligible New Zealanders not being able to access the advantages that Care Plus has to offer (CBG, 2006). CBG reported that “by April 2006 only 39% ... of predicted eligible patients were enrolled in PHOs that [were offering] Care Plus” (CBG, 2006, p. 11).

As mentioned above, significant variation was found in the manner in which Care Plus was implemented (CBG, 2006). The goals of enhanced care planning and increased teamwork were found to vary depending on the attitude and resources of PHOs. However, where nurses were supportive and actively involved in providing Care Plus, the programme ran more smoothly and was more successful.

A number of identified barriers to full implementation related specifically to nursing services. Limited funding, space, and nursing staff numbers were found to have the potential for reducing the uptake and impact of the programme, particularly in smaller PHOs or those in socio-economically deprived areas. The time required for Care Plus nursing consultations, care plan completion, and training were also found to be significant constraining factors. While the majority of GPs valued nurses’ involvement in managing chronic conditions, there was variable support for autonomous nursing practice. The Care Plus evaluation recommended exploration of incentives and barriers to independent nursing practice, ongoing training and support for nurses, making home-visit nursing services available, more simple and standardised care plans, increased focus on the use of brief interventions and use of electronic systems, a Care Plus nurse co-ordinator at a PHO and/or national level, and exploration of a shared workforce across practices (CBG, 2006).

The evaluators recommended a series of free short-term courses for nurses that would increase their clinical skills and knowledge for prescribing for specific conditions. They also noted that, while short-term courses would enhance the nurses’ clinical capability, these would not contribute to an overall qualification and would not equip the nurses to meet the requirements of the current legislation for prescribing (CBG, 2006).

2.3.2 RICF Funding Stream

In 2002, the government allocated $2.4 million for the development of innovative services to reduce inequalities in health. As a result, 36 projects were funded. A large number of these projects involved nursing outreach initiatives that targeted specific populations and areas of need. These projects were also evaluated by CBG Health Research Limited (CBG, 2007).

Examples of successful nursing-based projects included the following: a youth-based health clinic; a school-based clinic; free nurse-visits for all patient groups; an outreach service for a predominantly Māori community (which provided immunisations, sexual health services, care for chronic conditions, and home visits); and home visits for patients with attendance issues (CBG, 2007).
The RICF projects provided opportunities to pilot a wide range of initiatives for improving disadvantaged and hard-to-reach populations’ access to services. The evaluators concluded that PHOs were well-placed to address barriers to access for high-risk populations. They recommended ongoing targeted consultation-subsidies and transport support, improved information technology, and home visits by nurses and community health workers (CBG, 2007).

Innovations developed within the RICF projects have informed the development of initiatives within PHOs and DHBs that provide appropriate services for specific population groups and that enhance leadership for PHC nurses (CBG, 2007). The wide range of RICF projects demonstrated many different ways of working with disadvantaged and hard-to-reach groups to reduce inequalities in health.

2.3.3 **PHC nursing innovation projects**

In 2002, $7.25 million was made available for supporting innovative developments in PHC nursing that would align with the intentions of the Strategy. Eleven projects were funded and each was evaluated (Primary Health Care Nurse Innovation Evaluation Team, 2006). It was anticipated that the innovations would address fragmentation and duplication of services, improve access, address inequalities, and support the integration of services across the continuum of primary and secondary care services.

There were two general approaches: the development of leadership infrastructure and inter-organisational networks across DHBs and/or PHOs; and the development of new and expanded practice.

The first approach included the following: involvement in governance, management and clinical committees in DHBs and PHOs; creating networks for PHC nurses; developing links between primary and secondary sectors; workforce development; and new initiatives in response to health issues (Primary Health Care Nurse Innovation Evaluation Team, 2006). The evaluation found these innovations to be mostly successful. All were effective in focusing and developing the PHC nursing workforce in the direction of the Strategy; each led to improved communication between disparate nursing services and has become an ongoing mechanism for PHC nursing service development in its region. The innovations were also found to have the potential for addressing fragmentation and duplication between services.

One successful leadership model was the Counties Manukau District Health Board innovation (Primary Health Care Nurse Innovation Evaluation Team, 2006). This innovation established a PHC nursing reference group to focus on leadership, governance, workforce development, and collaboration issues. Initiatives undertaken included a stocktake of PHC nurses in the DHB to inform a workforce development plan, practical initiatives for supporting nurses who undertake postgraduate education, and a “return to PHC nursing” course. Nurse leader positions were established within PHOs, creating support for nurses who were involved in governance roles and managing clinical placements. Considerable achievements were made in advancing the NP role in the region.

The second approach focused on new, expanded or modified nursing services for specifically targeted groups. These included: outreach nursing clinics; mobile case management for patients with chronic disease; youth health services; and an expanded role for rural nurses. Most were an extension of existing services, focusing on populations as well as individuals – and especially on populations that experienced barriers in accessing PHC services. There was a mixed degree of success with these models (Primary Health Care Nurse Innovation Evaluation Team, 2006).
The evaluation team reported the innovations as having different levels of success in terms of meeting the DHB objectives and Ministry goals (Primary Health Care Nurse Innovation Evaluation Team, 2006). Although the evaluation described some examples of new models of service delivery by nurses, it did not evaluate the effectiveness of the initiatives.

### 2.4 International Literature

Internationally, many countries are experiencing PHC issues similar to New Zealand’s. In terms of devolving health services to community settings, increasing interdisciplinary work in primary settings, and re-focusing towards prevention, the literature indicates that trends in the UK, US, Canada, and Australia are moving in the same direction as they are in New Zealand (Armstrong, 2005; Bodenheimer, 2003; Department of Health, 2006a; Dodoo, Roland & Green, 2005).

The shift in PHC is giving rise to new and expanded nursing roles. However, considerable confusion remains regarding titles, scope of practice, and educational preparation for these new roles (Carnwell & Daly, 2003; Woodward, 2006). Woodward (2006) reported that holistic, autonomous, nurse-led care in the UK is now the norm for many long-term conditions. Chronic conditions such as asthma and diabetes are now often managed with very little GP involvement. The advent of nurse prescribing for practice nurses in the UK has further increased their autonomy (Woodward, 2006). Woodward suggested that changes in funding agreements with primary care organisations would enable practice nurses to have greater input into practice policies.

Halcomb, Patterson and Davidson (2005) reported that in Australia the role of the practice nurse is broad and diverse. However, it is often limited to the traditional nursing tasks of assisting GPs in treating illness and injury. Gibson and Heartfield (2005) reported the role of the practice nurse can include receptionist work, management of busy treatment rooms, case management, health assessments, and triage. Halcomb et al. (2005) claimed the status of practice nursing is low, that practice nurses lack a career pathway, and that they experience professional isolation and role confusion.

Nurses working in advanced roles include NPs and nurse specialists. Many countries have seen a substantial increase in the type and number of nurses working in advanced roles. NPs in particular have demonstrated they have the skills and knowledge to respond to their communities’ needs and provide appropriate services cost effectively. Sibbald, Shen and McBride (2004) reported that practice nurses working in advanced roles in the UK demonstrate care equal to that provided by doctors, and that this can lead to increased patient satisfaction. Similarly Laurant, Reeves, Hermens, Braspenning, Gol and Sibbald (2004), in a systematic review of doctor substitution by nurses in PHC, reported that there were no appreciable differences in patient outcomes, the processes of care, and the costs of providing care. This was also reported by Sibbald, Laurant and Reeves (2006). Nurses working in advanced roles with some level of (limited) prescriptive authority has been reported in seven OECD countries. These include Australia, Canada, England, and the US (Buchan & Calman, 2005).

An Australian national study of practice nurses found that expansion of the nursing role was facilitated by education and training, collaboration with GPs, and opportunities to deliver broader services (Halcomb, Davidson, Daly, Yallopp & Tofler, 2004).

Martin, Cleverdon, Kelly, and Shanahan (2007) reported a range of barriers hampering the expansion of the nurses’ role within the UK’s National Health Service (NHS). These included institutional barriers such as doctors’ reluctance to support nursing developments. Woodward (2006) reported the main barrier to
further career development for practice nurses is their continued employment by GPs rather than by the NHS. This, she suggested, raises the issue of power, gender and equality in working relationships and in the decision-making process.

Martin et al. (2007) also suggested that there is a need for greater flexibility, leadership, governance, and research in PHC nursing and that education for nurses must become both more flexible in terms of the skills it offers and more readily available.

The UK is currently considering changes to nursing education to enable nurses to begin their careers in either a hospital or the community (Department of Health, 2006a). The Department of Health is also exploring alternative models of employment for nurses. Woodward (2006) suggested that a visible, attractive career pathway and appropriate remuneration are needed to promote the recruitment and retention of practice nurses. Following a review of international literature, Sibbald et al. (2004) reported that teamwork is fundamental to the success of PHC – as is mentoring, inter-professional education, and leadership.

Bodenheimer (2003) suggested that regular communication and clearly defined roles within interdisciplinary teams are important components of innovative models of PHC in the US. In Australia this is supported by the expansion of inter-professional education. McNair, Stone, Sims, and Curtis (2005) reported that undergraduate students in medicine, nursing, physiotherapy and pharmacy improved their (self-reported) teamwork skills and knowledge by undertaking placements.

Overall, the international literature indicates that PHC in the UK, US, Canada and Australia is moving in the same direction as in New Zealand. This movement is fostering advanced and expanded nursing roles. Barriers to the expansion of practice nurse roles in these countries generally parallel barriers experienced within New Zealand – for example, the continued employment of practice nurses by GPs and problems with the recruitment and retention of practice nurses, exacerbated by lack of attractive career pathways and by inappropriate workload and remuneration.
3 METHODOLOGY

This chapter describes the methodology used to collect the data presented in this report. Data from the following two components of the Evaluation of the Implementation and Intermediate Outcomes of the Primary Health Care Strategy is presented: semi-structured interviews with practice nurses, GPs, practice managers, board members, and board chairs; and surveys of practice nurses, GPs, and practice managers. Data from structured interviews with nurse leaders are outlined, as an extension to the evaluation.

The Multi-Region Ethics Committee advised that ethical approval was not required for the interview and survey components of the evaluation, as no data were identifiable.

3.1 Second Phase Interviews

The First Phase interviews for the Evaluation of the Implementation and Intermediate Outcomes of the Primary Health Care Strategy were undertaken in 2004. The Second Phase qualitative interviews were undertaken with practice nurses, GPs, practice managers, board members, and board chairs in 2006. These interviews were intended to “take the pulse” of the PHC sector five years after the implementation of the Strategy. A total of 110 interviews were conducted as part of the Second Phase.

3.1.1 Selection of PHOs

A list of the PHOs existing at the end of 2004 was obtained from the Ministry website. PHOs were categorised on the basis of their size (up to 20,000 registered patients; 20,000 - 100,000; more than 100,000), their funding formula (Access, mixed and Interim), their previous existence as an IPA (yes/no), and their focus (Māori, Pacific, and other). The PHOs were categorised into the seven types of PHOs shown in Table 1. (For this report, the PHOs are not grouped by funding formula but are reported on as a whole.)

Twenty PHOs were chosen by purposive sampling, giving recognition to the type of PHO. They were over-sampled for Māori and Pacific PHOs (Table 1). Sampling was confined to seven DHBs distributed in Northland, Waikato, Auckland, Lower Hutt, Wellington, and Canterbury.

Table 2: PHO Type and Number Selected

<table>
<thead>
<tr>
<th>PHO type</th>
<th>Total number</th>
<th>Number selected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Large IPA-based</td>
<td>9</td>
<td>5</td>
</tr>
<tr>
<td>Māori</td>
<td>15</td>
<td>4</td>
</tr>
<tr>
<td>Pacific</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Medium-sized Access</td>
<td>9</td>
<td>2</td>
</tr>
<tr>
<td>Medium-sized mixed/Interim</td>
<td>17</td>
<td>2</td>
</tr>
<tr>
<td>Small Access</td>
<td>13</td>
<td>2</td>
</tr>
<tr>
<td>Small mixed/Interim</td>
<td>15</td>
<td>3</td>
</tr>
<tr>
<td>TOTAL</td>
<td>81</td>
<td>20</td>
</tr>
</tbody>
</table>
3.1.2 Selection of Interviewees

The following people within each PHO were selected to take part in the Second Phase interviews: the PHO chair; the PHO manager; a Māori, a Pacific and a community PHO board member; a doctor and nurse who were PHO board members; and a doctor and nurse who were not board members. On average, eight interviews were conducted within each PHO. Additional interviews were conducted with the relevant DHB primary care managers, and with representatives of the Ministry and primary care bodies such as the NZMA and IPAC.

3.1.3 Interview Process

Semi-structured interviews were conducted according to the Second Phase Interview Guide (see Appendix 1), which was developed by the research team and the Steering Group. The Second Phase Interview Guide contained seven key questions on the following issues:

- funding
- equalising access
- chronic conditions
- community input
- workforce and teamwork
- functioning of PHOs/MSOs
- relationships with DHBs and the Ministry.

The Second Phase interviews were conducted by seven interviewers trained to use the Interview Guide. Typically the interviews were conducted on a one-to-one basis, although a number of interviews were conducted with two or more interviewees present.

3.1.4 Qualitative Analysis

The following types of interview data were analysed for this report:

- a summary statement for each PHO, with quotations added
- notes for each PHO, with quotations added
- notes for each interview, with quotations added
- transcription of each interview.

The interviews for this report were analysed thematically, in terms of capability, capacity and collaboration. These themes were selected for consistency with the Strategy’s vision for nurses, and to determine how PHC nursing has developed since the introduction of the Strategy.

3.2 Survey

The survey component of this evaluation quantifies the impressions gained from the semi-structured interviews. The surveys were undertaken with PHC providers at the practice and PHO level, and specific survey questionnaires were developed for each group (practice nurses, GPs, and practice managers). These questionnaires were based on information obtained from PHO board members, PHO executives, practice managers, GPs, and practice nurses.
3.2.1 Survey Instruments

Questionnaires for the Practice Nurse, GP and Practice Surveys were developed from the information gained from the First Phase of interviews in 2004. Input was sought from the Steering Group on the content of the questionnaires.

The questionnaires were piloted in early 2006 and the majority of pilot respondents stated that they were too long. As a result, to reduce the burden on respondents and to maximise the response rate, the questionnaires were abbreviated.

The final Practice Nurse Survey Questionnaire (see Appendix 2) contained questions on workload and responsibilities, teamwork and role, postgraduate nursing education, work satisfaction, and demographics. The GP Survey Questionnaire (see Appendix 3) contained questions on workload, teamwork and nurses’ role, work satisfaction, and demographics. The Practice Survey Questionnaire (see Appendix 4) contained questions on patients and access, services provided, practice personnel, roles and teamwork, workload and responsibilities, teamwork and roles, practice policies, practice ownership and management, relationship with the PHO, and funding variables. The Practice Survey Questionnaire was completed by the practice manager.

3.2.2 Eligibility

A list of general practices was generated from data supplied by HealthPAC. Two lists were provided: one contained PHO-affiliated practices (N= 1,097); the other contained a mixture of practices and individual doctors (N = 8,786). From these, 1462 practices were deemed eligible for the survey.

3.2.3 Recruitment

In each practice, the person responsible for management or administration (most commonly the manager but sometimes the receptionist, practice nurse or GP) was approached by telephone and invited to have the practice participate in the survey. If they agreed, they were then sent the questionnaires and accompanying letters of invitation via email or mail and were asked to distribute the questionnaires and invitation letters to 50% of the nurses and 50% of the GPs at their practice. Where there was only one GP or one nurse, that GP or nurse was sent the questionnaire and invitation letter.

The completed questionnaires were returned via email, or by post in the postage-paid envelopes. Follow-up phone calls with practice managers encouraged the return of the questionnaires.

The recruitment period was from August 2006 to June 2007. Six percent of practices refused to participate and 23% of eligible practices returned completed questionnaires.

3.2.4 Analysis

This report presents survey findings that relate to the development of PHC nursing since the introduction of the Strategy.

