

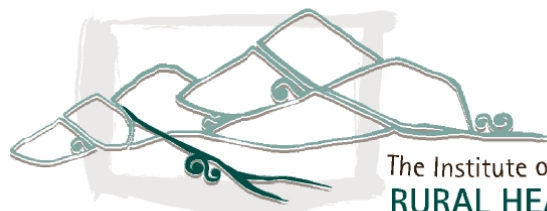
The Institute of
RURAL HEALTH

Te Mata o te Oranga, e kore e huna, e kore e mutunga

**IDENTIFYING TRAINING AND SUPPORT SERVICES
REQUIRED TO ENCOURAGE RURAL NURSES TO BECOME
RURAL NURSE PRACTITIONERS**

Institute of Rural Health

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Introduction

This report is prepared by The Institute of Rural Health to analyse current literature related to the implementation of the Nurse Practitioner's role in the Waikato District Health Board area. It is a step in the development of a strategy to manage nursing workforce issues in rural areas. The report places the development and implementation of the Nurse Practitioners role with the New Zealand Primary Health Care Strategy; identifies barriers to the implementation of the role, presents the views of key stakeholders and offers options and models for supporting rural Nurse Practitioners in Waikato.

Recommendations

1. Create a District Health Board workforce development plan for Nurse Practitioners with models specific to local settings, and a Nurse Practitioner position description that is appropriate and realistic. Quality systems need to be in place for aspects such as clinical supervision and professional mentoring of nurse Practitioners.
2. Develop strategic and business planning incorporating the development of Nurse Practitioner positions.
3. Create links between academics and the District Health Board with a view to establishing an evaluative process for the Nurse Practitioner role.
4. Devise a strategic plan to ensure Nurse Practitioner prescribing is protected and endorsed within the rural environment.
5. Establish functions within the District Health Board that are designated Nurse Practitioner roles and remove structural barriers within the sector which prevent career paths for nurse with advanced nursing skills. This involves the District Health Board being actively involved with Primary Health Organisations in delimiting and creating positions that align the Nurse Practitioner's role with the Primary Health Care Strategy. This will ensure that the majority of NP positions address the needs of the rural communities and populations within the parameters of a health service model which is encompassing of all modalities of health service delivery and increase the level of job satisfaction experienced by nurses.
6. Undertake an education and marketing campaign to explain the Nurse Practitioner role to District Health Board, Primary Health Organisation, the public, consumer groups, and medical and allied health colleagues.
7. Address issues related to role definition.
8. Identify and assist nurses in attaining Nurse Practitioner status by financial support to post graduate Masters Programmes endorsed by New Zealand Nurses Council.

NURSE PRACTITIONERS AND THE PRIMARY HEALTH CARE STRATEGY

Carryer, Digman, Horsburgh, Hughes, & Martin (1999) describe primary health care as a conceptual framework for providing public health and primary care services; it includes delivering essential, affordable, accessible, and acceptable health care to the community, with an emphasis on disease prevention and health promotion, community involvement, multi-sectoral cooperation, and the use of appropriate technologies. As a concept and as a framework for the provision of health care this strategy represents a significant move away from models of care based in the traditional approaches of biomedicine where the General Practitioner (GP) provides the focal point of all health care decision-making. Although the literature (Horrocks, 2002; Carryer, Digman, Hughes, & Martin, 1999) acknowledges that the initial precursor for the development of the Nurse Practitioner role stemmed from the short fall in GP recruitment, the reduction in junior doctors and the consequent difficulties of providing primary care services. This coupled with the expected growth in primary care activity over the next decade and the Ministry of Health's strategic direction (2001) means that much of health care provision traditionally carried out by general practitioners will need to be reviewed and apportioned to appropriately qualified personnel. This includes illnesses that can be treated without recourse to medical advice and minor self limiting illnesses which require no specific treatment, but requires health education, health promotion and disease prevention.

It is evident that from the perspective of the Primary Health Care Strategy, that traditional biomedical practice alone are insufficient in terms of providing the care demanded by the rural population. Notably, Carryer (1999, etal.) aptly summarise this point by asserting that primary care is often used interchangeably with primary medical care and that this contributes to an emphasis on immediate clinical crises or illness oriented care rather than population health strategies.

