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Discourse

Will Nurse Practitioners Achieve Full Integration Into the Canadian Health-Care System?

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Introduction

Nurse practitioners (NPs) were first introduced in urban Canada in a wave of activity between the late 1960s and mid-1980s. During this time NP education programs were set up, NPs and physicians experimented successfully with collaboration, and the safety and effectiveness of the role were established in groundbreaking randomized controlled trials (Spitzer et al., 1974, 1975). In spite of these early accomplishments, the financial, legislative, professional, and public support for the role was insufficient to enable it to take hold in the health-care system (Haines, 1993; Spitzer, 1984). In the mid-1990s, calls for improved accessibility to primary health care to address the needs associated with burgeoning chronic disease and an aging population led to renewed interest in the NP role, culminating in the multi-million-dollar federally funded Canadian Nurse Practitioner Initiative (CNPI) (2006). The vision of the CNPI was "a renewed and strengthened primary healthcare system that optimizes the contributions of nurse practitioners to the health of all Canadians and a system in which nurse practitioners are recognized and utilized across Canada as essential providers of quality healthcare" (2006, p. 8). While much has been done to incorporate the NP role into the Canadian health-care system, its sustained integration remains a vision, not a reality. This is perhaps not surprising given the decades of policy legacies that have shaped, supported, and reinforced a physician-centred model of health-care delivery in Canada (Hutchison, Abelson, & Lavis, 2001). Still, the question of whether the day will come when NPs reach full integration into the health-care system lingers, the demise of past efforts a chilling reminder of how quickly a good idea can be abandoned (Spitzer, 1984).

The aim of this article is to examine the forces for and against full integration of NPs into primary and acute care. Legislative/regulatory, education, and practice issues influencing such integration are outlined.

The article draws on the findings from a recently completed decision support synthesis conducted to develop a better understanding of advanced practice nursing roles in Canada (DiCenso et al., 2009).

Legislative and Regulatory Building Blocks

The quest to achieve a cross-jurisdictional harmonized approach to the legislation and regulation of the NP role across Canada is ongoing. It is motivated by an awareness of the need for clearly defined roles to facilitate health-care access, enhance workforce mobility, and strengthen the credibility of NPs with other health professionals and the public. The Canadian Nurse Practitioner Core Competency Framework (Canadian Nurses Association [CNA], 2005), the Canadian Nurse Practitioner Exam Program (http://www.cna-nurses.ca/CNA/nursing/npexam/ancc/default_e.aspx), and recent changes to the Internal Trade Agreement (Forum of Labour Market Ministers, 2009) were watersheds in moving this agenda forward. Nevertheless, agreement on a pan-Canadian legislative and regulatory framework has not been achieved, largely because inter-jurisdictional inconsistencies persist in some key areas, such as NPs' educational preparation and scope of practice (CNA, 2009).

In addition to the challenges associated with legislation that authorizes NP practice, there are many other legal acts and policies restricting how NPs provide patient care. In some provinces, legislation governing hospitals specifies that only physicians may prescribe drugs and order diagnostic tests. Consequently, in these settings NPs must practise using medical directives that can reinforce medical control structures and limit NP practice (Hurlock-Chorostecki, van Soeren, & Goodwin, 2008; McNamara, Giguère, St-Louis, & Boileau, 2009). The efficiency and comprehensiveness of NP practice are further compromised by vital statistics acts specifying that only physicians can sign death certificates and motor vehicle acts stipulating that only physicians can perform driver medical examinations. Similar restrictions are contained in the *Canada Pension Act,* the *Tax Act,* and the *Employment Insurance Act*. Clearly, the physician role is deeply integrated into our health and social systems and, in some ways, provides a measure of the distance yet to be travelled to achieve a comparable level of structural integration for NPs. Making changes to legislation sounds deceptively simple; anyone who has done it will tell you it is anything but.

Education — the Cornerstone

Although master's-level preparation for NPs is endorsed by the CNPI (2006) and the CNA (2008), three provinces continue to educate NPs for primary health care settings at the baccalaureate or post-baccalaure-

ate level. The nursing profession agrees in principle that standardization at the master's level is vital to ensuring that NPs are educated in all the competencies that define advanced nursing practice (CNA, 2008). The opposition to this idea comes primarily from provincial governments concerned about the lack of evidence to justify the time and expense associated with graduate education (DiCenso et al., 2009). Thus, it is not at all certain that CNPI's (2006) goal of having all pre-licensure NP education at the master's level by 2015 will be reached. And failure to meet this goal will likely delay realization of a pan-Canadian legislative and regulatory framework.

Several other education-related issues are influencing NP integration. The absence of pan-Canadian education standards for NP programs, beyond the current consensus on graduate entry-level education and a minimum of 700 clinical hours (Canadian Association of Schools of Nursing, 2004; DiCenso et al., 2009), results in inconsistencies in knowledge, skills, and abilities across jurisdictions. While it is clear that standards are needed, how to move forward in setting them is not. Even if we determine which organization(s) will take the lead and where the resources will come from, the availability and accessibility of specialty NP education, along with cross-jurisdictional differences in what constitutes clinical specialization, will likely confound deliberations about standards (DiCenso et al., 2009). In some provinces NPs are educated and licensed to practise in a specific clinical specialty, such as cardiology or nephrology, whereas in others they are educated and licensed to practise with a specific population, such as adults or children. At issue is how best to meet the need for NP specialty education while taking into account the realities of the Canadian context. Not only is our country geographically vast, but it also has relatively few NPs, who work in many different specialty and subspecialty areas, and resources dedicated to NP education are already stretched (Martin-Misener et al., forthcoming).