The data from the three survey questionnaires were entered into Microsoft Excel. Data from the relevant questions were analysed for descriptive statistics using Microsoft Excel.
3.3 Nurse Leader Interviews

Interviews with 18 nurse leaders were undertaken in 2006, as an extension to the overall evaluation, in order to gain a broader perspective and to explore ways of increasing the development of nursing in the PHC sector.

3.3.1 Interviewees

The nurse leaders included representatives from the Nursing Council of New Zealand, the Ministry, DHBs, the NZNO Primary Health Care Nurses Advisory Council, the College of Nurses and its Primary Health Nursing Network Group, academics responsible for PHC nursing programmes, and PHOs. Amongst the representatives from these organisations were Māori and Pacific nurses (including those who provided leadership within their organisations) and practice nurses.

3.3.2 Interview Process

Two senior researchers conducted structured interviews with the individual nurse leaders. The interviews followed the Nurse Leaders Interview Guide (see Appendix 5), which contained questions on the following issues:

- the importance of nursing to the implementation of the PHC Strategy
- the impact of the development of PHOs on PHC nursing
- the impact of funding streams on the delivery of nursing services
- the NP role
- education, training and career development
- nurses’ participation in management and governance.

The nurse leader interviews were conducted between July 2006 and October 2006.

3.3.3 Qualitative Analysis

To determine the development of PHC nursing since the introduction of the Strategy, transcriptions of the interviews were analysed and the following three themes emerged: capability, capacity and collaboration. These were then used in the following layers of analysis.

The following chapter presents the results.
4 RESULTS

This chapter reports on the findings from the Second Phase interviews with practice nurses, GPs, practice managers, board members, and board chairs in relation to the development of nursing in the PHO environment. It also reports on relevant questions in the Practice Nurse, GP, and Practice Survey Questionnaires and in the interviews with nurse leaders which explored the nurse leaders’ perceptions of the development of PHC nursing since the introduction of the Strategy in 2001.

The response rate for the Practice Nurse Survey was 38%. While this rate is not high, the respondents were representative of practice nurses in terms of age and experience (see Table 5 on page 37). The response rate for the GP Survey was 25.6% and for the Practice Survey 26.7%. This chapter will report on the findings under the themes of capability, capacity and collaboration.

4.1 Capability

This theme presents the results on the skills, knowledge and practice of the nurses in the PHO environment.

The nurse leaders perceived nursing to be crucial to the success of the Strategy, with nurses having the essential knowledge and skills to achieve the Strategy’s purpose – reducing health inequalities, improving the health of the population, and preventing disease.

*The development of PHOs offered huge potential for nursing. [Nurse leader]*

*... to harness the skills of PHC nurses in innovative ways – which was one of the big promises of the Strategy. [Nurse leader]*

Data from the interviews with practice nurses, GPs, practice managers and nurse leaders indicates that there has been substantial growth in the development of the capability of nurses in the PHO environment since the Strategy’s introduction. This has involved many nurses in developing their skills and knowledge to meet the requirements of the people they care for.

In particular, the practice nurses perceived opportunities to develop their roles around chronic conditions and prioritising under-served and vulnerable populations. This was also recognised by the nurse leaders:

*... rural populations ... people with chronic conditions ... complex cases GPs can’t manage by themselves, that’s where primary health care nurses are going to step in. [Nurse leader]*

In the area of chronic condition management, some interviewees identified nursing roles that had begun to develop before PHOs were established – for example, the development of government-funded mobile disease-state nursing services in 2001.

Many nurses in the new PHO environment are providing more services and functioning more autonomously, especially in larger practices. Figure 1 shows the range of services reported in the Practice Survey as being provided by practice nurses. In nearly all practices it was reported that practice
nurses had the responsibility for providing telephone follow-ups, triage of phone calls, and triage of walk-in patients. General consultations, well child consultations, chronic care, and speciality clinics such as diabetes and health promotion were also reported to be widely provided by practice nurses. Forty-five percent of practices stated that they had outreach nurse services available.

Figure 1: Services Provided by Practice Nurses

Some interviewees suggested that the expanded practice-nurse role was due to the shortage of doctors, resulting in nurses having to take a more active role in providing services. The majority, though, saw the role increasing as a result of the changes in the funding of PHC. They suggested that SIA, RICF and health promotion funding have enabled nurses to provide innovations such as a mobile bus, school-based clinics, a one stop shop for youth, outlying nurse-led clinics, health expos, Māori hui, programmes in schools, community action projects, programmes on injury prevention, group safety, marae safety, water safety, drinking water safety, road safety, healthy schools, health promotion in meat works and high schools, sexual health, and health promotion. In addition, clinics have been established for diabetes identification and education, as have soup kitchens; and there are now mobile and evening nursing clinics to improve access to services for under-served populations.

*We are introducing a few new clinics and they will all be nurse-led clinics ... now you may not be able to get a nurse appointment for two weeks.* [Nurse]

*We have an annual diabetes screening ... we are also running a men’s clinic, so that’s bringing in some people and we are also looking at running a clinic for spirometry for COAD and people who have bad asthma. We’re very busy!* [Practice nurse]

The requirements of new projects such as Get Checked, Care Plus, and Youth Health have also led to the expansion of nurses’ roles.
Several nurse leaders reported that the development of PHOs had made little real difference to overall nursing practice. For some practice nurses, they suggested, this is because they or their GP employers have not embraced the opportunities that the new environment has provided; for other nurses, it is because they – particularly those nurses working with Māori providers or in rural areas where there is a shortage of GPs – were already offering innovative and expanded services to their populations. Many Māori nurses working for Māori provider organisations, the nurse leaders contended, continued practising in the same way:

At the end of the day we were doing the same things as usual ... heavily reliant on our nursing staff to be our clinical experts with the assistance of GPs. The PHO came into line with what was happening ... and allowed more capacity to build. [Māori nurse leader]

Māori nurse leaders explained that the new environment had led to Māori nurses employed in some Māori-led PHOs gaining new service contracts for the provision of mobile services and other nurse-led initiatives. The nurse leaders also suggested there had been a greater valuing of the roles of Māori nurses by other health professionals.

[PHOs] gave us autonomy ... co-ordination roles ... opportunities for more contracts, and a lot of those will be nursing-led into the future. [Māori nurse leader]

Their [Māori-led PHOs’] philosophy and their desire to improve access allows Māori and Pacific nurses to grow and for their role to be respected to a far greater extent than mainstream nurses. [Nurse leader]

I think Māori nurses, because they’ve worked for Iwi providers, have been able to carve a niche for themselves. [Nurse leader]

Māori nurses are in a far better place in terms of Māori-led PHOs. [Nurse leader]

**Accident-related care**

The nurse leaders suggested that, in the new environment, the potential exists for PHC nurses to take a lead role in providing acute accident-related care. The nurses, they said, had the necessary skills and knowledge to do this. The practice nurses, GPs and practice managers were not asked about accident-related care.

There is a role for NPs here. [Nurse leader]

Nurses are very competent in taking on this role but they should be appropriately rewarded and valued for it. [Nurse leader]

Current Accident Compensation Corporation (ACC) contracts with PHC providers do not allow full funding for comprehensive accident-related care provided by nurses. When nurses do undertake consultations with ACC patients, GPs also see the patients, in order to access the maximum funding.
Nurses need … reimbursement such as ACC to acknowledge their work and match the service provided. [Nurse leader]

… GPs usually see them [ACC patients] to ensure additional funding and this results in funding-centred care rather than patient-centred care. [Nurse leader]

Nurse Practitioners (NPs)

The nurse leaders perceived NPs as having the potential to improve PHC significantly, offering greater access and choice for patients and freeing GPs to concentrate on more “complex care”. NPs were seen as providing a level of care and expertise different from that of other nurses, and as capable of being highly effective in addressing population health needs.

There is a dire need for NPs in primary health care, which is difficult to realise. [Nurse leader]

They will have the required qualifications and skills and be able to lead … and give consumers an opportunity to have a real choice. [Nurse leader]

The nurse leaders were enthusiastic about PHC opportunities for NPs. These included working with young people in non-traditional settings, broader population-health approaches such as sexual health and women's health, an increased role across PHOs in running clinics and prescribing, working in remote areas, working with the aged, chronic disease case-management, primary mental health care, and minor illness.

…the purest manifestation of a NP to me is a primary health care NP. I don’t see them as opposition to GPs or providing a whole alternative service. I see them as individuals who are able to do everything we are advocating for in terms of helping people change their behaviour in the community context. [Nurse leader]

Practice nurses see the potential for the NP role. As noted in Section 4.1.2 below, a surprising 82% of practice nurses reported that they were interested in pursuing NP status. Despite encouragement for nurses to attain NP accreditation, the nurse leaders reported there was still a lack of employment opportunities and funding streams to develop the role, and that accredited NPs often lacked appropriate support.

… half the NPs that are qualified still haven’t got jobs [as NPs]. [Nurse leader]

However, further development of the NP role was supported by GPs, practice managers, and board members.

4.1.1 GP Responsiveness to the Changing Practice Nurse Role

Table 3 presents the results from the GP Survey regarding the expanded role of practice nurses. The majority of GPs stated that they encouraged the practice nurses they worked with to increase their role
in the practice; and three-quarters of GPs reported that practice nurses had taken on an increased role since the implementation of the Strategy.

Table 3: GP Responses to the Expanded Role of Practice Nurses

<table>
<thead>
<tr>
<th>GP responses</th>
<th>Yes (%)</th>
<th>Limited extent (%)</th>
<th>No (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Encouraged nurses to take on expanded role in their practice</td>
<td>87.5</td>
<td>11.3</td>
<td>1.1</td>
</tr>
<tr>
<td>Nurses have taken up the opportunity for an increased role</td>
<td>75.6</td>
<td>22.9</td>
<td>1.6</td>
</tr>
<tr>
<td>Expanded nurse role leads to increased work satisfaction [for GPs]</td>
<td>92.9</td>
<td>2.6</td>
<td>4.5</td>
</tr>
<tr>
<td>Expanded nurse role frees up GP time</td>
<td>77.5</td>
<td>16.8</td>
<td>5.7</td>
</tr>
<tr>
<td>Expanded nurse role is a more efficient use of personnel</td>
<td>90.3</td>
<td>5.2</td>
<td>4.5</td>
</tr>
</tbody>
</table>

One GP suggested:

... the community based medicine that is now being pushed ... is a nurse oriented type of work. [GP]

This was supported by a PHO manager who is also a GP. He suggested that nurses are able to provide a large number of PHC services, and that for much of the work there is no need for a doctor.

We have always had a very independent nursing staff, the philosophy has not changed but we have the additional services. We have expanded the nursing staff; we have a Care Plus nurse and an outreach nurse. We have a phone nurse on all the time who triages calls and we have an acute nurse who triages the walk-in acute patients to decide if they need to be seen by the doctor and we have a consulting nurse running a clinic ... we have some specialised clinic s ... it works smoothly. [GP]

Where a patient’s needs are met by a nurse rather than a GP (such as where a nurse performs diabetes checks, smears, or triage), this was often seen to free up doctors’ time, be cost effective, and to lead to greater job satisfaction for team members.

In many areas the expanded role has resulted in increased acceptance of nurses by their communities as “their first port of call” and people now have more choice about who will provide the services they need. In some practices, the nurses rather than the GPs see patients for follow-up visits. In addition, mainly in the larger practices, nurses are becoming more specialised as – for example – diabetes nurses, asthma nurses, and respiratory nurses. The 2006/07 New Zealand Health Survey found 22.7% of children and 28.7% of adults visited a practice nurse without seeing a GP (Ministry of Health, 2008).

There is a marked contrast between PHO managers or GPs who take advantage of the new structures and opportunities to expand the nurses’ role, and those who perceive the nurses as there to support the doctors.
The first group is responsible for the substantial developments that have taken place, and they provide encouragement for their nurses to undertake new and innovative developments that will increase access to appropriate services for their populations. They see possibilities for nurses being more involved in projects such as Care Plus and agree that nurses add value to patient consultations. The chair of one rural PHO suggested that utilising the particular skills of each profession, and breaking down the silo mentality of old, is potentially more cost effective and offers more choice and better outcomes for patients.

The second group remains very GP-oriented. They argue there are no financial incentives to use nurses fully, they perceive general practice as still being doctor focused, and they suggest that nurses are there to “support the doctors”.

... there are certainly things that they [the nurses] could be doing which would free up our time. [PHO manager]

One PHO manager suggested that if nurses took on more responsibility it would “reduce GPs’ work rate”. Other PHO managers explained that those practising in the old business-oriented model will not use their nurses fully.

There are still practices where the more patients you see the more money you make ... it’s a real conflict with you being proactive, doing Care Plus ... Those practices in the old model will not use their nurses ... if you can get $60 for a smear why have the nurse do it for $10? They haven’t switched. [PHO manager]

A patient comes in to have some stitches out – if a nurse saw them it was about $15, if a doctor saw them it was about $32 ... the doctors are running the business and they do not want to lose out [on] any money. [PHO manager]

In some PHOs there is an awareness of the need to adapt to the new environment but change is slower. According to the GP chair of an Access PHO:

We have not changed as much as we could have [with capitation] ... I do not know if that is us or the patients ... it’s still very much doctor orientated ... Patients still come to see us rather than the nurses. [GP PHO chair]

A GP from a medium-sized PHO reported:

There are many things that a good experienced practice nurse could do and again it is a matter of habit and history that I suspect it is not being done as much as it could be done. We have a way to go in this area. [GP]

While many GPs are accepting of nurses as more equal members of the practice team, others are not. Some reported feeling “anxious” and “suspicious” of nurses taking over their roles and them being “shafted”. One PHO board-member GP reported the changes as being “a bit scary” and said that in their practice they had stopped their nurses doing individual consultations. One practice nurse saw the GPs’ anxiety as:
A key issue ... for the doctors [is] understanding the role of the nurse ... that she is not trying to take over ... that she is not trying to be the doctor ... she is offering a different service. [Practice nurse]

It was reported that some GPs were still working in a traditional medical model with its historic ways of working and have yet to whole-heartedly embrace the potential of the Strategy.

Some small South Island rural practices that consist of a single GP with his wife as practice manager were reported to remain very resistant to employing nurses who would increase the practices’ role in population health and community intervention work.

4.1.2 Education and Career Development

A number of interviewees drew attention to a need for greater capability-building and diversification of skills within the PHC nursing workforce, especially in relation to the expanded practice nurse role and the demands placed on nurses as a result of services moving from secondary to primary care.

When asked about nurses’ preparation for working in PHC, the nurse leaders noted some improvements in the PHC content of undergraduate nursing programmes; but overall the majority perceived current education programmes as failing to meet the needs of PHC nurses.

... nurses in PHC have to have all the clinical skills and knowledge but they also have to be extremely efficient in the art of communication, therapeutic relationships ... building capacity and health promotion ... I don't think the current undergraduate programmes currently do this. [Nurse leader]

They suggested the programmes remain too focused on hospital nursing.

Sometimes it appears that PHC streams are a tack-on that you can add on or not to what are seen to be the most important skills, which are the generalist hospital skills. [Nurse leader]

... there was a belief that to make a PHC nurse you had to spend time on a ward. Those that came out of the wards hated it. [Nurse leader]

In addition, they argued that the needs of some groups of nurses, such as Māori nurses, were often overlooked.

I think existing systems don’t see that Māori nurses need support at every step of the way – from being a student getting into sciences, to undergraduate and being supported as an RN and being treasured. [Nurse leader]

The nurse leaders recognised that there are increasing numbers of PHC nursing postgraduate papers and programmes on offer because of increased funding opportunities, but the majority voiced concern that some programmes lack a coherent framework and that the content varies across institutions.
... there’s supposed to be a national framework and there isn’t. Lots of PHC papers are available but there is confusion about how to construct them into a programme. The quality varies considerably. [Nurse leader]

... postgraduate education [needs to be] standardised as far as core concepts, policy, theory, research, [and] evidence-base is concerned. Also a range of advanced-practice clinical specialty options [need to be] made available. Cross crediting [needs to be] made more available to nurses across courses. [Nurse leader]

... education is expanding horizons and assisting in role development but content needs to be more specific to PHC nursing development. Currently it does not require core PHC knowledge such as family psychology, counselling and primary mental health care. [Nurse leader]

Table 4 summarises the Practice Nurse Survey results relating to the nurses’ education and career development opportunities. The majority of practice nurses reported being interested in advancing their career by taking on an NP role (82%). Postgraduate courses were available locally to 59% of the practice nurses; over half (59%) of them received encouragement from their practices to attend courses; and 56% reported having their attendance supported through paid leave. Fewer practices covered the cost of postgraduate courses (36%).

