

Critical Review of the final Evaluation of the HWNZ Physician Assistant Demonstration Pilot, Counties Manukau DHB

In the current environment of fiscal restraint, we may well ask why Aotearoa New Zealand is pursuing recruitment of US Physician's Assistants on the basis of this pilot. What value can be derived from a flawed trial which assessed productivity improvements found from the addition of two US PAs to a busy acute surgical team, working weekday shifts only, at a cost of NZ\$130,000 each, compared with another team with no additional personnel working 24/7? Before wider implementation of the PA role is considered, there needs to be a comprehensive consideration of ways the health workforce may be evolved, including utilisation of existing nursing roles, to meet future health needs.

Introduction

The final Evaluation of the Physician Assistant Demonstration Pilot at Counties Manukau District Health Board (CMDHB) is a highly significant report in the context of Aotearoa New Zealand's health workforce. It purportedly provides the evidence of success on which a new, as yet unregulated, health practitioner role is already being implemented, the impact of which has been neither costed nor assessed, but which has already affected the recruitment and employment of nurse practitioners (NPs), and prompted legislative changes to the regulatory environment governing public safety. The Siggins Miller report (the Report), presented as independent and positive, thus warrants careful scrutiny, as its recommendations have significant implications for public assurance of the long term sustainability of a safe, well educated, health workforce able to meet the needs of New Zealanders.

The New Zealand Nurses Organisation (NZNO) finds that the Report is wanting in several ways: it is methodologically flawed, factually incorrect in places, deficient in data sources, and demonstrates both poor understanding of the health workforce context in Aotearoa, and faulty logic in the sweeping conclusions it draws. As such it would be neither wise nor safe to act on its recommendations.

More seriously, evident deficiencies in the design and governance of the pilot, the unusual circumstances of its precipitate implementation without consultation or policy analysis, and irregularities in the evaluation process, must call into question the processes of the commissioning agency Health Workforce New Zealand (HWNZ). Its singular failure to constructively engage with key stakeholders to identify the barriers to a fully integrated health workforce and plan for solutions consistent with the health system environment was disturbing; but to persist, in the same blinkered mode, with further roll out of PA positions and modification of the regulatory system for a small group of generalist overseas health professionals on the basis of the questionable 'success' of the pilot, is unconscionable.

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The following tracks NZNO's experience of the implementation and progress of the pilot; it is not a mere recital of events, but an attempt to describe the context and way in which health workforce innovation is currently being implemented, in response to increasing sector concern about the lack of integrated long-term health workforce planning. This critique challenges HWNZ's actions with regard to the implementation of a Physician Assistant role in Aotearoa, though NZNO does not challenge the role *per se*. It advocates comprehensive consultation, collaboration and evidenced-based policy development in determining and planning for the most appropriate and sustainable health practitioner mix to meet New Zealand's future health needs.

Background

Barely two months after the Medical Council of New Zealand (MCNZ) had put out a consultation paper on the *Regulation and Training of Physician Assistants*, in October 2009, the newly constituted HWNZ in a joint venture with the Auckland University of Medical and Health Sciences (AU) and the Northern Region DHBs (NRDHB) had decided on a plan for a medical model PA role in surgery to be piloted at CMDHB. Since PAs are neither trained nor regulated in Aotearoa, the PAs would be recruited from overseas. The MCNZ's consultation paper had emerged from discussion initially in response to a lawyer's request, subsequently denied, that the MCNZ register a registered nurse (RN) as a PA. In its submission (NZNO, 2009), NZNO congratulated the MCNZ on beginning what it anticipated would be a considered national debate on the value of creating new roles such as the PA role, versus extending or further developing existing roles, given New Zealand's limited resources. It should be noted that the consultation paper directed discussion of the PA role to its consideration for International Medical Graduates (IMGs) unable to gain registration as doctors, the exploration of which NZNO gave cautious approval to, subject to developing a PA training programme.

At that time the PA role was well established in the United States, being developed in the United Kingdom, and piloted in Australia where training courses had been established in Queensland and South Australia. However, there had been no exploratory research or policy work in Aotearoa, no preliminary engagement with the health sector, comparative studies or financial analysis, and there was no training, education or regulation for PAs whose role was outside the experience of most health practitioners.