Despite the guidance being offered by professional organisations and the Ministry of Health (2002; 2001) the practical realities of implementing the role of Nurse Practitioner within existing health care structures presents some challenges. Under the current system, many health authorities talk about the goal of providing "the right service by the right provider", this premise remains rhetoric as long as health care provision is not reshaped to incorporate the unique qualities and functions of diverse health professionals, and in this case rural Nurse Practitioners.

Primary health care requires a knowledge and skill set which is qualitatively different than that required for the management of illness and injury. The agenda in primary health care is to work with communities and the people in them to achieve permanent improvement in the quality of their lives. Key principles, therefore in improving the health status of populations include equity, access, empowerment, self-determinism, and inter-sectoral collaboration (McMurray, 1999).

Inter-sectoral collaboration requires the effective use of the multidisciplinary team. The use of multidisciplinary teams is supported as being more effective in primary health care than the use of single, stand-alone practitioners (Neale, 1999). However, there are barriers to their effectiveness. That is, collaboration between health professionals is critical but poor identification of disciplinary skills, confusion over accountability, inequitable workloads, vested interests, role ambiguity, status differentials and struggles with authority and power persist and effect the functioning of streamlined health care provision (Breen, 2004). Clarke & Mass (1998) note that collaboration involves true partnerships in which the power of all members is valued and there is recognition and acceptance of separate and combined spheres of activity and responsibility. It may be postulated that the concept of collaboration is difficult to embrace for many medical practitioners who have been taught and socialised

in hospital settings to believe that they and their knowledge provide natural leadership to any team (Chiarella 1998; Liplely 1998). Moreover, in many community settings and especially within general practice where current funding structures perpetuate an employer/employee relationship or the notion of delegated medical authority nursing is confined to an assistive role and collaboration and the appropriate expression of nursing is precluded (Mundinger, Totten, Friedewald, Sin & Shelaukin, 2000; Nichols, 1992).

Carryer (1999, et al.) expands this view by purporting that major obstacles to changing the relationships between medical practitioners and nurses already working in the community are reflected in structures in which ownership and funding of IPAs and general practices is in medical hands and nurses are inevitably employees. This relationship is mutually constraining for both groups. Nurses and medical practitioners, alike, frequently find it very difficult to envisage different ways of working. Many practice nurses, for example, will actually claim that they prefer the security of their employee status, without reflecting on their inability to provide real nursing services from that vantage point. Within this context there is much confusion about accountability with some medical practitioners in the community continuing to believe that they will be held responsible for any clinical errors that nurses may make. The fact that some nurses share this erroneous belief, is demonstrated in that practice nurses as a group have particularly low membership of any professional organisation and thus limited uptake of indemnity insurance (Michel 1997).

The Primary Care Strategy (2001) enables nurses to provide care to groups and individuals in the community. The Honourable Annette King, Minister of Health, in her forward to Nurse Practitioners in New Zealand (2002) states that within a primary care nursing framework, Nurse Practitioners will have the opportunity to practice as part of the health care team, to lead specialty focused clinics in communities, or to establish independent primary health care and that these roles will be complementary to other health professional roles. Moreover, within a primary health care framework the way forward is to provide opportunities for new collaborative and multidisciplinary approaches to providing services between primary and disability support services, to ensure barriers to accessing primary health care services are minimised for people experiencing disabilities. For specific population groups with health needs that change over time and require a range of care and services from different providers, the development of collaborative relationships is essential. The Nurse Practitioner role is focused on patient and population needs and improving health outcomes, thus the Nurse Practitioner is in the ideal position to work with these groups in the attainment for mutual goals for patient needs.

While nurses have experience with forming partnerships with individuals, families and communities in many community settings and especially within general practice the employer/employee relationship or the notion of delegated medical authority, as previously discussed, confines nursing to an assistant role and frequently precludes collaboration and the appropriate utilisation of nurses with advanced skills. Nurse Practitioners are familiar with concepts that go well beyond disease and injury treatment to the use of strategies related to health promotion, education, patient advocacy, including social and environmental barriers to health.