<table>
<thead>
<tr>
<th>Practice nurse responses</th>
<th>Yes (%)</th>
<th>No (%)</th>
<th>Not sure (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interested in becoming an NP</td>
<td>82</td>
<td>18</td>
<td>n/a</td>
</tr>
<tr>
<td>Postgraduate courses available locally</td>
<td>59</td>
<td>32</td>
<td>9</td>
</tr>
<tr>
<td>Practice encourages postgraduate courses</td>
<td>59</td>
<td>31</td>
<td>10</td>
</tr>
<tr>
<td>Practice provides paid leave for postgraduate courses</td>
<td>56</td>
<td>22</td>
<td>22</td>
</tr>
</tbody>
</table>

Although questions about education and career development were not directly asked during the Second Phase interviews, some PHOs and practices were reported to be very supportive of nurses’ ongoing education – conducting workforce surveys of education and training needs, and actively supporting their nurses’ postgraduate studies. The example was given of one Māori practice that paid half the costs associated with postgraduate courses for their nurses when scholarships were not available.

We are constantly looking at how we can help and up-skill and empower the nurses to provide primary services in the community. [Manager, small rural PHO]

Another example was given of a PHO that had been actively involved in increasing the locally grown workforce through encouraging the local provision of PHC nursing education.

In another area, an IPA rather than a PHO led the up-skilling and support of nurses through a nursing committee. The role of the PHO was then to pick up and maintain this development.
While it was recognised that some progress had been made on improving access to postgraduate education through relief-staff bureaus and improvements in the provision for release time, the nurse leaders said that for many practice nurses there remained significant barriers to access – both practical and attitudinal. Employer attitudes were of particular concern.

... it’s very hard to get that individual out of the practice [for further education] because they’re just seen as that practice’s resource ... a PHO should be able to have an overview of its nursing workforce ... able to work in a way so it can pull the nurses from practice time and relieve people from duty for education. [Nurse leader]

Almost all the nurse leaders were positive about the opportunities provided by scholarships – not just opportunities for individual nurses, but wider opportunities from the secondary effects of promoting postgraduate education and the value of PHC nursing.

[The PHO environment has created] new opportunities to develop nurses’ potential and supported postgraduate education. [Nurse leader]

I think that there are programmes certainly locally [where] I can see stuff starting to happen. [Nurse leader]

There is a hugely raised awareness and general discourse about the importance of PHC nursing now. [Nurse leader]

### 4.1.3 Barriers to the Expanded Role

While the Strategy set out clear opportunities for nursing development, some interviewees reported that many health professionals, including nurses, were unaware of the role of PHOs and their potential for influencing the provision of health care services.

The make up of PHOs is not understood – what they’re about and what they’re for. [Nurse leader]

The need to create a greater awareness, within PHC nursing, of the opportunities under the PHO structure for promoting health and preventing disease was commonly agreed. Nurse leaders stated that where PHOs have implemented Ministry recommendations around shared governance and community partnerships there are some good examples of expanded nursing roles.

However, for most nurses employed in general practices, the nurse leaders consider there has been little or no change in their level of autonomy. Increasingly nurses are being expected to undertake a greater workload in order to meet new contracts agreed by the general practice management.

I think they’ve probably become less autonomous as more things are put upon them that GPs say within their business they have to meet. [Nurse leader]

A lot of rhetoric but no follow-up ... practice nurses are disheartened and there is increasing fragmentation of nursing services. [Nurse leader]
Though there are some significant exceptions, the majority of PHOs replicate what we used to have ... an old IPA-type of operation with a new plaque on the door. [Nurse Leader]

A number of factors are reported to be causing increased demands on nurses’ time in the PHO environment: a large administrative burden and time taken to comply with reporting requirements; time needed to access new funding streams; maintaining professional quality with ongoing training and education; dealing with a large number of very sick patients; completing immunisations; and meeting increasing demands and expectations from health consumers. Some interviewees described a lack of support structure for nurses new to PHC, and one of the contributing reasons for this was nursing workloads that limited the capacity of practices to provide support for new graduates.

Lack of time for both nursing and medical staff was also reported to be limiting nurses’ ability to take on new initiatives such as Care Plus and health promotion initiatives and to develop innovative new services. In some cases, lack of time was also seen to be limiting their ability to increase the number of registered patients.

... it [the PHO environment] hasn’t made much difference to practice. It’s increased the workload. [Nurse leader]

Where Care Plus has been implemented, lack of relief staff has in some cases led to cancelling of Care Plus clinics. Furthermore, in some PHOs “expanded roles” had been enabled only through specific innovation or SIA funding and had occurred only in relation to narrowly defined projects and locations. Less than 30% of practice nurses reported being satisfied with the level of career development opportunities available to them.

Everyone is really, really busy and often we have unrealistic expectations. We get really excited about something but then have to be realistic about our ability to deliver this on top of what’s already being done. [Practice nurse board member]

Access to education and training was thought to limit capability-building in some instances, particularly in rural areas. Significant differences in the level of support for nurses were reported between practices.

... There is whole lot of really good functioning practices and there [are] some that are mediocre and are not releasing the nurses for any training even if the nurses want to. [PHO manager]

Furthermore, GP attitudes towards nurses and concerns about their competency were cited as contributing reasons for too few practices having changed from the traditional medical model.

... there is the historic thinking within general practice that nurses cannot do certain things. [DHB manager]

Additionally, some patients’ attitudes to multidisciplinary approaches and nurse consultations were seen as a barrier:

... there is still the assumption by some that a doctor should always be the main provider. [Manager, small Access PHO]
Some nurses themselves limited the development of expanded practice nurse roles. It was reported that some nurses have not taken up opportunities to up-skill, and that their competency, confidence, and willingness to take on new roles were limiting their role development. Some expressed a view that nurses need to be more “proactive and confident” about the way they practice.

... some nurses have not kept up and do not want a full nursing role. [Manager, IPA-based PHO]

There are a number of nurses who have not kept up with the play. They actually moved into the regular hours of practice nurse/receptionist role and it suited them. [PHO manager]

Nurses have to step outside their comfort zone and move on from being “beck and call” girls. [PHO manager]

Despite disappointment about the pace and the inconsistency of nurses’ development, a deeply held belief about the importance of PHC was apparent:

Primary health care is the place of the future. [Nurse leader]

### 4.1.4 Areas for Capability Building

Responses to the need to build capability for the PHC nursing workforce centred on improvements to the nursing knowledge-base and improved autonomy in expanded roles.

Some interviewees expressed a need for a more national approach to improving nursing capability, with greater recognition of the learning needs and experiences of nurses in practice. This could be achieved through PHOs having a larger role in planning for professional development or (as was noted by nurse leaders in some areas) by PHOs at least linking with other PHOs in co-ordinating workforce development.

It was also stated that, in order to realise their potential, more practice nurses need to be encouraged into education and consistent standards for practice need to be developed.

I would like to see nurse education, that has been at this stage retained by the DHB, to come to the PHO because I believe the PHO can provide adequate training of nurses through its primary care teams, rather than it being distorted between secondary care and primary care nursing. [Manager, small rural PHO]

... it’s very, very variable and we desperately need some consistent standards across practices to pull the profession up. [Manager, IPA-based PHO]

There are scattered pockets of nurses doing different things. [Nurse leader]
Several areas were identified as being in particular need of increased training and education. These included Māori tikanga, governance, mental health assessment and early intervention, and a greater awareness of (and opportunities for) liaison with voluntary agencies.

Further development of the NP role was supported by practice nurses, GPs, practice managers, PHO managers, and board members as providing opportunities for PHC. They also identified the need for support and greater flexibility when implementing the NP role within PHC. One PHO manager commented on the attractiveness of the concept of the NP for rural areas.

A few interviewees, however, perceived difficulties with the role, seeing it as focusing on one end of the nursing spectrum while much needed to be done by nurses who don’t aspire to the role.

I am not convinced that nurse practitioners are the solution – we need first of all to improve the capability of “Joe-average” practice nurses. We need to do work with general practice about how they use practice nurses … [The Strategy] provides a leverage model for nurses to do more. [DHBNZ member]

There has been a lot of focus from “above” on the nurse practitioner role, which is not particularly helpful, it’s one end of the spectrum but there is so much more that can be done by nurses that don’t aspire to that role. [Practice nurse board member, IPA-based PHO]

There’s nothing in-between and we need to develop a really good range of clinical nurse specialists in all these areas in PHC, or PHC nurses that are generalist specialists to bridge that gap. [Nurse leader]

The nurse leaders suggested that control over, and access to, funding was a key concern for practice nurses. They argued that existing funding streams through general practice replicate the old gatekeeper relationship and are an “absolute barrier” to delivering nursing services, promoting autonomous practice, and developing nursing-led service models. Furthermore, they argued, this employer-employee relationship inhibits nurses’ decision-making about how care is offered and reduces their confidence to change things.

… as long as the funding is funnelled through the general practitioner and the nurse doesn’t have any control over the funding – that’s a problem. [Nurse leader]

… capitation was meant to provide freedom in general practices for practice nurses. It hasn’t – the GPs employ them and decide what they can do … Nurses do not decide how nursing services will be provided – GPs do. [Nurse leader]

… unbundle/extricate funding from capitation to enable nurses to be part of a truly autonomous nursing service. To work alongside GPs, not be employed by them – and be flexible, accessible and mobile. [Nurse leader]

Obtaining support for nursing innovations and securing appropriate funding is difficult for many PHC nurses, the nurse leaders maintained.
... if you want to do something innovative you need a huge amount of support and a big buy-in from your employer. [Nurse leader]

Some Second Phase interviewees considered that greater flexibility with funding streams would enable practice teams to address and deliver a wider variety of services to the enrolled populations, including domiciliary visits by practice nurses and palliative care nursing.

*We could do dressings in the home ... we could do that just as well [as district nurses]. We could have our own midwife which would offer a really good service to our patients. It would make us almost completely self-sufficient!* [Practice nurse]

*We need to get back to the community model [with midwives, doctors and community nurses working together]. We could do a lot more with cardiac and with respiratory.* [Manager, IPA-based PHO]

The nurse leaders noted some positive funding developments such as nurse education, health promotion and SIA funding, but they questioned the sustainability of some of these initiatives. Funding streams were also thought by some to fragment and divide the PHC nursing role, weakening the “umbrella identity of the PHC nurse”.

*I would like to see the PHC nurse role integrated into a specialist role under a PHC nurse title managed through PHOs.* [Nurse leader]

### 4.2 Capacity

This theme reports on findings that relate to the size and demographic extent of the PHC nursing workforce, to recruitment and retention issues, and to environmental opportunities and barriers. These are crucial factors in enabling PHC nurses to meet the Strategy’s vision, particularly in terms of managing recruitment and retention of nurses.

The demographic details of the 384 Practice Nurse Survey respondents are summarised in Table 5. The majority (71.2%) were aged between 41 and 60 years of age; very few were in the 20 to 30-year age group. Of the 364 respondents, only four were male. Over 60% were NZ European; very few identified as Māori, Pacific or Asian. Nearly a third of respondents identified as “Other”, but their ethnicity was not specified.

**Table 5: Demographics from the Practice Nurse Survey**

<table>
<thead>
<tr>
<th>Demographic</th>
<th>N (n=384)</th>
<th>%</th>
</tr>
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<tbody>
<tr>
<td><strong>Age range (yrs)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20-30</td>
<td>13</td>
<td>3.6</td>
</tr>
<tr>
<td>31-40</td>
<td>64</td>
<td>17.7</td>
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<tr>
<td>41-50</td>
<td>150</td>
<td>41.4</td>
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<td>27</td>
<td>7.5</td>
</tr>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>380</td>
<td>98.9</td>
</tr>
<tr>
<td>Male</td>
<td>4</td>
<td>1.9</td>
</tr>
<tr>
<td><strong>Ethnicity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NZ European</td>
<td>220</td>
<td>60.4</td>
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</tr>
<tr>
<td>Māori</td>
<td>18</td>
<td>4.9</td>
</tr>
<tr>
<td>Pacific</td>
<td>4</td>
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<tr>
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<td>6</td>
<td>1.6</td>
</tr>
<tr>
<td>Other</td>
<td>116</td>
<td>31.9</td>
</tr>
</tbody>
</table>

Note: *N does not total 384, because of non-responses.

Length of experience as a practice nurse is presented in Figure 2 below. Over 50% of survey respondents had been a practice nurse for at least 10 years and of these 34% had been working as a practice nurse for five years or less. Forty-two per cent had over 10 years’ experience. It is not known how long the respondents had been working in their current practice or if they had moved to a practice nurse role from secondary care.

Figure 2: Number of Years as a Practice Nurse

![Number of Years as a Practice Nurse](image)

The number of hours the practice nurses worked per week is shown in Figure 3. Only two percent reported working more than 40 hours per week. The majority (52%) worked 30 hours or less per week.
Figure 3: Number of Hours Worked per Week

<table>
<thead>
<tr>
<th>Hours Per Week</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-10</td>
<td>5</td>
</tr>
<tr>
<td>11-20</td>
<td>15</td>
</tr>
<tr>
<td>21-30</td>
<td>35</td>
</tr>
<tr>
<td>31+</td>
<td>50</td>
</tr>
</tbody>
</table>

4.2.1 Recruitment and Retention

The responding practices employed on average 2.5 full-time equivalent (FTE) practice nurses, and 12% of practices reported they had a vacancy for a practice nurse. Data from the interviews indicated that, while some practices reported no problem filling nursing positions, many practices reported that recruiting nurses in PHC – particularly experienced nurses – was difficult. Some noted difficulty attracting young nurses; but other interviewees commented that younger nurses are increasingly looking at PHC options.

*Practice nurses are a bit thin on the ground but [the practice] has a good reputation... two of the other four practices have significant problems and are bringing people in from overseas. [PHO manager]*

*I think the increase in [nursing] salaries is improving retention and that primary care nursing is an exciting place to work at the moment ... the PHO model may increase nurses running their own clinics, instead of just helping the doctor ... and taking nursing out into the community. [GP board member]*

Some practices reported getting no responses to job advertisements. Māori practices are hard hit by recruitment difficulties, and finding Pacific-speaking staff is particularly difficult. Both the nurse leaders and the practice nurses reported that many of the nurses employed in Māori-led practices receive lower salaries than other PHC nurses in similar roles. The nurse leaders identified this as a barrier to the development of the Māori PHC nursing workforce and as a key factor in influencing nurses’ return to a mainstream health provider.

The most common barrier to recruitment and retention of PHC nursing staff was seen to be the salary difference between primary and secondary care. The interviewees reported the 2005 MECA (multi-employer collective agreement) for DHB nurses caused a migration from primary to secondary care. Many practice nurses expressed an urgent need for their employers to address pay parity with DHBs. A few practices have dealt with this by increasing practice nurse salaries. (The survey data showed less than 20% of practice nurses were satisfied with their current level of income.)
The nurse leaders argued that the MECA had compounded recruitment and retention issues in PHC and had led to some services, such as mental health and family violence, being sidelined. They suggested it remained to be seen whether attempts to introduce a MECA for PHC would challenge the migratory trend.

*I’m continually told it’s harder and harder to get good PHC nurses into PHC positions, especially in aged care and in places like Plunket, family planning and prisons. Fewer people are applying for these positions, especially since the MECA came in.* [Nurse leader]

*… once they go into the DHBs they are usually lost to primary nursing.* [Nurse leader]

Increased demand on infrastructure, including space, was identified by some interviewees as a limiting factor on the ability of practices to take on more staff and initiate more services.