By contrast, there was a substantial and consistent evidence-base for the large body of government policy and strategic documents (see NZNO Manifesto, 2011) supporting expanded roles and deployment for RNs and NPs, and for the regulation of advanced paramedics (AP), who are a significant source of PAs in the US. All three roles, which to some extent overlap the PA scope, are well established and supported in the New Zealand health system. Professional input from these practitioner groups, and the associated regulatory, educational and other practitioner agencies, could fairly be expected to be germane to the potential introduction of PAs, for which there is more than one model.

Barriers preventing nurses working to the top of their scope were well documented and progress towards removing them to allow, for example, NPs to work as authorised

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prescribers and implementing expanded practice for nurses, had been proceeding slowly, as had the regulation of APs.

The Pilot

NZNO rejected the PA pilot proposed by CMDHB – the first official notification that this role was being considered - and, along with others, expressed serious reservation about its value, as such a pilot could not determine the full costs of training and regulating PAs (or continuing to recruit them from overseas), nor the comparative value of utilising existing roles (NZNO, 2010a). Ironically, the pilot's plan to utilise the PA in pre-admission clinics mirrored the requests for nurse-led preadmission clinics which had been consistently turned down by CMDHB, yet the opportunity for a comparative study was ignored.

Governance

A month later, NZNO had a brief opportunity (in spite of HPCAA requirements for full and proper consultation with appropriate professionals and colleges, consultation at every stage has been characterised by inappropriately short timeframes) to respond to NRDHB on the Governance documents for the pilot. Several issues were identified including concerns with patient consent; the legitimate interface and protocols for diagnostic testing, ordering blood products, and administering medication; lack of PA registration; assigned activities overlapping the junior doctor role and training, lack of nursing representation on the Regional Governance Group (RGG) though the role required close interface with nursing staff, and the absence of a comprehensive assessment of workforce capacity and future needs before introducing this new cadre of health worker (NZNO, 2010b). It was also noted, presciently as it turns out, that appropriately qualified and credentialed NPs were approved by the Royal Australian and New Zealand College of Radiologists (RANZCR) to refer for diagnostic testing and that local protocols and guidelines had been developed detailing the precise circumstances under which an NP could request radiology. NZNO advised that the same requirements should be made of PAs. Radiologists would later identify the inadequate preparation of PAs for diagnostic testing i.e. training and certification, as a major reason for their dissatisfaction with the pilot.

Life Extinct

Interestingly, the governance documents did not identify that PAs would be able to pronounce 'life extinct', a barrier to efficient and humane practice that nurses, particularly NPs in rural practice, face. Under legislation for Death Certification, only doctors may certify death but, by arrangement with the Coroner's Office and New Zealand Police, APs are also authorised to certify life extinct for which protocols have been established. It is not clear how changes to the law were facilitated to allow unregulated PAs, without knowledge or experience of Aotearoa tikanga in this sensitive area, to certify life extinct, when even expert and experienced New Zealand nurses may not.

In spite of inadequate and selective consultation, enough 'flags' had been raised at this point to encourage caution and to warrant significant changes to the pilot if it were to fulfil its principal purpose of determining the value of PAs in Aotearoa. Instead it was proceeded with virtually unchanged and two US PAs on salaries of US \$90,000 (NZ \$130, 000) were appointed as supernumeraries, working the week day shifts in the

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acute surgical wards at CMDHB i.e. as extra staff covering largely planned elective surgery. The performance of the team with PAs was to be evaluated against a team with *no* added staff, working in acute surgery around the clock - '24/7'.

Formative Evaluation

A letter dated 15 June 2010 from HWNZ announced that a contract with Pam Oliver Ltd had been signed to evaluate the one year "Physician Assistant Trial and Evaluation". To ensure the "*opportunity for input into the evaluation*" HWNZ invited contributions by the following week, 21st June 2010, declaring at the same time the extraordinary prerogative that "*the requirement that the evaluation be independent means that the scope will be determined ultimately by the evaluator and HWNZ*".

Following an in-depth interview, in which NZNO again noted that the pilot was not fit for purpose for the above reasons, NZNO was confident that the evaluator had a good understanding of the nursing issues identified in relation to the pilot and its evaluation, and would be kept informed of progress. The potential for further rollout of the PAs until the model had been tested and evaluated, was strongly rejected and the need for regulation of PAs in light of the initiation of diagnosing and treatment, reiterated.