In recognition of these skills the New Zealand Nursing Council (NCNZ) announced, in 2001, the formal registration of nurses functioning at an advanced level of clinical practice, and bestowed upon them the title of Nurse Practitioner. Thus, the movement to health care provision within this strategy must be premised by the equal placement of individuals within the multidisciplinary team, a team in which nurses play a vital role. Studies have shown repeatedly that, within their level of education, nurse practitioners provide quality, cost-efficient treatment of common acute illnesses and management of minor chronic disorders (Breen, 2004, Ministry of Health, 2001; Cleary, 2001; Chapple & MacDonald, 1999; Dobson; 1999; Wise, 1997). Moreover, evidence (Hughes, Sullivan-Marx, & Fairman, 2002;

Knudston, 2000) suggests that the care provided by these nurses improve the outcomes for these groups allowing people to stay at home rather than be admitted to hospitals or continuing care facilities.

A view strongly supported by The Honourable Annette King, Minister of Health, when she stated that 'Nurse Practitioners provide an innovative way of reaching communities through District Health Boards, and meeting health needs across all sectors in a cost-effective way' (Ministry of Health, 2002: 4).

Nationally it has been identified that planning for the successful implementation of Nurse Practitioners, is intricately linked to the successful achievement of New Zealand health strategies across a wide range of sectors and settings. For the nursing profession, this presents an opportunity to critically evaluate and redefine its scopes of practice, address current constraints to effective practice, and to ensure that nurses are viewed as strong, effective and visible members of the primary health care workforce. It is a significant opportunity for Nursing to reposition itself for new ways of delivering services in primary health care settings and communities. Moreover, the Ministry of Health (2002) postulates that it is time to enhance a generic skills set of all nurses working in primary health care so that the result will be the more effective utilisation of advances in nursing practice.

The movement to the use of Nurse Practitioner's role, in the rural setting, to a role that encompasses skills and knowledge traditionally allocated to medicine will necessitate a transitory period and effective change management. King (2003) states "it is clear that historical practices will need to change and the models we [sic] develop for health care need to embrace the positive contribution Nurse Practitioners can make". Paradoxically, to date, there is no guarantee of a Nurse Practitioner position being established in a particular health care agency. Another complexity of this transitional phase in the introduction of a Model which embraces the Nurse Practitioner as its focal point, is that Nurse Practitioner positions may be established, but that there is no endorsed Nurse Practitioner within the specific area of practice to apply for the position. District Health Boards must plan for this. Interestingly, Nurse Practitioner Advisory Committee - NZ's Nurse Practitioner Implementation Survey in 2003, indicated that at this point few major organisations had developed implementation plans for Nurse Practitioner roles. Nurse Practitioner Advisory Committee - NZ is working to ensure there is a strategy to introduce Nurse Practitioner roles into each District Health Board.

BARRIERS TO THE IMPLEMENTATION OF THE NURSE PRACTITIONER ROLE

The literature related to the Nurse Practitioner's role and barriers to the appropriate implementation of the role, illustrates that New Zealand faces the same challenges faced by Nurse Practitioners and managing Health Authorities internationally regardless of the zeal possessed by Nurse Practitioners to decrease costs, increase quality of care and access to health services.

Hughes (2003), identified four key areas of concern to the implementation of the Nurse Practitioner role. Areas of concern related to the inability to access laboratory services, including the inability of to make referral to diagnostic imaging services; contractual arrangements with District Health Boards, legislative barriers; and Nurse prescribing rights (Kaplan, 2004). Interestingly, Booth's research in 1995 found that barriers generally fell into three areas: prescriptive authority, reimbursement, and regulation of practice, and yet to date modest progress has been made to address these issues.

In 2003, at the Forum to Progress the Nurse Practitioner's Role, participants identified a number of challenges specific to New Zealand. These challenges included insufficient recognition of the strengths of the Nurse Practitioner role within District Health Boards, opposition to the role of Nurse Prescribers, the current lack of equity in the funding distributed by the Clinical Training Agency and the personal financial burden of attaining Nurse Practitioner status.

One of the consistent themes expounded by nurses at the Forum related to the lack of current incentives for providers in the health system that does not support the integrated health care required to implement the objectives of the Primary Health Care strategy and the directions of the Ministry of Health in relation to the Nurse Practitioner's role. Nurses believed that health providers all have their own "territory" and while nurses and doctors say they want to find better ways of working together, there's no incentive to make it work.