*… designing projects that will involve greater amounts of nurse time are likely to fail … general practice is working well beyond capacity currently.* [GP board member, IPA-based PHO]

*All of these projects demand time and they are challenging the capacity of the existing workforce.* [GP board member, IPA-based PHO]

A number of interviewees suggested that increasing nursing resources would allow PHC initiatives to flourish.

*… there has been a real mindset change in our practice that we should employ more nurses to allow some of this stuff to go to its full fruition.* [GP]

In the interviews, most informants referred to a serious workload problem in practices; for many PHOs this was the main issue of concern and had major implications for the retention of nurses. In addition, high workloads for nursing staff are leading to division of roles and greater specialisation in nursing, and are limiting the capacity of the practice nurses to provide support for new graduates.

*… they are overwhelmed about what it means to get a novice into their practice and having to orientate them from the start.* [PHO manager]

Some practices are facing a high turnover of nurses. As well as salary concerns, high stress and lack of control were cited as contributing factors.

A lack of work-life balance appeared to be an issue with the majority of survey respondents. Less than 40% reported that they were satisfied with their current work-life balance, though 80% of respondents found working as a practice nurse rewarding in some way. Any extra demands, they claimed, would lead to further fatigue and loss of staff.

Recruiting nurses to remote areas was said to be difficult because of the lack of other work and lifestyle amenities. It was suggested that the frequently larger role of rural nurses may contribute to a higher level of burnout for them.
The nurse leaders reported that, in general, opportunities for nurses are tempered by the difficulties and frustrations of some highly skilled and qualified nurses who are unable to implement new initiatives. They suggested this results from the nurses’ inability to directly manage pressures of work volume and to access resources. The nurse leaders highlighted the need to improve the capability and capacity of the PHC nursing workforce, including introducing more positions for NPs.

### 4.2.2 Areas for Capacity Building

There were a number of examples where practices had made an effort to provide attractive working conditions and had introduced strategies to improve retention of nursing staff and recruitment of new staff.

*Practice nurses are a bit thin on the ground but [the practice] has a good reputation ... We now have a very happy and focused group of people ... people now know what they should be doing and we have a formal performance appraisal process ... in some cases the results have been stunning.* [PHO manager]

*... if their income was higher and I could spend an hour a week teaching them what I know ... the team concept [would be] reinforced ... they [would] feel looked after ... those sort of things would make a great difference to nursing turnover.* [GP]

*We kind of try to run the organisation like a bit of a whānau-based organisation. I support the women in the organisation when they have babies and generally allow them to bring their babies for the first year until they are big enough to go into kōhanga. We take all the staff away on a team building trip.* [PHO chair]

Some larger PHOs were reported to be working to promote PHC nursing as an exciting career choice, running scholarship programmes and increasing exposure of new graduates to PHC by providing short-term work experience.

*We have worked very hard at promoting primary care nursing and the organisation to students, really selling the community as an exciting career choice with opportunities for new roles in the future.* [Practice nurse board member]

A number of interviewees suggested PHC needed to be made more attractive to new graduates, for example by having more structured career pathways:

*We have to raise the status of primary care, empower the professionals to develop sub-specialties and build its capacity.* [PHO board member]

As well, the nurse leaders suggested that professional orientation and support such as that offered by the Nursing Entry to Practice Programme for PHC nurses are essential for addressing capacity issues.

As was found in the evaluation of the nursing innovations projects (Primary Health Care Nurse Innovation Evaluation Team, 2006), some DHBs are reported to be active in building the capacity of PHC nursing in their region. One DHB member described an internship programme for those of its nurses...
wanting to move from the hospital or other areas to PHC, which is intended to take the training load off practice nurses.

... the practices that are short of nurses do not have the time and capacity to take on people who are new to primary care ... you cannot take on people with minimal training and drop them into practices like that where nurses have a lot of responsibility. [DHB member]

Building capability and capacity within the Māori and Pacific nursing workforce was reported to be particularly important. The current paucity of staff means the nurses often have to take on leadership roles and are susceptible to “poaching” from other organisations.

... in a lot of Māori PHOs and providers you have to get non-Māori nurses in because there's such a shortage. [Māori nurse leader]

... they often end up being in leadership roles because there aren’t enough of them and the workload for them becomes huge. [Nurse leader]

The establishment of a Pacific nurse leader position in one DHB, Counties Manukau, was seen as a positive move. But the broader context was also noted:

... Pacific Island health organisations ... are not funded as well as they should be. They end up delivering a lot of service to a lot of people with very little resource and that can’t be easy or fun. [Pacific nurse leader]

To overcome shortages in rural areas, some practices are concentrating on promoting the cultural and lifestyle advantages of the area. Another suggestion was to increase the remuneration of those nurses who work remotely.

4.3 Collaboration

This theme reports on the findings that relate to PHC teamwork and collaboration since the implementation of the Strategy.

There was general agreement among interviewees that teamwork is imperative to the future of PHC. Many practice nurses saw teamwork as incorporating equality, multidisciplinary care, complementary practice (rather than substitution), respect for the nurses’ level of skill and their opinions, and making best use of each professional’s skills.

To me this is the most appropriate person doing the job, utilising the capabilities of each member of the team. We don’t need to have doctors doing things that nurses could do better, or as well as, rather keep the doctors’ skills for what only they can do. [Practice nurse board member, IPA-based PHO]

The nurse leaders reported practice nurses as anticipating that the PHO environment would result in their working more collaboratively in teams with other health workers and patients, and across sectors.
The PHO would be a team with everyone working together in more equal way. [Nurse leader]

It was suggested that better teamwork is achieved when there is good leadership, shared values, and a common vision amongst the team members.

There are some excellent examples where people are valued ... and they’re all working towards the same vision – they’re very patient-focused as a multidisciplinary team – and they don’t see one or the other as having power over the other ones in the team. [Nurse leader]

Where there is good leadership and less emphasis on retaining profit ... [they] have all hands on deck and work as a team. [Nurse leader]

Some practice nurses described being recognised as autonomous members of the practice team and having a collegial relationship with GPs.

The neat thing about working here is the team approach where we are respected for the level of skill we bring to our work. [Practice nurse, small Access PHO]

We have always had a close working relationship [with the doctors] ... they respect us as professionals ... they have always been incredibly good ... we are probably very fortunate. [Practice nurse, small Interim PHO]

One interviewee spoke of an egalitarian and effective management team in a small PHO, which consisted of the practice manager, office manager, practice nurse manager, an executive partner, and a deputy.

... it’s extremely supportive and innovative. [Practice nurse]

One IPA-based PHO estimated that about a third of practices are actively moving towards a team approach. This PHO manager thought larger PHOs enabled the specialisation that promoted teamwork. However, practice nurses from small rural PHOs also reported that teamwork has “always been a feature of their practice”.

Many practice nurses commented on the developing team approach within their practice.

Well the doctors are all still paired to a nurse – that’s still there but there’s less, much less dependence on the nurse running around after the doctor all day. [Practice nurse]

Teamwork [works well here] ... the staff are very constant ... we have strategic planning every year ... we have full staff meetings ... and at those meetings everyone has the opportunity to input their thoughts and ideas ... and I think that is the philosophy of the practice ... we are quite a social bunch and we do celebrate individual success and we worked hard on that together. [Practice nurse board member]
Combined meetings and education sessions involving the “entire team” were mentioned as facilitators of teamwork, and some interviewees reported that there had been more collaboration between nurses since the implementation of Care Plus.

In general, Pacific PHO staff reported having a team-based working style in keeping with their culture.

*It’s part of our culture to work as a team, we don’t compete with each other, we work as a team. That is the only way that we work.* [Staff, Pacific PHO]

*As services move into the community, we are organising the Pacific community to work as a team. Pacific people need to work together as a team, that is how it works best.* [Staff, Pacific PHO]

One DHB manager observed that the highest level of teamwork was in Māori and rural practices, and suggested this could be a consequence of insufficient numbers of GPs. This view is also consistent with the perception that Māori practices have a stronger history of working as teams of nurses and doctors.

*Māori providers have fewer GPs and thus they have been more innovative about teamwork.* [DHB manager]

It was evident in some PHOs that collaboration and teamwork has extended beyond the traditional practice team. Many PHOs are moving towards employment of a wider range of nurses and other health professionals. In particular, nurses and others foresaw that community health workers – employed most often to assist in accessing low users and linking them with services – will increasingly be important members of the teams.

*The community health worker will go with the nurse to deal with a client – the community worker will deal with the social issues and the nurse will deal with the asthma issues.* [PHO chair]

*We need these additional skills as part of the practice team.* [Practice nurse board member]

Some PHOs are making a conscious effort to increase teamwork; they have, for example, developed sentinel practices which can be used to demonstrate best practice in teamwork. Another concept being investigated is virtual teams – a sharing of expertise across a virtual network of clinicians, NGOs, and allied professionals.

A few practice nurses commented on the real benefit resulting from the PHO environment: strong, accessible linkages have been formed with local social workers, mental health nurses and other professionals. The nurse leaders gave examples of collaboration with external providers such as drug and alcohol units, mental health agencies, and domestic violence support units. The practice nurse respondents (n=384) reported that, in an “average” week, they contact other community health services such as Plunket, public health, district nurses and Family Planning 5.3 times on behalf of patients and 1.4 times on behalf of non-health social services (which include Work and Income, the Department of Corrections, and Housing New Zealand). In addition, the nurses reported contacting hospital doctors and services 7.2 times on behalf of patients.
Both SIA and health promotion funds have been useful in enabling PHOs to become involved with NGOs and other providers – such as the Cancer Society, Asthma Society and the Heart Foundation – and to link with community activities for health promotion.

The nurse leaders suggested new positions for practice nurses as “integration leaders”, facilitating collaboration between different nursing groups through working in shared projects. This was seen to be a practical strategy for developing teams amongst nurses. In addition, professional networks are thought to assist collegiality and improve professional communication. Examples were given of attempts to bring nurses together for this purpose.

*I see a disconnection between practice nurses and other primary health care nurses and providers in the community. There is nervousness about “taking over roles”. I organise “meet the other players” evenings ... all kinds of people are invited to connect and find out what others provide ... it’s been successful. [Nurse leader]*

*The practices that are involved in a PHO are starting to bring people together i.e. through nurse leader roles ... more than they have in the past. [Nurse leader]*

The nurse leaders reported examples of PHC nurses more generally engaged in teamwork and collaboration. These included nurse-led school-based services (where collaboration takes place with social workers, counsellors, and public health nurses), sexual health nurses working within schools, mental health nurses co-ordinating care between primary and secondary services, nursing outreach immunisation programmes for Meningococcal B, and public health units undertaking prevention strategies. Māori PHC nurses in rural areas were reported to be working collaboratively with non-health sectors.

Table 6 summarises the findings on teamwork from the GP, Practice Nurse and Practice Surveys. It was consistently reported by respondents in all three groups that their practice operates as a team, even though some practice nurses claim that the employment relationship with their GPs prevents them from expanding their roles and working more effectively within their practices. The impact of the expanded nurse role on teamwork was examined only in the GP Survey; and the vast majority (93%) of GP respondents said that the expanded nurse role has the potential to increase teamwork.

| **Table 6: Perspectives on Teamwork from the GP, Practice Nurse and Practice Surveys** |
|---------------------------------|-----------|---|
| **Respondent:**                | Perspectives on teamwork | **Yes (%)** |
| **GP**                         | Practice works as team    | 79.7 |
|                                | Expanded nurse role leads to increased teamwork | 93.3 |
| **Practice nurse**             | Practice works as team    | 78.0 |
| **Practice manager**           | Practice works as team    | 80.5 |
|                                | Practice holds regular team meetings | 76.0 |

While GPs voiced strong support for the need for teamwork, their interpretation of teamwork varied. One referred to the importance of equality amongst health providers, and of patients having a choice.
The doctor should not be greater than a nurse. We are all health professionals. We all must work together ... for example with smears, you can choose to have a nurse and develop a relationship. [GP]

In some cases, GPs gave the impression that their understanding of real teamwork was limited. Others stated that teamwork was well established before the introduction of PHOs.

Most practices are well oiled machines where teamwork is exemplary ... team-based styles {were} implicit in the delivery of general practice health care well before the PHO movement. [GP board member]

In contrast, as mentioned in Chapter 2, Schoen et al. (2007) found in their 2006 survey of health care in seven countries that New Zealand demonstrated low levels of multidisciplinary teamwork in general practice. Effective multidisciplinary care, they argued, is one of the factors that contribute to patients having positive experiences of health care.

This study’s survey respondents identified several factors contributing to both the slow development of teamwork within practices and collaboration with other PHC nurses and other health professionals. These included patch protection issues between GPs and nurses and other professionals, GPs’ attitudes towards nurses and nursing, nurses’ competence and confidence and their willingness to embrace a fuller nursing role, workload, and space.

One PHO manager reported that larger practices are making the most changes in terms of teamwork.

... it’s easier when there are enough people to be able to specialise. [Manager, IPA-based PHO]

Some nurse leaders perceived the employer-employee relationship between GPs and nurses as not being conducive to nurses and GPs working together more equitably, despite this being an expectation of the Strategy.

The hierarchical nature of teams created by GP employment in itself reduces collaboration. [Nurse leader]

Others disagreed.

The employer-employee relationship is in my view made too much of when looking at barriers to teamwork. [Practice nurse board member]

With the increasing focus on the potential contribution of nurses and NPs to PHC, nurse leaders suggested there is a growing unease amongst GPs about the proposed changes in roles and boundaries.

There is nervousness about the NP role. GPs see themselves as the corner stone and nurses as second players. [Nurse leader]
While some nurse leaders suggested Care Plus has promoted teamwork, others suggested it does little to encourage collaboration.

[The PHO environment] has resulted in nurses and [doctors] doing things together for their patients [but] only when there are funding streams which facilitate that such as Care Plus. [Nurse leader]

While the above examples indicate a high level of support for collaboration among health professionals, and while there are good examples of teamwork happening, a number of interviewees reported that “true” teamwork has been slow to take off in a significant way.

A strong theme emerging from the interviews was the impact of funding pathways on teamwork and relationships. Some interviewees felt strongly that funding mechanisms would need to change in order to achieve the level of teamwork envisaged in the Strategy. Business incentives are driving many GPs to focus on seeing more patients, as a means of maintaining their personal income. This is perceived as a powerful incentive against using nurses in expanded roles, and as inhibiting development of a multidisciplinary team approach.

[Practices] cannot remain funded on a GP register. Enrolments should be able to happen anywhere ... with nurse providers who are part of a PHO. [DHB manager]

4.3.1 Nurses’ Role in Governance

Few PHC nurses were thought to be participating at a governance level within DHBs, PHOs, NGOs, or other health provider organisations – despite this being an expectation of the Strategy. The nurse leaders reported that nurses are lacking in confidence in organisational settings that are frequently “medically dominated”. They stated the power a GP holds as an employer is identified as a barrier to effective participation in PHO governance. Where nurses are members of governance groups, the position is often considered “token” because a “voice” articulating nursing perspectives is not apparent.

... it’s easy to put your part-time practice nurse on the board and then do things how you’ve always done them. [Nurse leader]

Nurses might be on groups but don’t articulate their views or [aren’t] asked for their views – they’re just there for some politically correct reason. That’s where we need to provide nurses with some skills around governance and helping them to be more assertive in these types of roles. [Nurse leader]

One DHB was singled out for being known to have nursing (including PHC) representation at the different levels of organisational governance. This was a result of persistent persuasion by senior nurses.

We have nurses at every governance level across the DHB. There is not a governance meeting ... that a nurse is not involved in ... a primary health care nurse is also on the clinical board. [Nurse leader]

The nurse leaders strongly advocated that nurses should contribute to governance. This, they believed, would avoid organisational changes being imposed on nurses by doctors and managers. The nurse
leaders suggested that the development of skills in strategic planning, policy development, and assertiveness would assist nurses in becoming more effective contributors. While directors of nursing were generally considered not to have much experience in PHC, they were recognised as having requisite skills in leadership. They could therefore have greater involvement in mentoring PHC nurses in governance.