The limitations of the trial were indeed evident, and these were duly reported in the formative evaluation by Pam Oliver Ltd. which identified a number of caveats and concerns, notably that far more work was needed before roll out of the initiative, and hinted that the trial lacked appropriate high level direction and governance. For example:

"This report summarises the findings on the establishment and early implementation phases of the Trial and the first three months of the PAs' experience. As such it is not intended to provide substantial information on the impacts or outcomes of the Trial."

... the period was "not a fair test" of the PAs' impact on workflow and productivity.

The impacts of the Trial overall "were to be reported comprehensively" in the summative evaluation.

"Stakeholders identified a number of issues in the Trial's implementation which had the potential to cause significant problems, including several that still need to be addressed, some urgently if the Trial is to demonstrate what it was intended to within the remaining pilot period. These mostly focused on: the absence of a clear set of goals for the Trial; insufficient strategic communications about the Trial; a disjointed induction for the PAs; a lack of structured supervision and mentoring; insufficiently structured PA role development; a loss of project management and governance application."

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And although participants gave a qualified yes to the question *Is the PA role suited to the New Zealand workforce?* The evaluation noted:

"However, all evaluation participants felt that it was **too early in the Trial** to make any confident predictions about how well suited the PA role would be to primary care settings, and they were also cautious in their assessments of how valuable the PA role would be in non-surgical hospital contexts."

The formative evaluation report was neither published nor distributed as anticipated in January 2011, and it was not until May 2011 that Ms Oliver, honouring her commitment to those she had consulted with, informed them that her contract had been terminated in January following the submission of the report, which remained unavailable. NZNO wrote to HWNZ expressing its concern, asking for the evaluation, and noting the need to repeat its consultation with the new evaluator, which did occur in due course. The evaluation was subsequently made available, but HWNZ offered no explanation for the irregular proceedings. In the absence of further information, it is difficult not to conclude that the less than glowing report pointing out the inability of the pilot to meet the aims must have been a motivating factor.

The Siggins Miller Evaluation

Unusually, after a formative evaluation that was highly circumspect as to the design, governance and limitations of the trial, a highly positive summative evaluation followed.

Siggins Miller is an Australian consulting group, and, while the Trans Tasman Mutual Recognition Act 1997 (TTMR) evidences the synergy between Australasian workforces, there are key differences in health system structure, and the regulatory and cultural environments, which it is not always possible for tauiwi, to understand, acknowledge or respect. Nevertheless, the evaluation team for the pilot was highly qualified, had some experience of Aotearoa's health workforce and was able to consult with relevant stakeholders. It is therefore surprising that professional attitudes, abilities and relationships between health workforce groups should be misrepresented in the Report, and errors made in relation to regulation. The recommendation prioritising:

"... removing the regulatory barriers to PAs practicing (sic) to the top of their license (sic)" (iv)

when PAs are not regulated, and have no licence (scope) to practise to the top of, is a case in point.

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Methodologically, the most serious flaws were the lack of mutual exclusivity between comparison groups and the lack of other suitable controls such as other supernumerary staff. Thus the only research question that could be, and was, answered conclusively and affirmatively, was *Can PA be useful and popular?* The answer to the salient question, however, *Are PA the most appropriate answer to New Zealand's growing staffing issues?* was not. While there is no doubt that the two PAs in the pilot involved were highly skilled, trained and valued by their colleagues, there is also no doubt that any trained, skilled, personable and professional supernumerary staff would have increased output, morale and job satisfaction, particularly as these staff were provided during a period of workforce shortages and increased demand. It is not possible to determine the best workforce model for the future without a full analysis of the costs of introducing a new role, and comparative studies, which the Report fails to mention.

Other methodological flaws included serious deficits in data sources, changes throughout the trial to the roles and activities, lack of a regulatory framework that would allow PAs to work to their training and scope, and the simultaneous introduction of other initiatives such as the patient discharge lounge which meant (as the researchers identified) that caution should apply to the interpretation of results. Certainly there are other early discharge strategies that have been implemented in New Zealand that have been very successful - nurse initiated discharges at Christchurch Hospital, for example, which could have illuminated this area, had the comparison been made. Also, while Program Logic models are entirely appropriate in this situation, it is less than satisfactory to impose a new framework *post-hoc*, eight months into a year-long trial.