Another concern voiced by Nurses at this Forum related to the issue of dichotomous agendas. That is, while professional organisations talk positively about the need to work together, in reality, they seem unwilling to give up parts of their "scope of practice" unless there is some corresponding compensation. While some professions are interested in expanding their scope of practice at the "higher" end of more complex services, they are unwilling to give up any services at the "lower" end where others could perform this function and be suitably remunerated. The Health Workforce Advisory Committee Stocktake Report or HWAC (2002:29) states "Nurse Practitioners can be expected to complement the roles of General Practitioner's and other health practitioners, but their scopes of practice may overlap in some areas, leading to skill mix changes between the groups. This may allow the best use of scarce workforce resources to achieve quality care". As previously mentioned in some cases, legislation is a barrier; for example, existing legislation limits the use of nurse practitioners except in areas that are under-served by physicians. In other cases, union contracts require the use of particular health providers even though others could probably do the work and at less cost.

INTERVIEWS WITH KEY STAKEHOLDERS

Focus groups were held with key stakeholders with the purpose of identifying implementation barriers and putting forward ideas to address these barriers. The first focus group encompassed industry and professional members; the second, Nurse Practitioners; and the third nurses.

Summary of Discussions

1. Industry & Professional Members

A focus group was held with key professional and industry stakeholders. Key stakeholders were representative of:

- ♦ Waikato Institute of Technology
- ♦ Waikato Primary Health Organisation
- ♦ Waikato District Health Board – Funding & Planning
- ♦ New Zealand Nurse's Organisation

Representatives from the Waikato District Health Board Maori Health & Development Unit, Community Services and a Waikato District Health Board Professional Nurse Advisor were also invited but failed to attend. Focus questions related to perceived barriers to the implementation of the rural Nurse Practitioner's role.

Identified issues came under the following headings:

Political - Stakeholders expressed concern in relation to NZ Nursing Councils lack of commitment to ensuring Nurse Prescribers legislation is approved. Concerns were also expressed in relation to the development of potential roles for Nurse Practitioners and the perceived fear of other health professionals in relation to NPs replacing doctors. It was suggested that the Waikato District Health Board develop a plan to raise awareness of the NP role and to strategically develop positions and business cases to support the development of NP roles.

Financial - Stakeholders expressed concern in relation to the lack of financial incentives for Nurses to undertake the Nurse Practitioner's role. It was evident that nurses first had to assume the financial debt of obtaining a Master's qualification, via a New Zealand Nursing Council endorsed program; and second once the qualification was obtained the lack of remuneration afforded those in advanced clinical practice roles. Further, stakeholders believed that current models of care were focused in biomedical/acute care frameworks and this discouraged nurses working in the community-based rural sector from undertaking a pathway that was not relevant or applicable to their health care setting.

- Personal/Social - Stakeholders reiterated that biomedical models of care precluded nurses in the rural sector from undertaking the Nurse Practitioner role. Moreover, it was purported that nurses felt undervalued and believed that their work environments did not support them in their roles. Another issue identified here related to Nurse Practitioner's development of confidence and the lack of mentoring to encourage and support Nurse Practitioner's in neophyte roles
- Strategic - Stakeholders identified the lack of strategic and business planning for the development and implementation of rural nurse practitioners in Waikato. The need to develop alliances and clear position descriptions was highlighted.

2. Nurse Practitioners

Two Nurse Practitioners based in the Waikato were interviewed. Interview questions related to the barriers and obstacles confronted by them in their roles as Nurse Practitioner's. issues relating to career pathways; alignment with community needs, ongoing support by Primary Health Organisations and the District Health Board.

Identified issues came under the following headings:

- Political - Institutional barriers relating to Prescribing legislation, relationship with the Accident Compensation Corporation and practice regulation were identified. Both Nurse Practitioners have completed prescribing requirements set by the New Zealand Nursing Council but are unable to do so because of legislative restrictions.
- Financial - Both Nurse Practitioner's identified the personal financial burden of obtaining Master's qualification, and related concerns as to the viability of commencing practice as a business entity over a salaried position. Both are currently in salaried positions.
- Personal/Social - Individual psychological barriers relating to self doubt and self belief were identified. In fact, psychological barriers remained the primary concern in both cases with this barrier impacting on decision-making, and their perceived risk of autonomous practice. Horizontal violence from peers also rated as a concern in that the nursing environment is not prepared for nurses who have chosen the Nurse Practitioner career pathway. This has led to them working as individuals within a team rather than as member of the multidisciplinary team.