The Second Phase interviewees advocated that nursing leadership at the PHO level should develop nurses’ roles and provide PHO boards with a nursing perspective. Some interviewees pointed to examples of nurses’ involvement in governance.

... setting the higher-levels direction of the organisation. [Staff, Māori PHO]

Some practice nurse board members who were interviewed generally expressed satisfaction with the way PHO boards are working and reported respectful relationships with other board members.

[There is a] great deal of trust and respect across the different groups. [Practice nurse board member]

However, other boards were said to be GP dominated.

... you find that the board is always dominated and driven by the GPs. So it is always GPs’ needs [that] are a priority rather than looking at all aspects of the organisation. [PHO board member]

The employer-employee relationship was seen as perpetuating the power differential.

As far as having a fair argument with a practice nurse who is employed by a GP as to how the money is dished out ... there is not only a power difference but they are running a business ... everyone is pally-pally buddy-buddy but there is still that ... they are the employer and we are the employee ... and that would all be abolished if we were all salaried by the PHO. [Practice nurse board member]

Another PHO board member suggested separate meetings – one for GPs and another for other practice staff – in order to encourage more free expression of opinions.

Some practice owners are uncomfortable if employees are there and nurses don’t often want to talk about certain things in front of the owners. [Pacific PHO board member]

When asked what they would most like to achieve as board members, nurses in these roles generally suggested support for nursing services (including increased numbers of nursing services), a greater variety of nurses within PHOs, and a stronger voice for nursing.

... a wider variety of nurses working in PHC/PHOs. We have developed mental health and Māori health nurses since the PHO started, but I would like to further develop this. [Practice nurse board member]
... a stronger practice nurse role, new programmes specific to our area. [Practice nurse board member]

... more nursing services to support GPs. [Practice nurse board member]

... nurses having their say and more voice on new initiatives. [Practice nurse board member]

... provide good communication to and from the nurses I represent. [Practice nurse board member]

... seeing the expansion of nursing services to meet patient needs. [Practice nurse board member]

... make some improvements for practice nurses and the programmes we can provide. [Practice nurse board member]

One practice nurse described having become “more committed and passionate in advocating for the PHO in outside forums” since becoming a board member.

In the Practice Survey, only 34% of practice manager respondents reported that their practice had a formal management committee. Members of the management committees commonly included the practice manager (27%), GPs (27%), practice nurses (13%), and administration staff (10%). Additional members were cited by less than 10% of the practices, with such members including community representatives, patients, community health workers, PHO board members, and other health professionals.

Nursing committees in larger PHOs proved to be an avenue for communication, workforce development, and input into PHO decision-making.

_We have a nursing committee which covers all our practices and a workforce development manager. It [the committee] develops nurses in their roles and helps them communicate with other nurses ... and to give advice to the PHO boards from a nursing perspective._ [PHO manager]

### 4.3.2 Building Collaboration

A number of board members identified increased or improved teamwork as a priority area for change in PHC.

_[I envision] a completely integrated primary health care system incorporating GPs, nurses, dentists, pharmacy, district nurses, mental health – all working together to achieve better patient outcomes._ [Board member]

Some interviewees reported that PHOs and/or DHBs could play a greater role in developing teamwork within practices.
... they do do things but it is always in the evenings and unpaid time and everyone is exhausted. [GP, Māori PHO]

Others suggested that charging for nurse visits would help to recognise the value of nurses and would in turn promote nurses as more equal members of the practice teams – although this concept is still foreign to some nurses.

... nurses are just beginning to accept that they should be charging for their services. [Practice nurse]

Only a quarter of the practices reported that they routinely charged for a nurse consultation. A further 61% of practices sometimes charged for a nurse visit.

Some PHOs are keen to pursue salaried models, and have proposed to their DHBs that they should bring practices together into larger centres under such a model. However, a small number of interviewees identified potential issues of concern with this, including staff commitment.

I would be reluctant to see a salary model for GPs until all the pros and cons are understood. It may well be the answer but there is also a downside. [DHB manager]

Some interviewees expressed a view that capitation does not provide incentives for teamwork and greater use of nurses.

... there is no reward for mainstream practices that are using the nurses differently and are charging $25. [DHB manager]

It was reported that patients should be able to consult nurses as well as doctors, and it was recognised that greater incentives may be needed for practices to use nurses more effectively.

One contributing barrier to greater collaboration between nursing services was thought to be the physical and operational dislocation of PHC nursing services. Some PHO and DHB interviewees felt strongly that having some PHC nursing services operating from DHBs rather than being linked to the primary sector does not fit well with the intentions of the Strategy, and that many of these services would be better placed within the community. It was recognised that a number of nursing services had been moved from secondary care to PHO management; but on the whole it was perceived that there were other DHB-controlled services that could benefit from PHO management.

PHOs are really the foundation of primary health care but we have primary health care sitting under the DHB. [PHO manager]

... would like to see all primary health contracts come through the PHO as this would make it easier for the communities to gel and work together. [Manager, Access PHO]

... they [DHBs] have set up various specialist nursing services to run in parallel with outpatient clinics ... people who are stable enough to be seen by a nurse are certainly stable enough to be seen in primary care. [GP board member]
Interviewees identified district nursing in particular as needing to move to the PHC sector, with some nurses suggesting this would allow for more direct communication of patient information. Other services thought to benefit from being PHO based – or at least strongly linked with PHOs – include public health nursing, diabetes care, audiology, health promotion, school-based services, outpatients follow-up, screening, plaster care, and paediatric outreach. The employment structure and divisions in the nursing sector were perceived to be preventing the integration of nursing services. To accommodate such moves the structure of PHC nursing would require greater integration.

_The service that we should look at moving, that would be best out in the primary care environment is district nursing ... nursing services are working in isolation. They have to be brought together and it needs structure. [DHB manager]_

_... we need to integrate nursing services, bring them together – restructure, fit all the different divisions together, public health nursing, community nursing, district nursing, practice nursing, through the PHOs – but not with the current nursing models and employment arrangements. [DHB manager]_

A few interviewees highlighted the complications of bringing more nursing services into the PHOs. These included difficult management arrangements, capacity, and problems aligning the work of district nurses with outreach nurses. In one example where district nurses have been contracted by the PHO, increased administrative load on practices and some problems between GPs and some district nurses needed resolution.

_... at the moment some district nurses are employed by practices, but our practice chooses not to take on this business. [GP board member, rural Interim PHO]_

_... district nurses are feeling pushed around. [Chair, rural Interim PHO]_

One identified barrier to greater integration of nursing services in PHOs was the perception that the nursing services currently based in DHBs allowed wider coverage – although there has been some discussion about sharing district nurses between practices and PHOs. It was also suggested that incentives from the Ministry of Health and greater DHB knowledge of the PHC sector would encourage the deployment of nursing services into PHC.

This chapter has reported findings related to practice nurses’ current and potential capability, the capacity of their workforce, and collaboration within practices and with other nurses working in the PHC sector. The following chapter discusses these findings in the wider context of the Strategy and future developments.
5 DISCUSSION

This chapter discusses the development of PHC nursing since the introduction of The Primary Health Care Strategy, and the need for further development if the Strategy goals are to be fully realised. It identifies the factors that have contributed to positive developments, discusses the constraints to effective and innovative practice, and suggests strategies to overcome these constraints.

PHC has been placed in a pivotal position within the health care system and is now responsible for taking a population-based approach to health care in order to remove inequalities in health and improve health outcomes for all New Zealanders (Minister of Health, 2001). This represents a changed role for many nurses working in the PHC sector, as practice nurses (the largest group in this sector) and GPs previously had been focused on providing personal health services. In the new environment, nurses – along with other health professionals working in PHC – have a responsibility to ensure that culturally appropriate and socially acceptable high-quality services are universally available and accessible to all New Zealanders (Minister of Health, 2001).

This chapter discusses the results from the previous chapter, drawing on the literature reviewed in Chapter 2. It also discusses the developments and constraints identified in Chapter 2, and suggests strategies for overcoming the latter. It concludes by outlining a vision for PHC nursing in the PHO environment, and sets out the potential policy and practice implications that would result from realising this vision.

5.1 Capability

5.1.1 Positive Developments

There has been substantial growth in the development of nursing roles and nurses’ capability in the PHO environment in New Zealand since the introduction of the Strategy, especially around the management of chronic conditions and working with people in underserved and vulnerable groups.

Two factors have most influenced the expansion of the nurses’ roles. Firstly, where practices and PHOs have embraced the intentions of the Strategy to improve the health of the population, nurses’ roles have expanded and so have increased access to services. Secondly, where nurses’ roles have expanded this has been as a result of additional funding for specific programmes – for example Care Plus, RICF, SIA, and the nursing innovations projects. This has resulted in more cost-effective services, greater acceptance by patients of nurses as their first port of call, increased choice of provider for patients, freeing up of GPs’ time, and greater job satisfaction for the general practice teams.

While nurses working for Māori providers reported they were already providing many of the services before the introduction of the Strategy, within the new environment they gained service contracts for mobile clinics and nurse-led initiatives.

Participants across the disciplines recognised the value of developing NP roles, and a surprising 82% of practice nurses reported their interest in pursuing NP status. This figure requires further investigation to ascertain the practice nurses’ understanding of the educational and clinical requirements for NP status, as to date only a small percentage of nurses have achieved NP accreditation.
The following section will discuss the educational preparation required for nurses in the specialty area of PHC and will provide an education and career pathway model.

### 5.1.2 Education to Increase Capability

Ensuring access to culturally appropriate and socially acceptable population-based services, as well as to personal health services, has required a reorientation of practice nurses’ work (Expert Advisory Group on Primary Health Care Nursing, 2003). This has also been the case in the UK, Australia and the US (Armstrong, 2005; Department of Health, 2006b; Dodoo et al., 2005; Minister of Health, 2001). For many practice nurses this requires learning new knowledge and skills (Cumming et al., 2005; Denny et al., 2005; Nelson et al., 2003) and for those entering this specialty area it requires undertaking further education to acquire the core knowledge and skills necessary for practice.

Because PHC is a specialty area of practice with its own specific body of knowledge, it is important that new graduates and other nurses moving into the area complete at least a Postgraduate Certificate in PHC Nursing. We suggest the new graduates undertake the CTA/DHB-funded Nursing Entry to Practice Programme in their first year following graduation, as part of this.

Core PHC knowledge the nurses require includes: understanding population health and health determinants, equity issues, community assessment and community empowerment, health promotion, collaborative action and working with diverse groups. It should also include mental health and chronic care management as PHC nurses now have greater responsibility for people within these groups.

The Ministry-funded postgraduate primary health nursing scholarships awarded since 2003 and the CTA rural primary health nursing funding have proved to be very beneficial in encouraging PHC nurses to undertake postgraduate education and to increase their clinical skills and knowledge. In addition, the rural nursing scholarships awarded to rural nurses for the completion of the last year of their Master’s qualification – the educational requirement for NP accreditation – have enabled and encouraged rural nurses to pursue NP accreditation. Continuation of these scholarships, or similar funding for PHC nurses, would encourage more nurses to develop their clinical and knowledge capability.

Currently few NPs are working in PHC, but the role has the potential to enhance access to services and choice of provider. NPs have extensive clinical and contextual knowledge of their specialty area that enables them to respond to the health needs of their communities and develop appropriate and cost-effective services (Bodheimer, 2003; Boville, Saran, Salem, Clough, Jones, Radwany & Sweet, 2007).

NPs have the potential to develop innovative ways of reaching communities and meeting health needs for under-served populations (Ministry of Health, 2002a), but nurse leaders have reported that some GPs feel uneasy about the changing roles and boundaries. NP positions for chronic care management funded by PHOs would enable NPs to work across practices, improving access for patients and developing and mentoring practice nurses as they expand their practice and take on new roles.

It would be a real advantage for all nurses pursuing NP accreditation to be mentored through the final stages of their Master’s programmes, both during the development of their portfolios for submission to the Nursing Council and through the accreditation process. Providing ongoing education that is related to setting up a new business would also benefit NPs, once the necessary changes have been made to the funding formula to enable them to obtain funding for their patients. Some universities have laboratories for new business ventures and this option could be explored for NPs.
The model shown in Figure 4 provides both an education and career pathway for PHC nurses. A need for the latter was also identified in the national and international literature (DHBNZ Nursing and Midwifery Workforce Strategy Group, 2007; Gibson & Heartfield, 2005; Woodward, 2006). The model demonstrates the two scopes of practice within PHC – registered nurse and NP – and the levels of education required for advancing practice within the specialty of PHC nursing practice.

The nurse leaders suggested there is a real need for up-to-date data on the PHC nursing workforce and nurses’ educational needs, to allow a national approach to planning and developing PHC nurses for their crucial role in the PHC environment.

5.1.3 Increased Access to Nursing Services

While some Māori nurses reported innovative and often autonomous approaches to reaching targeted populations, other nurses reported that access to nursing services is often fragmented and inconsistent. This, many of them reported, was due to them being unable to directly access resources that would enable them to develop these new roles. The pressures of work volume were a further barrier. This supports arguments put forward by the Expert Advisory Group on Primary Health Care Nursing (2003).

Māori nurses described ways they had developed their practice and improved access to appropriate services for patients. By adhering to traditional practices and whakapapa links with the patients’ hapū,
Māori nurses reported developing strong and trusting relationships, facilitating movement through services, and encouraging other members of the hapū to utilise health services. Similar strong and trusting relationships were found in Pacific nursing practice, where Pacific nurses called on culturally-based practices and relationships.

Care Plus has enabled many nurses to play an important role in providing services for people with chronic conditions (CBG, 2006). Nurses’ involvement ranges from the programme being offered exclusively by nurses, to nurses having no involvement at all (CBG, 2006). Overall, however, the programme has proved inequitable: many eligible people are prevented from accessing these enhanced services because their PHOs and/or practices do not offer Care Plus. The evaluators reported that while there is generally support for the concept, many practices perceive the programme to be “administratively complex, not flexible enough, and underfunded” (CBG, 2006, p. 6). In addition, the evaluators suggested, limited nursing resources as well as space and time may be limiting the uptake.

The practice nurses and nurse leaders supported CBG’s recommendation that, to increase efficiency, PHOs should develop nurse home-visiting programmes for Care Plus enrollees. Inclusion of NPs with prescribing rights in PHC teams would provide a very real advantage for enrollees and would increase practices’ efficiency and effectiveness. The profession could also further explore the concept of obtaining prescribing rights for nurses who have specialised in an aspect of PHC, such as chronic care management, and who have completed at least a postgraduate diploma in the specialty area and a Nursing Council-accredited prescribing programme.

Both Care Plus and RICF have provided opportunities for nurses to expand their practice and offer innovative services to under-served populations and people with high needs as a way of reducing inequalities in health, but the ad-hoc nature of the programmes has limited their ability to enhance access to appropriate services for all those eligible in a way that is sustainable. It is imperative that the learning from these opportunities contributes to the development of new services and new ways of working. Strong incentives for GPs to embrace opportunities for developing services for high-risk and high-needs populations are discussed below (see Section 5.4).

The funding for the 11 PHC nursing innovation projects likewise enabled the development of new initiatives within PHOs and DHBs, both for specific population groups and to enhance nursing leadership. It is too early to determine the impact that the Care Plus and RICF programmes and the nursing initiatives have had on health outcomes but the extent to which access has been improved for specific groups is shown in the formal evaluations.

As for Care Plus and the RICF projects, it is important that the learning from the nursing innovation projects is incorporated into new models of care.

Providing mental health services through general practices was perceived to be an important part of the Strategy (Dowell et al., 2007; Minister of Health, 2005, 2006c; O’Brien, Hughes & Kidd, 2006). Dowell et al. (2007), in an evaluation of 20 of the Ministry-funded primary mental health care initiatives, suggested that the introduction of primary mental health care models would have significant workforce implications, especially for nurses. It would affect both those currently working in PHC and those moving into the PHC environment. Working with people presenting with mental health problems in the PHC environment, the evaluators suggested, is very different from working in the secondary sector. The nurses will require further education and training and ongoing support, as will the GPs. In some areas
shared care between primary and secondary services has been introduced, to ensure appropriate skills are available (Dowell et al., 2007; O’Brien et al., 2006).