The selective provision of supernumerary staff, and the timing of the trial, coinciding as it did with 11-25% house officer vacancies and unprecedented increased patient demand, is likely to have significantly influenced the qualitative results. Indeed it is highly unusual for such qualitative data to be presented in support of a claim for improved productivity and efficiency, which cannot be assessed when no data is presented about the vacancy rate in the two groups. The fact that house officers asked to be placed in the PA teams also raises possibilities of better retention and/or the best candidates being selectively placed in the PA teams. No evidence is provided as to whether the surgeons or registrars were also selectively for or against the PA, nor was any economic data provided.

An unaccountable omission, particularly in view of Aotearoa's leadership in the area of cultural competence, was the lack of any reference to the need for cultural awareness training for US PAs, who were working in an unfamiliar multi-cultural patient environment and health system, or whether it was provided and/or evaluated. That omission is even more serious in light of the proposed roll out of PAs in rural primary care positions. Also questionable was reliance on patient satisfaction reports - generally a weak indicator of patient outcomes - and the assessment that patients at CMDHB lacked the literacy to complete a written questionnaire. That is an extraordinary generalisation in an elective surgery environment and an inadequate justification for restricting evaluation of patient satisfaction to face to face interviews. Moreover, since any skilled, highly communicative extra time with patients and family is likely to be highly valued, it is hardly surprising that patients valued the PAs.

While Siggins Miller cannot be responsible for the views expressed by interviewees,

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it is accountable for the conclusions and recommendations presented in the seriously misleading Executive Summary, which does not reflect the body of the Report. It is entirely inappropriate, for example, to advise against utilisation of other workforce groups without a comparative trial in New Zealand, or to conclude from a selective trial of two PAs in a surgical ward that:

"...this new role could be confidently introduced in a range of hospital settings including emergency departments, general medicines, acute, and elective surgery, paediatrics, orthopaedics, and preoperative assessment clinics" (iv)

The "*global experience with PAs*" with which the above was prefaced was not borne out by the international literature review supplied, which largely echoes this experience, showing rushed, piece-meal and inconclusive 'evaluations' of the roles in other countries, followed by wholesale implementation.

The glib assurance that there is "*no need to further test this role as useful, safe and appropriate for New Zealand*" and dismissal of stakeholder concerns as "*being more about stakeholder management*" in no way reflects the sober caution implicit in the following:

"...with the exception of those not directly involved with the PAs such as the New Zealand Nurses Organisation, the New Zealand Resident Doctors Association, the Association of Salaried Medical Specialists the Medical Council and the Director of Clinical Training at Auckland DHB, the consistent view of all those directly involved (is) that the positive outcomes of this trial could be attributed specifically to the training of the PAs." (p18)

And again:

With the exception of nursing and medical stakeholder groups and the radiology consultants, interviewees felt conducting further trials was not necessary... (p25)

What possible justification can there be for marginalising the concerns and considered advice of all the major health workforce organisations (and other key stakeholders) who

have a fundamental interest in public safety, and who have the experience, knowledge and capacity to review the pilot in the context of current and future workforce development in favour of the subjective assessment of the trial participants and a handful (four) of in-patient face to face interviews? The precedence given to the views of the very limited number of individual participants, including the PAs and the pilot developers who had an interest in the outcome, over the concerns of the sector as a whole is disingenuous and misleading.

It is one thing for a participant to attribute resistance from the medical profession as a reason for the low uptake of NP roles, for example; it is quite another to fail to balance that opinion with well established facts, in this case the numerous legislative, funding, employment and regulatory barriers to the full utilisation NPs (and RNs). Ironically these are much the same barriers to PAs identified by the Report, although, as noted, some of these barriers were waived for the PAs in the pilot. Similarly, sweeping assertions like the following lack credibility, because they are made in the absence of robust discussion as to whether another skilled clinician in a high level support/link role could have achieved similar positive outcomes, and demonstrate a poor understanding of the education and regulatory frameworks governing nursing.

"To have the same impact on productivity, efficiency, continuity of care, patient satisfaction and outcomes, nurses would have to do a full two year post graduate PA course where they would receive training in the medical model, the factor thought to be largely responsible for the improvements noted at Middlemore. "(v)

Nurses are presented as not having a biomedical framework i.e. in assessment skills and diagnostic reasoning, though in fact, advanced assessment skills training for nurses uses the medical systems approach to patient assessment. Similarly, the medical approach underlies NPs clinical reasoning/ decision-making and prescribing papers: diagnostic reasoning is the primary assessment made during a NP viva.