Strategic - The lack of a structure and framework for the development of Nurse Practitioners was identified as a key issue for both. They expressed that there is a lack of nursing leadership in the Waikato and that this has meant a lack of nursing vision that has directly impacted on the lack of consideration for a clear nursing career pathway. The issue of forging alliances with key stakeholders, namely General Practitioners was seen as paramount in successfully implementing a career pathway for Nurse Practitioners.

3. Nurses

Participants: 40 Registered Practice Nurses. Nurses were divided into groups of five and six and responded to the question: What did they perceive to be barriers to the implementation of the Nurse Practitioner role in rural New Zealand.

1. The challenges that are most salient to the Nurse Practitioner are to differentiate their roles among other health professionals while creating a support environment for advanced nursing practice; creating a climate whereby the integrity of the system is maintained for both acute and primary care Nurse Practitioner and to provide a service with clear authoritative guidelines about the clinical and cost effectiveness of their interventions.
2. The Nurse Practitioner role requires clinical diagnosis and treatment with the inherent possibility of a need to prescribe. Prescription is set around particular groups of clients. This is problematic for nurses who are generalists and who are seeing patients with undifferentiated diagnosis.
3. Nurse Practitioners are not adequately reimbursed for the increase in their responsibilities and accountabilities. Appropriate incentives are not in place.
4. Lack of clarity in relation to reporting frameworks. The Nurse Practitioner is supposedly an equal member of the health team, however reality indicates that power differentials still exist between doctors and nurses.
5. Despite the Nurse Practitioners role being theoretically geared to holistic care of clients in the rural setting it is very much focused by the biomedical model and the need to treat disease and undertake medical interventions.
6. While many of the professional organisations talk positively about the need to work together, in reality, they seem unwilling to give up parts of their "scope of practice" unless there is some corresponding compensation. While some professions are interested in expanding their scope of practice at the "higher" end of more complex services, they are unwilling to give up any services at the lower end which are financially remunerated.
7. Those aspiring to be Nurse Practitioners feel that they are not supported in a role that may be at times in conflict with doctors.

8. Many nurses feel they have been marginalised and their opinions are not valued. This has a direct impact on efforts to retain nurses and to encourage nurses into advanced practice roles.

To summarise, the issues identified by stakeholders as barriers to the development and implementation of Nurse Practitioners in the Waikato align with issues identified in the literature. Key issues relate to:

- Lack of strategic planning in line with Ministry of Health directions
- Absence of academic/career pathways that align with the development of Nurse Practitioners. In fact, only 23 nurses in the Waikato District Health Board are undertaking post graduate study with the University of Auckland, whose Master's Programme is only one of a few Nursing qualifications endorsed by the New Zealand Nursing Council in the lead up to Nurse Practitioner endorsement.
- Health care models which remain medically focused do not permit Nurse Practitioners to develop within the scope of their practice and in line with the Primary Health Care Strategy.
- Lack of other health professional's awareness of the Nurse Practitioner's role and absence of position description
- Lack of mentorship of Nurse Practitioner's as they develop effective leadership skills
- Lack of financial incentives to undertake study to achieve Nurse Practitioner status and lack of equitable remuneration to undertake the role.

NURSE PRACTITIONER MODELS

In order to support rural Nurse Practitioners, as positions are identified and emerge, changes to current service provision and ways of working in the rural sector will require redress. This is inevitable and will be negotiated and shaped according to each particular role. Initially tensions and challenges will occur until the new positions are embedded within organisations, and during this transitions it should be noted that the Nurse Practitioner is not a doctor replacement although many Nurse Practitioners will assume a number of tasks that have traditionally been undertaken by doctors. These may include admitting and referral rights, requisitioning laboratory and radiology tests and prescribing medications if they have prescriptive authority. The creation and designation of Nurse Practitioner roles, within the Waikato District Health Board, will provide opportunities to rethink service provision so that it is more effective, gaps are closed and greater multidisciplinary cohesion occurs.