School-based nurses provide increased access and very real benefits for many children in their communities – especially for rural children, children who are socio-economically disadvantaged, and children who do not otherwise readily access health services (Mathias, 2002; Winnard, Denny & Fleming, 2005). Occupational health nurses also provide vital PHC services in the community. Both would benefit from closer links with PHOs and multidisciplinary PHC teams. When asked about nurses’ roles in providing accident-related care, the nurse leaders suggested that access to appropriate services in the community would be enhanced if current ACC contracts were amended so that they fully funded PHC nurses to provide comprehensive care to ACC patients, rather than requiring these patients to also be seen by a GP. This would ensure more efficient use of both the nurses’ and the GPs’ time. The nurse leaders believed nurses are capable of providing effective and efficient accident-related care.

Not all practice nurses have embraced the opportunities indicated in the Strategy and have increased access to services for their populations. Some believe their existing roles are appropriate and do not welcome the opportunity of increasing their clinical skills and knowledge and developing a population-based approach to their practice. GP attitudes have played a major part in both encouraging and discouraging their practice nurse employees to expand skills and knowledge and clinical roles. It has been mainly nurses in the larger practices who have developed their roles and enhanced the services offered to their patients. Often the changes have resulted from additional funding – for example SIA, RICF, Care Plus, and health promotion funding.

While scholarships and support for further education have encouraged some practice nurses to pursue further education and expand their roles, for others these incentives have not proved to be sufficient. Further incentives may be necessary for this group – because it is crucial that practice nurses and other PHC nurses, as well as GPs, recognise their responsibilities to provide appropriate services for their communities. Nurse leaders suggested that the introduction of standardised clinical performance indicators measuring the quality of care provided would be one way to ensure that effective care is provided and that GPs and practice nurses fulfil their responsibilities in terms of the Strategy.

5.2 Capacity

The Strategy requires – and it is crucial that we have – sufficient numbers of highly skilled and knowledgeable nurses in the PHC nursing workforce, along with a climate that encourages effective teamwork amongst health professionals and collaboration with other stakeholders including providers.

Recruitment and retention of practice nurses – especially experienced nurses and Māori and Pacific nurses – are key concerns. While 80% of the nurses in this study found practice nursing to be rewarding, there was considerable variation between practices in terms of retention. Some nurses and practices suggested the high turnover was due to the nurses’ lack of control over the work environment, their high stress and heavy workloads, a lack of time for introducing new initiatives, their inability to access resources, and a lack of appropriate infrastructure (especially space). Other practices reported very stable workforces.

The 2005 MECA (multi-employer collective agreement) for DHB nurses resulted in a depleted PHC nursing workforce and led to the reduction and even cessation of some services. The recently agreed MECA for PHC nurses, while not providing them with pay parity with DHB nurses, should go some way
towards resolving this. Historically PHC nurses in general practices have been paid well below the rates for DHB nurses (NZNO, 2007).

5.2.1 Recruitment to Build Capacity

Building capacity and capability in the Māori and Pacific nursing workforce is vitally important for offering culturally appropriate and acceptable health services as the numbers of Māori and Pacific in the population grow. This will best address the health inequalities and disparities in levels of service delivery. The current shortage of Māori and Pacific nurses has resulted in the nurses being “poached” from one organisation by another. In addition, unrealistic expectations are often placed on them – for example, they tend to accept leadership roles early in their careers and undertake workloads of both high volume and high intensity. Appropriate mentors would be of real benefit to Māori and Pacific nurses, and would provide them with the specific support they require. These mentors may need to come from other health professions.

Ratima et al. (2007), in their report on the Māori health and disability workforce, make recommendations for improving the recruitment and retention of Māori. The nurse leaders suggested that recruitment for Māori and Pacific nurses could be focused on schools, churches, marae, and fono – especially in the regional areas where PHC nurses are needed. There is anecdotal evidence of many Māori and Pacific nurses working outside the health sector; they could be encouraged to undertake re-entry to practice programmes, thus increasing the numbers over a short time.

A more general national-media marketing campaign and a texting campaign to high school students’ mobiles could promote interest in PHC nursing as a career and could reach a broader section of the public. Discussions could be held with Shortland Street editors about including the issue of PHC nursing careers in the storyline for their television programme.

The national marketing campaign would increase the public’s awareness of PHC nurses as providers of PHC services, would enhance people’s understanding of the work nurses do, and would give them a further choice of health professional. Such focused activities would go some way towards building a sustainable workforce.

A further way to build capacity would be to increase the exposure to PHC knowledge and practice in undergraduate programmes. It is imperative that students have good-quality clinical placements during their undergraduate years – so it will be important for PHOs and education providers to work together to ensure general practices and other PHC providers can provide this level of support. An ideal time to positively influence nursing students would be during the last clinical placement before they complete their degrees. This would leave them well-prepared for moving straight into PHC once they graduate.

Practice nurses and nurse leaders also suggested that a structured career pathway for PHC nurses would encourage nurses to consider PHC as their career choice.

It is imperative that NP roles are established in PHC. Continued financial support would encourage individual nurses to become NPs; but PHOs may need incentives to establish NP roles within the broader PHO team.

The barriers to the implementation of the NP role have been discussed widely elsewhere (Allen & Fabri, 2005; College of Nurses Aotearoa, 2006; Maw, 2005; NPAC-NZ, 2006; Renouf, 2007). These barriers
include the current funding model; legislative, regulatory and organisational barriers; and GP attitudes. In 2005 the Ministry set up the Nurse Practitioner Employment and Development Working Party in an effort to overcome some of the barriers and challenges to the implementation of the NP role. The final report outlining the Working Party’s recommendations has been submitted to the Ministry.

5.3 Collaboration

Effective teamwork within general practices and collaboration with other health professionals was reported to be imperative to the future of PHC. However, there are many different definitions and expectations of teamwork and this has resulted in GPs, practice nurses and practice managers in this study reporting high levels of practices operating as teams. In contrast, a 2006 survey of primary health physicians in seven countries found New Zealand to have low levels of routine use of multidisciplinary teams, far below that of the UK, Germany and the Netherlands (Schoen et al., 2006).

Effective teamwork that is characterised by good leadership, shared values, a common vision amongst members, a focus on patients, and less of an emphasis on profit has been slow to take off in a significant way. This has been attributed, in the present study, to patch protection, GP attitudes, funding models, and the hierarchical nature of teams created by GPs’ employment of practice nurses. While many GPs and practice nurses reported that they were working as teams before the Strategy was introduced, their understanding of the concept did not fit with the Strategy’s expectation that PHC would be provided by a range of health professionals who would provide multidisciplinary approaches to services and decision-making.

As indicated by Abel et al. (2005) and the then Minister of Health (2001), nurses from Māori, Pacific and rural practices in this current study reported strong histories of teamwork that predated the introduction of the Strategy. The nurse leaders interviewed for this study also suggested the Strategy mirrored existing approaches to care for many Māori.

Some PHOs are encouraging more effective teamwork in their practices and have developed sentinel practices as part of this. Likewise Care Plus, SIA, health promotion and other short-term funding sources have enabled more collaborative working both within practices and with NGOs and other providers. However, some PHO board members, practice nurses, and nurse leaders suggested that this is not always the case: business incentives have often inhibited the development of a multidisciplinary team approach, with GPs not including their practice nurses in the developments because of GPs’ focus on profit rather than on provision of the most appropriate services.

Earlier studies (College of Nurses Aotearoa, 2006; Expert Advisory Group on Primary Health Care Nursing, 2003; Minto, 2004, 2006; Ross, 2001) reported that practice nurses, nurse leaders and some PHO board members see the employer-employee relationship between GPs and practice nurses as not conducive to teamwork – nor to the two working together equitably. However in this study there were examples of effective multidisciplinary teams working together in both private-enterprise business models and in salaried practice models. GP attitudes seemed to be the most important variable, and the need to develop incentives for GPs to pursue the goals of the strategy became apparent.

Practice nurses, nurse leaders and PHO board members in this study reported that retaining some PHC nursing services in the DHBs, at a distance from the PHOs and the community, does not encourage collaboration amongst the different PHC nursing groups. Furthermore, DHB PHC managers as well as PHO managers reported that, for efficiency and the most effective outcomes, community-based PHC
nursing services need to be focused within PHOs and practices. This would prevent duplication of services and increase collaboration amongst health professionals and other providers – although there could be a remuneration issue in terms of the disparity between the DHB nursing MECA and the PHC nursing MECA.

5.3.1 Leadership, Mentorship and Governance

While one DHB was exemplary in ensuring PHC nursing leadership and representation in organisational governance, and while individual cases of nursing leadership were reported in PHOs, the vast majority of such organisations were lacking in this development.

The nurse leaders reported that within DHBs and PHOs there should be senior leadership roles for PHC nurses. DHBs should have directors of PHC nursing who oversee development of the PHC nursing groups within their geographical regions and provide a voice within the DHB for PHC nursing issues and development – including funding for education and PDRPs for all PHC nurses. These directors could also provide mentorship for the most senior nurses in the PHOs.

Nurse leaders within PHOs would provide leadership, establish mentorship programmes, and encourage collaboration within and across practices and with other PHC providers. They would represent PHO nurses in clinical meetings and establish clinical governance and PDRP programmes for the PHO nurses. They would also take responsibility for ensuring that appropriate education programmes are available for the nurses, ensure release time is available for the nurses to attend teaching days, and generally encourage development of new and innovative services in response to the Strategy’s goals and objectives.

Nurses often need mentoring to develop skills in strategic planning, policy development and assertiveness so that they can play a more effective part in these organisations. One PHO’s CEO provided a mentoring example in which she accompanied two senior PHO nurses to PHO and DHB board meetings over a period of a few months, providing them with background information on how the organisations were governed and what issues they were facing. This resulted in these nurses taking more responsibility within the PHO and providing mentorship for other nurses. Such simple but effective interventions do not require funding and could be implemented in other PHOs.

While some practice nurse board members reported respectful and trusting relationships with other board members, others reported that few nurses were participating at a governance level within DHBs, PHOs, NGOs, or other health provider organisations – despite this being an expectation of the Strategy. This was thought to be attributable to a lack of confidence by nurses when they sit around the board table with the GPs who are also their employers.

5.4 A Suggested Funding Model

The practice nurses and nurse leaders as well as the literature suggest that both the current employment relationships of most practice nurses and the funding mechanisms used by many practices inhibit nurses from developing innovative practice models, promoting autonomous services, expanding their roles, accessing postgraduate education, and developing collaborative teamwork (College of Nurses Aotearoa, 2006; Expert Advisory Group on Primary Health Care Nursing, 2003; Minto, 2004, 2006; Ross, 2001). Salaried models for GPs, some suggested, provide a more conducive environment for
equitable and collaborative working arrangements; others argued that practice nurses should be employed by DHBs or PHOs as a means of altering the nurses’ relationships with the GPs.

The problem, however, is multifaceted. Consultation with nurses, and with key stakeholders in PHOs, suggested that there are successful models of nurses working proactively in both private-enterprise business practice models and salaried practice models. There are also examples of effective multidisciplinary teams working together in both models. This indicates that it is not the source of the salary that is important. What is important is the relationship that exists between the nurses and the GPs, and the existence (or lack of) a shared vision about possible practice developments.

Where funding models at the practice level are focused on factors such as numbers of GP consultations and GP hours worked, we suggest changes be made to the way funding is distributed. This would enable and promote developments that are not at present being pursued in many practices. In these practices there is no provision for nurses to claim funding for the services they provide; GPs must “clip the ticket” to access the funding. Nor is there any incentive for such GPs to encourage their nurses to work autonomously and develop nurse-led services for the practice enrollees. The lack of development in these practices has implications for their patients, denying them a choice of provider and – in many cases – the development of more appropriate and acceptable services.

Not all general practices are funded in this way. Many are providing excellent services to their enrollees and continue to develop new initiatives that enhance the services offered to high-need population groups. Nevertheless, there are also many practices that see capitated funding as offering no incentive to increase the intensity of care for people with high levels of health and social need.

One solution would be to provide practices with a single baseline-funding stream and required clinical key-performance indicators and quality measures. This would then be supplemented by generous incentives for general practices and other providers who pursue the goals of the Strategy in terms of reducing inequalities in health and improving health outcomes. The quality measures should include measures of efficiency and support for the practice team (the doctors and nurses); as well, there should be quality measures where patients assess the practice’s performance.

This funding model would provide GPs and managers with very real incentives to be proactive in encouraging (or in some cases allowing) their nurses to be innovative and responsive to their communities’ needs and so deliver effective care. Nurses would in turn be accountable for their practice in terms of meeting clinical and quality indicators.

Avoiding ad-hoc funding for short-term projects (such as RICF) and additional optional services (such as Care Plus) would promote integration of programmes and sustainability for recipients, who are often from high-risk groups. Currently there is inequity in the way some projects and programmes are funded and delivered and this has in some cases resulted in poor use of resources. Such projects and programmes should be funded through the generous incentives offered to general practices and other providers who pursue the Strategy’s goals.

The current funding model that is tied to GPs is not conducive to PHOs employing NPs nor for them to be contracted as providers, as NPs are not able to access funding for the services they deliver in an equitable way. In the interests of efficiency and choice of appropriate provider, it is imperative that NPs are able to access funding within the PHOs so that they can work as independent members of the multidisciplinary teams. Their only current alternative is to charge their patients full fees: this is not
appropriate for the population groups who would most benefit from their care; nor is it an efficient use of scarce resources.

The suggested changes to the funding model would reward the general practices that are working hard to reduce health inequalities and improve health outcomes. It would also provide incentives for many GPs to change the way they currently manage their practices. This would inevitably mean that the nurses working in these practices would have opportunities to expand their practice and take on new responsibilities. The challenge for the nurses would be to respond by addressing their knowledge and skill gaps and proactively engaging with their communities to determine their needs.

5.5 Conclusion

Both the Strategy document (Minister of Health, 2001) and the nurse leaders interviewed for this project agree that PHC nurses have a crucial role to play in the Strategy’s implementation, and many nurses have accepted the challenge. However, for nurses working in general practice, the PHO environment has not always been conducive to the development of their role, expansion of their practice, and equal partnership in multidisciplinary teams. Nor has it been conducive to collaboration amongst the various groups of PHC nurses.

Where there have been substantial developments in the nurses’ role, PHO managers and GPs have been keen to embrace the vision of the Strategy. They have encouraged their nurses to undertake new and innovative developments, recognised that nurses add value to patient consultations, ensured that good leadership is provided in their practices, demonstrated effective teamwork, had good staff-retention, and supported nurses in undertaking postgraduate education. The nurses who have expanded their practice – many of whom are employed in larger practices – have had positive attitudes about the opportunities for development, have been keen to respond to their communities’ needs and, despite heavy workloads in many cases, have undertaken postgraduate education to enhance their skills and knowledge. Effective mentoring of nurses has been successful for involving them in governance at the PHO level.

The reported external barriers to nurses expanding their roles were the employer-employee relationship between GPs and practice nurses, GPs’ attitudes, lack of support and motivation from GPs, the current funding structures, poor remuneration, heavy workloads, lack of educational opportunities, lack of leadership, lack of physical resources, and patients not recognising the nurses as autonomous health professionals. Some nurses also reported a lack of self confidence, a belief that their current role is appropriate, and for some a lack of willingness to embrace change.

Providing generous incentives (as discussed in the funding model above) for general practices and other providers to increase access to culturally appropriate and socially acceptable population-based services as well as to personal health services would result in nurses working more effectively. It would also result in greater retention of nurses, would promote an environment that would encourage recruitment to PHC, and would overcome the current restrictions to the NP role. This would result in increased capacity and capability in the PHC workforce, more collaborative teams within practices and PHOs and the broader PHC sector, and a broader range of high-quality health services for the people of New Zealand.

If the goals of the Strategy are to be realised, it is imperative that PHOs, along with GPs and nurses working in general practice and in other provider units, embrace the opportunities that are available in
the new PHO environment. They need to develop strong multidisciplinary teams, encourage collaborations with other health and social service providers, and focus on improving health outcomes for all New Zealanders.