The Report reflects very badly indeed on the state of interdisciplinary collaboration and health workforce culture in the pilot sites. Without detailing the aspersions cast on health surgeons' ability to communicate with patients, NPs' ability to assess whether patients were acutely unwell, or the credibility of junior doctors who, having experienced working with PAs, now intend to pursue training in Australia (the latter proffered, with admirably circular reasoning, as a reason why more PAs are needed as they increase the risk of junior doctors leaving), NZNO would strongly dispute that the individual views expressed are an accurate reflection of prevailing attitudes and relationships in the health workforce. Doctors, nurses, specialists and allied health workers share evidence-based education, are bound by ethical standards to respect and value each other's work and work together collaboratively. The culture described is an issue for CMDHB - as, incidentally, is infection control - and does not evidence the national need for a new cadre of worker.

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The factors considered essential in producing positive outcomes in the trial are identified as shared understanding, proactive response rather than operating under protocols, and effective intermediaries between nurses and doctors. The positive impact generated by having the PA as a constant within the team to mitigate the disruption caused by the three monthly cycle of house surgeon change and six monthly Registrar change (which is real), indicates the need for a new linking role which *may* be best filled PA, or an NP, or an advanced practice nurse. There is nothing to prevent an advanced practice nursing position being established for this role immediately (and at less cost than the PA pilot) and seeing over time if the outcomes would be similarly positive.

A fundamental misunderstanding of New Zealand medicines regulation - curious given the emphasis on PA prescribing - is evident from the incorrect assertion that MCNZ had "given permission" for the introduction of "protocol-based prescribing" (p23) for which there is no prescriber category. Prescribing is governed by Medicines legislation, not the MCNZ. It is somewhat disquieting to reflect, however, that misunderstanding may have stemmed from discussion/assumptions around the new category of 'delegated prescriber', unexpectedly introduced in the recent Medicines Amendment Bill; it would be a serious breach of protocol and trust indeed if an international consultancy company were privy to information about upcoming medicines legislation before the New Zealand Health sector had an opportunity to consider it. There had been no consultation on the delegated prescriber category - to which considerable opposition has since been expressed - before the bill was introduced, and it is a long way from enactment, so the Report's identification of protocol prescribing as a 'possible solution' to enabling PA prescribing lacks currency.

Finally, and in view Scotland's experience of the difficulties of attracting and retaining US PAs because it could not match pay and employment conditions, it is significant that neither of the PAs remained, even though they were offered employment. The cited reason – the constraints on their role and lack of prescribing (p29) - is illuminating, and well understood by NPs who continue to experience the same barriers, though, significantly, the parallel was not drawn. Since it is highly unlikely that Aotearoa will continue to offer salaries commensurate with the US\$90,000 i.e. NZ\$130,000 for this generalist role, the risk of a high turnover of PAs is one that the Report should have considered, along with the vulnerability that comes with dependence on overseas recruitment.

In summary, this was a demonstration, not a trial or pilot for a fully evolved workforce strategy. Supernumerary, skilled staff mitigated against "huge pressures" due to staff shortages and increased patient load. The results, such as they were, cannot safely be extrapolated outside the confines of the elective surgical arena in a DHB (certainly not into rural primary care). The economic, employment and training costs for PAs and other medical staff, and the projected salaries and regulatory changes required to attract or retain US trained PAs over the period of time it will take to establish here, compared with the same considerations for existing roles, should have been carefully factored into the policy analysis and decision-making surrounding this new role before it was trialled. The confidence of the vast majority of the health workforce will have to be re-gained by real and appropriate consultation and truly independent and robust research, rather than be "managed", "led" and "changed" to push through these developments.

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Post Evaluation

Since the pilot, but without warning and well before the evaluation was released, NZNO became aware through various informal channels, including the media, that new PA positions were being funded by HWNZ at Midlands Health Network. The PA positions in rural primary health care - for which funding for NPs had been turned down - are entirely untested in Aotearoa and highly skilled and experienced locally-trained NPs are being overlooked in favour of foreign recruits for an unregulated role the need for which has not been established.