Within New Zealand four models of care have been delineated for the position and role of the Nurse Practitioner (Hughes, 2003). However as this is a new role, in New Zealand, further models may emerge dependent on consumer need and service configuration. The following outlines models under consideration.

Integrated Nursing Teams

A team of nurses and nurse practitioners provide, co-ordinate and manage health promotion and disease prevention across the continuum of care. For example, integrated primary health care nursing teams working out of primary health organisations and providing risk assessments, first-contact care, case management of clients with chronic conditions, and services for whanau, hapu, iwi and Maori communities.

Nurse Consultancy

The Nurse Practitioner works independently and refers clients to other health professionals, where required. Collaborative practice arrangements and care decisions may also dominate. For example, within hospital settings, between primary and secondary, and secondary and tertiary, health care services, or between non-government organisations. The Nurse Practitioner provides leadership to nurses and referral to other disciplines.

Independent Practice

Nurse Practitioners are self-employed and establish their own independent practices offering care and services direct to the public. For example, nurse practitioners contract themselves to provide services to other agencies, hospitals, primary health organisations, non-government organisations, and/or direct to clients.

Nurse Practitioner Specialty Services/Clinic

The Nurse Practitioner is the recognised lead health professional within the health care team for establishing and managing specialty clinics/services for a particular health specialty and/or population groups. For example, pain management, anaesthetics, wound management, rehabilitation, disease management.

Note that there may be an overlap in the models. For example, the Nurse Practitioner may work in the model of specialty in pain management, but also be in independent practice.

All models, aforementioned, may be implemented by the Waikato District Health Board but require strategic fore-thought and involvement of key stakeholders. Business and strategic planning are mandatory. Nurses need to be part of the planning process to make implementation of the Nurse Practitioner role via the District Health Board viable. This begins with a nursing presence in the funding and planning process across the District Health Board. Sessions related to the challenges and possibilities of implementing a paradigmatic shift in health care provision are required to establish the parameters for change and role clarity so as to ensure all parties involved in the new paradigm feel "heard" and "safe". Key alliances are important here. The District Health Board needs to establish a working party to review roles within the District Health Board which would be best served by a Nurse Practitioner, human resource implications, structural changes, reporting lines, job descriptions, contracting arrangements, and set up requirements for implementing the Nurse Practitioner role within Primary Health Organisations and within the acute sector. This group would also devise the accompanying audit tool and have input into District Health Board and Ministry of Health monitoring of Nurse Practitioner and Primary Health Organisations performance. In line with performance, protocols and guidelines that facilitate the efficacy of the Nurse Practitioner role require development and sanction buy the District Health Board. The challenges that are most salient to the Nurse Practitioner are to differentiate their roles among other health professionals while creating a support environment for advanced nursing practice; creating a climate whereby the integrity of the education system is maintained for both acute and primary care NPs and to provide a service with clear authoritative guidelines about the clinical and cost effectiveness of their interventions.

Protocols and guidelines provide a clinical governance framework that specifies the Nurse Practitioners accountabilities. Nurses, also, need to be consulted at the governance level of Primary Health Organisations as they are established to ensure adequate opportunities are provided for Nurse Practitioners. Primary Health Organisations are a key focus for successful implementation of the Nurse Practitioner role in New Zealand within the Primary Health Care Strategy.

Notably, for nurses to interact within this tier of governance assumes that they are politically informed and prepared to interact with members of all levels of the health team, they manifest a "key-hole" expertise. That is, Nurse Practitioners are acknowledged for clinical expertise and endorsement by the New Zealand Nursing Council includes effective nursing leadership and consultancy and scholarly inquiry into nursing practice. However, reality proposes that their expose to this level of decision-making is minimal despite undertaking Master's qualification in these areas. In respect of this, the emergent and transitory phase of this role of Nurse Practitioners, require professional mentorship within the District Health Board framework. This includes the preparation of successful business cases, negotiation skills, and tangible leadership skills. Maguire et al (1995) described the environment necessary to support nurse practitioners. They report that a strong nursing identity, interdependent collaboration, nursing leadership and opportunities to engage in interesting and varied work incorporating research are important considerations. In addition the ability to influence policy and clinical practice through positive professional relationships and organisation models is essential.

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