Establishing such an environment – one that encourages innovation, attracts and retains appropriately skilled nurses, and is focused on achieving the vision of the Strategy – has implications for both policy and practice. This research has identified four key areas for these: funding; education; leadership, mentorship and governance; and recruitment and retention.

5.6 Implications for Policy and Practice

**Funding** - To increase nursing capability and capacity:
- Offer incentives for PHOs to establish NP positions.
- Enable NPs to access Vote: Health funding.
- Adopt a single baseline-funding stream with incentives.
- Avoid ad-hoc short-term funding streams.
- Amend ACC contracts to fully fund PHC nurses so that they can provide comprehensive services to ACC patients.

**Education** - To improve capability:
- Advocate for all PHC nurses to have a PHC postgraduate qualification as part of developing necessary knowledge and skills.
- Continue scholarships and funding for postgraduate education.
- Promote quality of clinical placements for undergraduate students.

**Leadership, mentorship and governance** - To embed increased capability and capacity:
- Appoint directors of PHC nursing in DHBs to provide leadership.
- Appoint nurse leaders in PHOs.
- Establish mentoring programmes within PHOs and DHBs.
- Include and mentor PHC nurses in governance roles within DHBs and PHOs at strategic levels.
- Introduce PDRPs for all PHC nurses.
- Develop and implement nursing-sensitive patient outcome indicators.

**Recruitment and retention** - To improve capacity:
- Instigate a national advertising campaign to increase:
  - awareness of PHC nursing as a career choice
  - PHC nurses as providers of health care.
- Target Māori students through schools, workplaces, and hui/marae.
- Target Pacific students through schools, workplaces, churches, and fono.
- Provide incentives to establish NP positions.
REFERENCE LIST


Horsburgh, M., Kent, B., & Coster, G. (2005). *The role, function and services provided by HealthWEST PHO practice nurses: Survey findings May 2005.* School of Nursing, University of Auckland.


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APPENDIX 1 – SECOND PHASE INTERVIEW GUIDE

PHC Strategy Second Phase Interviews – PHO and Practice Interview Guide

**Issue 1 – Keeping, or bringing, the level of co-payments down**

- Do you have good data on the fees that are being charged?
- How would you summarise the present fee situation?
- Why do fees vary and what does fee variation achieve?
- What role does the PHO have in reducing fees?
- What has been done to reduce fees?
- What hinders achieving lower fees?
- What could be done to maintain a low fees environment?
- How can funding arrangements be improved?
- Do Māori or Pacific providers have particular issues with fees/fee setting?

**Issue 2 – Equalising access to care on the basis of need**

- Do you have good data on access to care (utilisation and meeting need*)?
- How would you describe the present equity of access?
- What is your role in improving access?
- What has been done to increase access?
- What helps achieve more equal access (eg SIA, RICF, health promotion funds)?
- What hinders achieving more equal access?
- How have low-users been attracted?
- Do the answers vary across Māori/Pacific/low SES/high SES practices?

**Issue 3 – Increasing the focus on chronic conditions**

- Do you have data on services for chronic conditions?
- To what extent have practices increased their focus on chronic conditions?
- What chronic conditions do you recognise; which of these have you addressed?
- What is the role of your organisation in increasing focus on chronic conditions?
- Has Care Plus been a useful model?
- What other programmes are emerging to deal with chronic conditions?
- Do Māori or Pacific providers have particular issues with chronic conditions?
**Issue 4 – Achieving and using community input**

What has the PHO done to obtain and use community input?

Has community input from PHO boards been useful?
Is there effective community input at the practice level?
How could community input be better sought and used?
Where does the voluntary sector fit in?

Have the DHB, PHO and practices worked together to improve community information, generate community input and foster health education?

How is information about health shared across the community?

Do Māori or Pacific providers have particular issues with community input?

**Issue 5 – Maintaining an efficient health workforce – including teamwork**

What data do you have on workforce recruitment and retention?
Are there difficulties in your area in recruiting doctors or nurses?

What problems do personnel face?

Is the role of nurses increasing?
Does the focus on chronic conditions lead to a wider role for nurses?

What does teamwork mean to you?
Do you think it an important part of primary care reform? Why?
Are personnel adopting team-based work styles?
When does this work and why?

What is the role of your organisation in managing workforce issues and what has been done?

Do Māori or Pacific providers have distinguishable approaches to workforce issues or teamwork?

What role is played by, or foreseen in the future for, community health workers?
**Issue 6 – Functioning of PHO (and MSO)**

What role does the management service organisation play (if applicable)?

How well is the PHO board working?

Are there any difficulties in the relationship between GPs, other providers and the community representatives on the PHO board (and generally)?

What is the role of the PHO in developing services?
How does the PHO influence service development at the practice level?

Is PHO management of funding and other resources adequate?

What opportunities and problems do you foresee for the future?
How will the performance management regime affect the PHO and its member practices?

Do Māori or Pacific providers have particular issues with PHO/MSO functioning?

**Issue 7 – Relationships with the DHB and Ministry; ACC**

What issues are there in the relationships with the Ministry?
How could these relationships be improved?

What issues are there in the relationships with the DHB?
How could these relationships be improved?

Have any services moved from the DHB to the PHO?
  If so, has this worked well?
Are there any services that should move from the DHB to the PHO?
What assists or inhibits service transfer or co-management?

Are there any implications for ACC in the implementation of the Strategy?
## PHC Strategy Second Phase Interviews – DHB Interview Guide

### Issue 1 – Keeping, or bringing, the level of co-payments down

- Do you have good data on the fees that are being charged?
- How would you summarise the present fee situation?

- Why do fees vary and what does fee variation achieve?
- What role does the DHB have in reducing fees?
- What has been done to reduce fees?
- What hinders achieving lower fees?
- What could be done to maintain a low fees environment?

- How can funding arrangements be improved?

- Do Māori or Pacific providers have particular issues with fees/fee setting?

### Issue 2 – Equalising access to care on the basis of need

- Do you have good data on access to care (utilisation and meeting need*)?
- How would you describe the present equity of access?

- What is your role in improving access?
- What has been done to increase access?
- What helps achieve more equal access (eg SIA, RICF, health promotion funds)?
- What hinders achieving more equal access?
- How have low-users been attracted?

- Do the answers vary across Māori/Pacific/low SES/high SES practices?

### Issue 3 – Increasing the focus on chronic conditions

- Do you have data on services for chronic conditions?
- To what extent have practices increased their focus on chronic conditions?

- What is the role of your organisation in increasing focus on chronic conditions?
- Has Care Plus been a useful model?
- What other programmes are emerging to deal with chronic conditions?

- Do Māori or Pacific providers have particular issues with chronic conditions?
**Issue 4 – Achieving and using community input**

What has the PHO done to obtain and use community input?

Has community input from PHO boards been useful?
Is there effective community input at the practice level?
How could community input be better sought and used?
Where does the voluntary sector fit in?

Have the DHB, PHO and practices worked together to improve community information, generate community input and foster health education?

How is information about health shared across the community?

Do Māori or Pacific providers have particular issues with community input?

**Issue 5 – Maintaining an efficient health workforce – including teamwork**

What data do you have on workforce recruitment and retention?
Are there difficulties in your area in recruiting doctors or nurses?

What problems do personnel face?

Is the role of nurses increasing?
Does the focus on chronic conditions lead to a wider role for nurses?

What does teamwork mean to you?
Do you think it an important part of primary care reform? Why?
Are personnel adopting team-based work styles?
When does this work and why?

What is the role of your organisation in managing workforce issues and what has been done?

Do Māori or Pacific providers have distinguishable approaches to workforce issues or teamwork?

What role is played by, or foreseen in the future for, community health workers?
Issue 6 – Functioning of PHO (and MSO)

What role do management service organisations play (if applicable)?

How well is the PHO board working?

Are there any difficulties in the relationship between GPs, other providers and the community representatives on the PHO board (and generally)?

What is the role of the PHO in developing services?
How does the PHO influence service development at the practice level?

Is PHO management of funding and other resources adequate?

What opportunities and problems do you foresee for the future?

How will the performance management regime affect the PHO and its member practices?

Do Māori or Pacific providers have particular issues with PHO/MSO functioning?

Issue 7 – Relationships with the DHB and Ministry; ACC

What issues are there in the relationships with the Ministry?
How could these relationships be improved?

What issues are there in the relationships with the DHB?
How could these relationships be improved?

Have any services moved from the DHB to the PHO?
   If so, has this worked well?
Are there any services that should move from the DHB to the PHO?
What assists or inhibits service transfer or co-management?

Are there any implications for ACC in the implementation of the Strategy?
APPENDIX 2 – PRACTICE NURSE SURVEY QUESTIONNAIRE

Primary Health Care Practice Nurse Questionnaire

(When options are presented, eg yes1, no2, please circle appropriate answer. 
DK = Don’t know, NA = Not applicable)

Workload and Responsibilities

1. How many hours per week do you work as a practice nurse?

2. Please estimate the percentage of the time you spend, during an “average” week, on each of the following activities

<table>
<thead>
<tr>
<th>Activities</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administrative (a)</td>
<td></td>
</tr>
<tr>
<td>Phone follow-up eg test results and screening recalls (b)</td>
<td></td>
</tr>
<tr>
<td>Providing nursing care for patients referred by the doctor (c)</td>
<td></td>
</tr>
<tr>
<td>Assessing needs of patients who walk- or phone-in (triage) (d)</td>
<td></td>
</tr>
<tr>
<td>Assessing and manage patient’s problems independently (e)</td>
<td></td>
</tr>
<tr>
<td>Undertaking “predetermined” care (eg dressings, immunisation) (f)</td>
<td></td>
</tr>
<tr>
<td>Consultations over chronic conditions (eg Care Plus) (g)</td>
<td></td>
</tr>
<tr>
<td>Specific care of those with mental health problems (h)</td>
<td></td>
</tr>
<tr>
<td>Education of groups of patients (i)</td>
<td></td>
</tr>
<tr>
<td>Other types (please name) (j)</td>
<td></td>
</tr>
</tbody>
</table>

3. Each week, on average, how many patients would make an appointment to see you?
4. Do you focus on any particular area of practice (e.g., venepuncture, Care Plus, smoking cessation, etc)? yes1, no2, If yes, please write in:

5. In an “average” week, how often do you contact hospital doctors/services on behalf of patients?

6. During an average week, how often do you contact other community health services (Plunket, Public Health and District nurses, Family Planning, Student Health, etc.) on behalf of patients?

7. During an average week, how often do you contact non-health social services (WINZ, Corrections, Housing, etc) on behalf of patients?

8. If a PHO practice, are you a member of:
   a. The PHO board yes1, no2, NA3
   b. The board of a Management Service Organisation yes1, no2, NA3
   c. A committee of either board yes1, no2, NA3

The Practice

9. Do the doctors, nurses and other clinicians of the practice operate as a team (defined as each person seen as an equal but contributing according to their knowledge and experience)? yes1, partially2, hardly at all3

10. Are your personal skills fully used? yes1, no2, DK9
    a. Please list skills which are not fully used:

    b. Please list skills you would like to develop if they would be used:

11. Are your personal skills recognised financially? yes1, no2, DK9

Since the practice joined the PHO (if not a PHO practice consider the last two years):

12. Has your hourly remuneration:
    increased1, remained the same2, decreased9

13. Over the next two years do you expect the range of your responsibilities to:
    increase1, be constant2, decrease3, DK4

14. In your own case have any of the following discouraged you from expanding your role? Please circle all that apply:
    Insufficient work1, GP reluctance2, Personal reluctance3,
    Inadequate training4, Lack of career path5
Postgraduate Nursing Education

15. What types of primary care nursing training have you received and what would you like (please mark (X) as appropriate)?

<table>
<thead>
<tr>
<th>Type of training</th>
<th>Have received</th>
<th>Would like</th>
</tr>
</thead>
<tbody>
<tr>
<td>“On the job” sessions with GPs, other practice nurse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>One off courses at DHB, PHO, Tech., etc</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Secondment to other practices or the hospital</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (specify)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

16. Are you interested in becoming a nurse practitioner? yes1, no2
17. Are postgraduate courses available locally? yes1, no2, DK9
18. Does the practice encourage you to take postgraduate courses? yes1, no2, DK9
19. Does the practice pay for pg courses? yes1, no2, DK9
20. Does the practice allow paid time-off for pg courses? yes1, no2, DK9

Work Satisfaction and Background

21. On a scale of 1(dis-satisfied) to 5(satisfied) how would you rate your experience of the following aspects of practice nursing?
   a. Rewarding work dis 1 – 2 – 3 – 4 – 5 satisfied
   b. Work/life balance dis 1 – 2 – 3 – 4 – 5 satisfied
   c. Personal income dis 1 – 2 – 3 – 4 – 5 satisfied
   d. Opportunity for development dis 1 – 2 – 3 – 4 – 5 satisfied
   e. Freedom to provide care as you wish dis 1 – 2 – 3 – 4 – 5 satisfied
   f. Clinical support dis 1 – 2 – 3 – 4 – 5 satisfied
   g. Administrative support dis 1 – 2 – 3 – 4 – 5 satisfied

22. Please give your age gender ethnicity

23. Please give the number of years you have spent in the following nursing roles: Hospital ward (a) Theatre (b) Emergency (c) Mental health (d) Other (e) (specify)

24. For how many years have you been a practice nurse?
25. For how long do you think you will remain a practice nurse?
26. Please write in any other comments you may have on the benefits and drawback of nursing in primary care:

27. Please mention any changes that you would like to see in primary health care in New Zealand:
APPENDIX 3 – GP SURVEY QUESTIONNAIRE

General Practitioner Questionnaire  ID# AR.XX

(When options are presented, eg yes1, no2, please circle appropriate answer. If using electronic version please put an X. DK = Don’t know, NA = Not applicable)

Workload

1. On an average week how many hours do you spend in the following general practice activities and how many hours did you spend on them before joining a PHO (ignore column 2 if not a PHO practitioner)?