Practice

For NPs to be fully integrated into the Canadian system, they must be sufficiently numerous to make a visible and measurable contribution. The increase in the number of licensed NPs in Canada from 800 in 2004 to 1,626 in 2008 is an encouraging sign (Canadian Institute for Health Information, 2010). On the other hand, in some regions the number of NP positions has not kept pace with the supply of new NP graduates. This mismatch reflects longstanding challenges with the funding of NP positions (CNPI, 2006). More fundamentally, it underscores the need for health human resource planning that is based on population needs. It is

time we came to grips with what types of health-care providers are needed to provide particular services.

The majority of NPs practise in the primary health care sector, where there are a number of persistent challenges to their full integration. First, primary health care is predominately serviced by a physician-led model of care based on a fee-for-service (FFS) payment mechanism (College of Family Physicians & Canadian Medical Association, 2009; Hutchison et al., 2001). For the most part, this model is incompatible with the inclusion of a government-employed, salaried NP, because the NP reduces the volume of patients who require medical services, thereby compromising the physician's income.

This perspective is being challenged by promising new models in British Columbia, in which salaried NPs employed by health authorities are being integrated into FFS practices (Canadian Health Services Research Foundation [CHSRF], 2010). In these demonstration projects, the NPs work independently and collaboratively with FFS physicians to deliver services to a patient population. The health authorities provide resources to the FFS practice for NP-related overhead costs, such as utilities, supplies, and office salaries. Although the evaluation results are pending, feedback from patients and health-care providers after 1 year are "overwhelmingly positive" (CHSRF, 2010, p. 2). This is an important development, because many Canadian FFS physicians are interested in working with NPs but do not necessarily want to change their method of remuneration (DiCenso, Paech, & IBM Corporation, 2003). The new evidence from British Columbia puts a crack in what has been a glass ceiling with limited deployment of NPs in primary health care.

NP-led clinics in Ontario are another example of an innovative team-based primary health care initiative intended to improve access to and continuity of care in areas where a large proportion of the population is without a regular provider (DiCenso et al., forthcoming). These clinics are funded directly by the Ontario Ministry of Health and Long-Term Care. Evaluation of the first of these models, with its NP-led governance structure, lower physician-to-NP ratio, and consultative physician role, is positive (DiCenso et al., forthcoming). However, the Ontario Medical Association (2008) opposes the clinics, claiming that they promote an independent practice model that is inconsistent with the principles and philosophy of collaborative practice.

While there is opposition to NPs from organized medicine, many practising physicians welcome NPs as members of the health-care team (DiCenso et al., 2009; Donald et al., 2009). Equally important, there are indications that medical and nursing organizations are working together to tackle issues of mutual interest, such as liability and scope of practice (Canadian Medical Protective Association & Canadian Nurse Protective

Society, 2005; CNA, 2003). The recent emphasis on interprofessional education is another promising enabler of NP integration, as signalled by a statement by the Association of Faculties of Medicine of Canada (2010): "Changes in the scope of practice of many health care providers and the emergence of new professions such as physician assistants and advanced nurse practitioners require a curriculum focused on inter- and intra-professional practice" (p. 28).

This cooperation is important, because as health-care teams grow more common, new concerns are coming to the fore and will require novel solutions. One of these is fair remuneration for all team members. Government monetary incentives for preventive care are causing tension because they are offered only to physicians, while NPs and other members of the team also provide this care (Nurse Practitioners' Association of Ontario, 2008). This example highlights the need for mechanisms whereby different health-provider groups can come together to negotiate health-care policy that is in the best interests of the public (Hutchison, 2008).

Finally, it is important to acknowledge that health-care teams are constantly changing and one of the new team members is the physician assistant. It is difficult to know whether the physician assistant is a threat to the NP role or is simply another type of health-care provider who can meet particular patient needs. The experience in the United States, where NPs and physician assistants have worked side by side for many years, suggests the latter.

Impact on the Health-Care System

The evidence showing that NPs are making a difference in Canada is accumulating. Patient satisfaction with the role is high (Thrasher & Purc-Stephenson, 2008), and many Canadians are willing to consult an NP but have not had the opportunity to do so (Harris/Decima, 2009; Regan, Wong, & Watson, 2010). NPs are increasing accessibility to primary health care in rural communities (Centre for Rural and Northern Health Research, 2006; Martin-Misener, Downe-Wamboldt, Cain, & Girouard, 2009), and in emergency departments they are reducing wait times, length of stays, and the proportion of patients who leave without being seen (Ducharme, Alder, Pelletier, Murray, & Tepper, 2009). A recent study of four primary health care models in Ontario found that high-quality chronic disease management was associated with the presence of an NP (Russell et al., 2009). This growing body of research is important for the continued integration of the role, because we live in an era when, more than ever, evidence and value for money matter (Health Council of Canada, 2009).

Conclusion

Without a crystal ball, it is impossible to tell for certain whether NPs will be fully incorporated into the Canadian health-care system. Weighing up the forces enabling and restraining integration, I believe there is reason for guarded optimism. It is inspiring to reflect on how far the implementation of the NP role has come in the last decade. Still, much remains to be done, and much time will likely pass, before the vision of full integration is realized. Achievement of this goal is not an end in itself but rather a means to a much greater end — a strengthened and sustained health-care system that will be there for the benefit of future generations of Canadians.

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