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The nurse practitioner role: Solution or servant in improving primary health care service delivery

Jenny Carryer, RN, PhD[a,*], Judy Yarwood, RN, MA (Hons)[b]

[a] *School of Nursing, Massey University, P.O. Box 11-222, Palmerston North, New Zealand*
[b] *Department of Nursing and Human Services, Christchurch Polytechnic Institute of Technology, City Campus, P.O. Box 540, Christchurch, New Zealand*

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Summary In New Zealand, as in many other countries, the demand for health services is escalating as chronic disease, population ageing and health disparities increase. It has been argued that a more comprehensive primary health care approach is needed combining biomedical approaches with a social determinants and social justice based approach.

The contemporary development of the nurse practitioner (NP) role in New Zealand (NZ) offers the possibility of taking up a more critical approach to strengthen and extend primary health care services (PHC). Nurse practitioners could simply be utilised to shore up the nature and style of existing primary care (PC) service configurations or, more usefully, they could lead a revolution in traditional approaches towards genuine primary health care delivery.
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1. Introduction

Based on the combined research and teaching experience of two long standing New Zealand nurse academics this paper, while not directly reporting research per se, draws on impressions gained from our previous combined research experiences. We have conducted New Zealand (NZ) research in the areas of family care and chronic illness (see for example, Carryer, Budge, Hansen, & Gibbs, 2010; Carryer, Budge, Hansen, & Gibbs, 2010; Carryer, Doolan-Noble, Gauld, & Budge, 2014; Carryer, Snell, Hunt, Perry, & Blakey, 2008; Yarwood, 2008). From this basis we suggest that a revolutionary approach is required to the way in which health services in the community are delivered. This is a personal essay raising the notion of the nurse practitioner (NP) role in primary health care (PHC) delivery in NZ as a potential catalyst for the transformation of primary health care services.

In writing the paper we have experienced a tension between writing of nurses versus writing of nurse practitioners. Nurse practitioners are of course nurses and practice from the basis of a nursing philosophy. Therefore we write

* Corresponding author. Tel.: +61 0274491302.
E-mail addresses: J.B.Carryer@massey.ac.nz (J. Carryer), judeyarwood@paradise.net.nz (J. Yarwood).

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at times of nurses and nursing as a discipline and at others we refer specifically to the role of nurse practitioner.

2. Health service challenges

A burgeoning level of chronic disease and escalating health inequalities are both challenging NZ's health systems (Matheson & Loring, 2011; Wilkinson & Pickett, 2010). This problem is not confined to NZ. Differences in the health status of individuals or social groups and the associated significant social and economic costs involved (World Health Organization, 2013) continue to challenge the most committed of nations (Adshead & Thorpe, 2009). In many countries health inequities are rising unabated, the unintended result of social and health policy change (Matheson & Loring, 2011; Wilkinson & Pickett, 2010). Recent world events point to increasing unemployment and economic hardship for many, particularly for those already marginalised through gender, age, sexuality, ethnicity and religious beliefs (World Health Organization, 2008).

Social determinants are known to impact negatively on people's health outcomes (Kondo, Sembajwe, & Kawachi, 2009; Marmot & Friel, 2008; Marmot, Friel, Bell, Houweling, & Taylor, 2008). This is especially so in NZ where unacceptable health disparities persist, particularly for Maori as indigenous peoples of the country (Baker, Telfar Barnard, & Kvalsvig, 2012; NZ Ministry of Health, 2012).

In writing this paper it is important to acknowledge the distinction between the notions of PHC and primary care (PC). McMurray and Clendon (2015) have captured the distinction succinctly. They note that PHC is a pathway to achieving basic human rights, it is essentially about social justice and PHC is inter-sectoral meaning that health care services operate in collaboration with the many other sectors impacting on human health. Primary care, in contrast, is the first point of entry into the health system when an individual requests personal medical care usually (in NZ at least) from a general practice (GP) setting. Importantly PC is almost always delivered in isolation from the broader framework of the social determinants of health.

Hefford, Crampton, and Foley (2005) argue that people need more health care, not more medical care. PHC (rather than front line PC) can do just that, with its focus on addressing social determinants of health, on ensuring people have access to warm and dry housing, nutritious food, occupations that pay a living wage and a safe living environment. However in NZ the volume of presenting problems at the PC level means that the focus is consistently directed away from a broader more long term PHC attention. Nursing is currently caught in the web of what has become known colloquially, as the tyranny of the acute.

The maintenance of medically focused funding streams and organisational structures, and the constant political appeasement of medical lobby groups continues to daunt even the most determined of commentators speaking on behalf of PHC (Robertson, 2014). Robertson has argued that the NZ PHC strategy, launched in 2001, failed because although it espoused a clear PHC vision the policy settings and operational drivers, which supported a much more limited attention to PC, remained in place. In support of Robertson's assertions Mays and Blick (2008) argued that there have been weak financial incentives to adopt new forms of care and an unrealised contribution to the wider health system as a whole. These authors conclude that the fundamental incentives in the system have not changed sufficiently to support new ways of delivering services.

The underlying philosophy of PHC with its focus on a social rather than a medical model of health (Mackey, Hatcher, Happell, & Cleary, 2013) mirrors that of nursing and its concern to maximise the possibilities for health in individuals and communities. Such an approach requires consideration of the social context of people's lives, which, according to the World Health Organization (2010) is about understanding the structure of society, or the social relations, which create stratification and assign individuals to different social positions. These positions mean that many people find themselves disadvantaged and vulnerable to poor health outcomes without the provision of specific and focused assistance.

Concurrently numerous reports now argue that the traditional approach to health service provision may be unsustainable (Mays, 2013; New Zealand Institute of Economic Research, 2004; The Treasury, 2014). The demand for services is growing and the workforce is contracting. NZ has recently learned that 81% of its GP workforce is older than 45 (NZ Doctor, 2014) and anecdotal media based reports note a similar concern for specialist medical services.

Universal obstacles for health service consumers include ready access, choice, safety, affordability and cultural comfort in contexts where distance, lack of transport, poverty, reduction of amenities and limited support services increasingly present significant challenge (Marmot et al., 2008; McMurray & Clendon, 2015). Analysis of health need raises the demand for coordination, continuity, seamlessness, attention to individual difference and the significance of context (Carryer et al., 2010a,b). Current models of GP care have been found incompatible with effective chronic condition care (Carryer et al., 2014).

The response to both escalating demand and contracting workforce availability in NZ has common themes; practitioners should work at the top of their license; new and creative ways are needed to ensure all people can access relevant personal health services and rigid occupational boundaries need to be dissolved (Lathrop, 2013; Mays, 2013). There is however a much less purposeful or focused discussion about addressing the social determinants of health and taking a preventative approach to service provision. There has been no demonstrable change to old models of care and old forms of service delivery, which continue to be operationally supported.

3. Nursing and primary health care

Villeneuve (2008) asks us to ''imagine the impact on global health if the elimination of disparities is the core goal of nursing for the 21st century'' (p. 334). Nurses know the causes of much human suffering, pain and misery and are in a position to intercede (Villeneuve, 2008). It is intrinsic to nursing's social responsibility to identify, challenge, and address social injustice and heath inequities/disparities (McMurray & Clendon, 2015; McMurray, 2007; Tyer-Viola et al., 2009).

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