<table>
<thead>
<tr>
<th></th>
<th>1 Now</th>
<th>2 Before</th>
</tr>
</thead>
<tbody>
<tr>
<td>Direct patient contact (a)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient paperwork (b)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Administrative (c)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CME (d)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (e)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOTAL general practice (f)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2. What is your booked length for a standard consultation? ______

3. How often are you on call in the evening? 1/____ at the weekend 1/____?

Since your practice joined a PHO and subsidies for some patients have increased (if not a PHO practitioner consider changes over the last two years), have you noticed any:

4. Change in the number of those presenting late in an illness? more1, same2, fewer3, DK4

5. Change in the number of those presenting unnecessarily more1, same2, fewer3, DK4

6. Change in the number of people you see: plus __ %, minus __ %

7. Change in the proportion of ACC patients: plus __ %, minus __ %

8. Please comment on any other changes in your practice over this period:

9. In an “average” week, how often do you contact hospital doctors/services on behalf of patients? ____

10. In an “average” week, how often do you contact other community-based health services (Plunket, Public Health & District nurses, Family Planning, Student Health, etc.) on behalf of patients? ____

11. In an “average” week, how often do you contact non-health social services (WINZ, Corrections, Housing etc) on behalf of patients? ____
12. How often (% of consultations) do you discuss patient management with another doctor (a) ______% , with a practice nurse (b) ______% 

13. How would you rate the services provided by your local hospital?
   - Emergency care: good1 adequate2 poor3
   - Elective care: good1 adequate2 poor3

The Practice

14. Do the doctors, nurses and other clinicians of the practice operate as a team (defined as each person seen as an equal but contributing according to their knowledge and experience)?
   - yes1, partially2, hardly at all3

15. Have you encouraged nurses to increase their role in your practice?
   - a. yes1, to a limited extent2, no3

   If yes, have they taken up the opportunity (b)?
   - yes1, to a limited extent2, no3

   If yes, please indicate areas in which they are making a greater or more independent contribution (c):
   - Care of chronic conditions 1 Care of mental illness 2
   - Procedures (wound-care, immunisation) 3
   - Outreach work 4 Transport 5 Translation services 6
   - Telephone advice 7 Telephone follow-up 8
   - Group health education or promotion classes 9
   - Quality management 10 Management 11 Administrative 12
   - Other 13 – please specify (d):

16. What advantages do you recognise in an expanded role for nurses?
   - Increased nurse work satisfaction (a) yes1, no2, DK3
   - Frees GP for care of complex cases (b) yes1, no2, DK3
   - More efficient use of personnel (c) yes1, no2, DK3
   - More potential for teamwork (d) yes1, no2, DK3
   - None (e) Other (f) – please specify:

17. With regard to Community Health Workers:
   - Do you work with them at present? yes1, no2, DK3
   - If no, do you think they could be useful? yes1, no2, DK3
Personal situation

18. Please give your age __, gender __, ethnicity

19. For how many years have you been in general practice? ____

20. For how long do you think you will remain in general practice? _____

21. What is your own employment situation in the practice?
   Owner or partner1, Salaried2, Trainee3, Long-term locum4, Other9 - please specify:

22. Since the practice joined the PHO *(if not a PHO practice, please consider the last two years)* has your income related to general practice:
   Increased1, Remained the same2, Decreased3

If a PHO practice *(otherwise skip to question 26)*

23. Are you a member of:
   a. The PHO board yes1, no2, NA3
   b. The board of the management service organisation yes1, no2, NA3
   c. A committee of either board yes1, no2, NA3

24. How would you rate the influence of the PHO board on the practice: *(tick answer)*

<table>
<thead>
<tr>
<th></th>
<th>Too much</th>
<th>About right</th>
<th>None</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. In questions of quality?</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>b. On services provided?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. On practice organisation?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. In relation to fees?</td>
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</table>

25. If there is a management organisation, how would you rate its influence on the practice: *(tick answer – ignore if no management organisation)*

<table>
<thead>
<tr>
<th></th>
<th>Too much</th>
<th>About right</th>
<th>None</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. In questions of quality?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. On services provided?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. On practice organisation?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. In relation to fees?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
26. Please select your preferred comment on the patient fee environment:

- Universal low cost access is desirable 1
- Affordable low cost access based on income and need is desirable 2
- Other comment – please write in

**Personal preferences and opinions**

27. On a scale of 1(dis-satisfied) to 5(satisfied) how would you rate your present experience of the following aspects of general medical practice?

- **Rewarding work (a)**
  - dis 1 – 2 – 3 – 4 – 5 satisfied
- **Work/life balance (d)**
  - dis 1 – 2 – 3 – 4 – 5 satisfied
- **Personal income (e)**
  - dis 1 – 2 – 3 – 4 – 5 satisfied
- **Opportunities for professional development (f)**
  - dis 1 – 2 – 3 – 4 – 5 satisfied
- **Freedom to practice as you wish (g)**
  - dis 1 – 2 – 3 – 4 – 5 satisfied
- **Clinical support (b)**
  - dis 1 – 2 – 3 – 4 – 5 satisfied
- **Administrative support (c)**
  - dis 1 – 2 – 3 – 4 – 5 satisfied

28. If you could get a similar return on your time (putting aside issues of capital investment etc.), would you prefer a salaried position or practice ownership?

- Salaried 1 – 2 – 3 – 4 – 5
- Ownership

29. Do you feel it appropriate for practices to seek out those registered with the practice who do not present for care?

- Yes 1, Only those with known risk factors 2, No 3

30. Please mention any changes that you would like to see in primary health care in New Zealand:
APPENDIX 4 – PRACTICE SURVEY QUESTIONNAIRE

Practice Questionnaire  
Practice ID Number AR 3  
(ID#)

(Please circle appropriate answer. DK = Don’t know, NA = Not applicable)

**PATIENTS AND ACCESS**

1. How many enrolled patients do you have?
2. Is this a designated rural practice? *circle answer* (a) Yes 1 No 2  
   If yes, what is the rural score? (b)
3. Please indicate the hours your practice is open *(eg 8.30am – 5.00pm)*.

<table>
<thead>
<tr>
<th>Day</th>
<th>Open</th>
<th>Close</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monday</td>
<td></td>
<td></td>
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<tr>
<td>Tuesday</td>
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<td>Wednesday</td>
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<td>Saturday</td>
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<tr>
<td>Sunday</td>
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</tbody>
</table>

4. Do you use a booking system for appointments?  Yes 1 No 2

5. What arrangements are made for “extras” – urgent or non-booked appointments, walk-ins etc? *(tick as many as apply)*
   a. We hold appointments open until the day
   b. We have a walk-in period
   c. There is a designated acute care doctor / nurse
   d. We use practice nurse triage
   e. Other (please specify) ________________________________

6. Approximately how many home visits are made each month (for the overall practice):  
   by doctors
   by nurses

7. What after-hours arrangements does the practice make? *(tick all that apply)*
   a. Provides own after-hours cover
   b. Collective (part)owned/run after-hours service
   c. Subscribe and sign out to after-hours service
   d. No formal arrangements
   e. Other (please specify) ________________________________
8. Are the following services provided at the practice?

<table>
<thead>
<tr>
<th>Services provided</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Medical or surgical specialist care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Mental health services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(psychologist/ psychiatrist/counsellors)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Pharmacy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Dental health services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. Minor surgery (lumps, bumps and lacerations,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>vasectomy etc)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>f. Sexual health services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>g. Dedicated health education / health promotion</td>
<td></td>
<td></td>
</tr>
<tr>
<td>sessions – please specify</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

9. Are the following services available to the practice?

<table>
<thead>
<tr>
<th>Services provided</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Outreach nurses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Community worker</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Transport assistance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Community newsletter / meetings</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

10. At June 1st 2006 how many patients had attended an initial Care Plus interview? _____
11. For each of the following categories, please indicate the number of people working at the practice (Please give full time equivalents (eg 0.1 = half a day/week).)

<table>
<thead>
<tr>
<th>Category of Personnel</th>
<th>FTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. General practitioners – partners</td>
<td></td>
</tr>
<tr>
<td>b. General practitioners – employees, trainees, long-term locums etc.</td>
<td></td>
</tr>
<tr>
<td>c. Practice nurses</td>
<td></td>
</tr>
<tr>
<td>d. Independent midwives</td>
<td></td>
</tr>
<tr>
<td>e. Nurse practitioners</td>
<td></td>
</tr>
<tr>
<td>f. Reception and administrative</td>
<td></td>
</tr>
<tr>
<td>g. Practice managers</td>
<td></td>
</tr>
<tr>
<td>h. Community health workers</td>
<td></td>
</tr>
<tr>
<td>g. Other</td>
<td></td>
</tr>
</tbody>
</table>

12. Are there any vacancies in the practice for a GP? (X answer)

(a) Yes 1 No 2

If yes, for how long has this vacancy existed? (b) months

13. Are there any vacancies in the practice for a nurse? (X answer)

(a) Yes 1 No 2

If yes, for how long has this vacancy existed? (b) months
14. Does the practice operate as a team (defined as each person seen as equal but contributing according to their knowledge and experience)? (X answer)  
   Yes 1  Partially 2  Hardly at all 3

15. Are there regular clinical team meetings?  (a)  Yes 1  No 2  
   If yes, how often do they occur?  (b)  days

16. If yes to Q15, who, among the following, attends these meetings?
   a. Manager  []
   a. Receptionist and administrative  []
   b. Administrative staff  []
   c. Practice nurses  []
   d. General practitioners  []
   e. Other health professionals  []
   f. Community health workers  []
   g. Others - please write in:

17. Does the practice computer system distinguish nurse visits? (X answer)  
   Yes 1  No 2

18. Do nurses provide the following services (X as appropriate).

<table>
<thead>
<tr>
<th>Nursing activities</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Telephone follow-up</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Triage of phone calls</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Triage of walk-in patients</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. General consultations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. Well child consultations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>f. Care of chronic conditions eg Care Plus</td>
<td></td>
<td></td>
</tr>
<tr>
<td>g. Mental health care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>h. Special clinics (health education, diabetes)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>i. Group health education or promotion</td>
<td></td>
<td></td>
</tr>
<tr>
<td>j. Community, or mobile, clinics or home visits</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
PRACTICE POLICIES

19. Please indicate if your practice has: (tick as appropriate)

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Completed an accredited quality programme (e.g. Cornerstone, Te Wana etc)?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A written policy on complaints?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A written policy on critical events investigation procedures?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A written training policy for general practitioners?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A written training policy for practice nurses?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A written training policy for managers and admin. staff?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

PRACTICE OWNERSHIP and MANAGEMENT

20. Is the practice owned by (X whichever applies):

   a. One or several of the general practitioners []
   b. A private company with shareholders outside the practice []
   c. An iwi or pan-tribal community organisation []
   d. Local community trust []
   e. Other community organisation []

   For regular daytime work, which payment options are used for:

21. GPs who do not share in profits (X as many as apply)?
    a. Fee per patient seen []
    b. Fee per sessions worked []
    c. Salary []
    d. Proportion of co-payments collected []

22. GPs who share practice income after expenses (X as many as apply)?
    a. Personal list size []
    b. Sessions worked []
    c. Number of patients seen []
    d. Proportion of co-payments collected []

23. Does the practice have a formal (separate) management committee? (X answer)
    Yes 1    No 2
24. If yes to Q23, who among the following, are included in the management committee? (X as many as apply)
   a. Practice manager [ ]
   b. Administrative staff [ ]
   c. Nurses [ ]
   d. GPs [ ]
   e. Other health professionals [ ]
   f. Community health workers [ ]
   g. Community representatives [ ]
   h. Patients [ ]
   i. PHO representatives [ ]
   j. Others please write in: __________________________________________

25. Do you identify your practice as a Māori practice? (X answer)
   Yes 1    No 2

26. If yes to Q25, why? (X all that apply)
   a. Eligible for funding under the Māori Provider Development Scheme [ ]
   b. Owned by an iwi / urban Māori authority [ ]
   c. Majority are Māori patients [ ]
   d. Any other – please specify _________________________________________

27. Do you receive Māori Provider Development Scheme (MPDS) funding? (X answer)
   Yes 1    No 2

28. Do you identify your practice as a Pacific Island practice? (circle answer)
   Yes 1    No 2

29. If yes, why (X tick all that apply)?
   a. Eligible for funding under the Pacific Provider Development Scheme [ ]
   b. Owned by a Pacific community group [ ]
   c. Majority are Pacific patients [ ]
   d. Any other - please specify _________________________________________
### RELATIONSHIP WITH PHO

30. Are you a member of a PHO?  
   Yes 1  No 2  

   **If not a PHO practice - please go to Question 43**

31. Please name PHO

32. Date of joining/becoming a PHO (mm/yy):

33. Was the practice funding capitated prior to joining PHO?  
   Yes 1  No 2

34. If yes to Q33, please give the date at which capitation funding commenced (mm/yy):

35. Is a member of your practice on the PHO board?  
   Yes 1  No 2

36. How would you rate the PHO (including the MSO (Management Service Organisation) if applicable) on the following characteristics: (X answer)

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>None</th>
<th>Poor 1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5 Good</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. IT support</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Management support</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Clinical support</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>d. Provision of information/news</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. Provision of education for health professionals <em>(may include Continuing Medical Education (CME), Continuing Nursing Education (CNE), prescribing &amp; test feedback, etc.)</em></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>f. Responsiveness to practice concerns</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>g. Responsiveness to clinicians’ concerns</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>h. Developing new programmes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>i. The direct provision of services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>j. Relationship with the community</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>k. Provision of education for patients</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>l. Community health promotion</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
37. Does the PHO (or MSO) provide:  
   (a) Locum doctors  Yes 1  No 2  
   (b) Fill-in nurses Yes 1  No 2  

38. What other services does the PHO (or MSO) provide? (please write in)  
_________________________________________________________________  
_________________________________________________________________  
_________________________________________________________________  
_________________________________________________________________  
_________________________________________________________________  

39. Are there any services that the PHO (or MSO) does not provide that you would like to see it initiate?  
   (X answer) (a) Yes 1  No 2  
   (b) If yes to Q 38, please list:  
_________________________________________________________________  
_________________________________________________________________  
_________________________________________________________________  
_________________________________________________________________  
_________________________________________________________________  

40. Do you think the PHO board is aware of the issues facing practices? (X answer)  
   yes 1, partial 2,  
   no 3, don’t know 4  

41. How would you rate the influence of the PHO board on the practice: (X answer)  

<table>
<thead>
<tr>
<th></th>
<th>Too much</th>
<th>About Right</th>
<th>None</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. In questions of quality?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. On services provided?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. On practice organisation?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. In relation to fees?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

42. Does the practice receive: (tick answer)  
   Access formula funding [ ]  
   Interim formula funding[ ]
43. Please estimate the change in the following, comparing the last twelve months with the period before the practice joined the PHO (If not a PHO practice please compare with two years ago): (tick answer)

<table>
<thead>
<tr>
<th></th>
<th>Increased</th>
<th>Same</th>
<th>Decreased</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Total practice income</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Perceived practice busy-ness (include all clinical activities – doctor visits, nurse visits, procedures, phone calls etc.)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Funds owed to the practice by patients</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

44. Are charges made for the following services? (X answer)

<table>
<thead>
<tr>
<th>Service</th>
<th>Always</th>
<th>Sometimes</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>Long visit surcharge</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurse visit</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Care Plus visits</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cardiogram</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Repeat prescription</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Letter</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (write in)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

45. Please provide your standard day-time charges (after subsidy) for a patient visit:

**Medical Fees**

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Standard</th>
<th>With card (CSC, HUHC)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients aged &lt;6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patients 6 - 18</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patients 19 - 24</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patients 25 - 44</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patients 45 - 64</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patients 65+</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## ACC fees

<table>
<thead>
<tr>
<th></th>
<th>Standard</th>
<th>With card (CSC, HUHC)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients aged &lt;6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patients 6 -18</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patients 19 - 24</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patients 25 - 44</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patients 45 - 64</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patients 65+</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

46. Please mention any changes that you would like to see in health care in New Zealand:

---

**Date of completion**

day___ month____ year_____

**Position/title of informant**

_____________________________________________
APPENDIX 5 – NURSE LEADERS INTERVIEW GUIDE

PRIMARY HEALTH CARE STRATEGY EVALUATION
QUESTIONS FOR CONSULTATION WITH NURSE LEADERS

Participant:

Occupation:

Address:

According to The Primary Health Care Strategy (Minister of Health, 2001) primary health care nursing was perceived “to be crucial to the implementation of the strategy”.

1. How crucial do you perceive primary health care nursing is to the successful implementation of the Strategy?

2. How has the development of PHOs impacted on primary health care nurses?

3. What have been some of the positive influences on the ways that nurses practise within the PHO environment?

4. What have been some of the negative influences on the ways that nurses practise within the PHO environment?

5. Has the PHO environment enabled nurses to expand their roles?

6. Has there been any real change in the organisation of primary health care nursing services and has this improved the effectiveness of nursing services?

7. What have the implications been for Māori nurses?

8. What have the implications been for Pacific nurses?

9. What have the implications been for patients/clients?

10. Has there been any real change in the utilisation of primary health care nursing services?

11. How do current funding streams impact on the delivery of nursing services?

12. Are nurses working more autonomously in the PHO environment?
13. Are nurses working more collaboratively in the PHO environment?  
   Prompt: provide examples.

14. Has the new primary health care environment resulted in better teamwork amongst primary health care nurses, doctors and other health workers?

15. Do you perceive an increased role for nurse practitioners in primary health care?

16. Do New Zealand’s undergraduate nursing programmes prepare nurses adequately for practising in the primary health care environment?

17. Are primary health care nurses able to access appropriate postgraduate education and training?

18. Were the scholarships offered by the Ministry of Health a good way to promote postgraduate education and the development of the nurse practitioner role?

19. Are nurses participating more in primary health care management?

20. Are nurses participating more in primary health care governance?

21. What role do you perceive primary health care nurses have in relation to accident-related care?

22. If you could make one change to primary health care nursing, what would it be?