Prior to the publication of the evaluation, NZNO, on the recommendation of MCNZ, approached HWNZ's newly appointed Senior Project Manager for the PA pilot, Priyesh Tiwari and met with him and US PA consultant Professor Ruth Ballweg, Washington University, Seattle, and outlined our concerns. Professor Ballweg wholeheartedly endorsed NZNO's view that the PA role, like any new workforce role, cannot be transplanted from one health environment to another, but rather needs careful planning, comprehensive sector engagement and evidence to develop the most appropriate model. She also spoke of the synergy between PAs and NPs in the health environment she worked in, and interdisciplinary education. In the interests of genuine collaboration to find the best workforce models for Aotearoa, NZNO recommended her to Nursing Council's attention. Subsequently, NZNO has been invited to participate in the development of further PA and comparative pilots.

Discussion

Throughout the PA Pilot/Demonstration/Trial, the level of consultation, policy development, communication, transparency and planning around the PA role has been grossly inadequate. NZNO welcomes innovation, and has consistently welcomed discussion, data collection, modelling, and analysis which would inform urgently needed planning to address future health workforce needs, including consideration of the PA role. Increasing health demand will inevitably exacerbate current workforce shortages, and our over-reliance on internationally qualified health practitioners, loss of locally trained graduates and limited resources can only be mitigated by the careful introduction of innovation within the context of long-term strategic workforce planning.

In spite of the strong reservations expressed by "nursing and medical stakeholder groups" and the evident inadequacies of the both the pilot and the evaluation, HWNZ continues to present the PA pilot as independent and positive:

"The final evaluation report of the first Physician Assistant demonstration has been published on our website. The final evaluation report found that PAs had a positive impact on the existing workforce, theatre efficiency, productivity, speed of treatment, continuity of care and patient satisfaction. The report also found that the PAs did not compromise patient safety and that the results of this demonstration are fairly generalisable to other settings and specialties. The final evaluation report recommends HWNZ look at the role of PAs in high demand areas like rural

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or primary care settings, assess demand for the role, create a well organised induction programme, establish a PA training programme, and work towards removing regulatory barriers for PAs to practise at the top of their scope."

HWNZ Stakeholder Bulletin, March 2012

It prematurely plans further rollout, regardless of the far reaching and significant change to health care in New Zealand, requiring as it does legislative and educational change.

In this context we note the new prescriber categories - temporary and delegated - introduced in the long-awaited Medicines Amendment Bill (April 2012) which also proposes NPs as authorised prescribers. In retrospect, it seems likely that these newly proposed prescriber roles were developed for the purpose of fast-tracking PAs authority to prescribe, in anticipation of the role being introduced, and before it was regulated.

It is somewhat sobering to observe the speed and ease with which fiscal, regulatory, and employment barriers to the introduction of the PA role for foreign recruits, the needs and costs of which have not been established, have been removed, in comparison to the persistence of barriers to nursing innovation.

Whilst HWNZ's zeal in cutting through 'red tape' to fast-track innovation is admirable in one sense, it also carries a high risk of compromising frameworks that ensure public safety and the quality of the health workforce. The PA role initially mooted by CEO chair Professor Gorman was envisaged as an unregulated role, an unworkable contravention of the HPCAA, subsequently dropped (College of Nurses, Aotearoa meeting, Wellington 2009).

The continued failure of HWNZ to consult comprehensively, develop robust problem identification and documents, undertake comprehensive and detailed evaluations which are reported accurately has seriously undermined stakeholder trust. HWNZ has been seemingly impervious to many efforts by the sector to constructively engage with and influence health workforce planning. Far from indicating protectionism, the lack of critical stakeholder support for the imposition of the PA role, reflects widespread concern that a flawed evaluation of a limited demonstration is being used to implement change for which there is little evidence or support.

Conclusion

The central question that NZNO asks is: *What is the best mix of professionals to meet the health need of the population in the future?* This requires identification of the workforce gaps and issues and then consideration of the range of options available - a process that requires inclusive engagement with various stakeholders including representative associations for the various health professionals. It is during this process that consideration can be given to whether existing health practitioner roles and /or funding models are, or can be, developed or realigned to meet future need, and if not, whether new roles such as the PA role are suitable, sustainable and sufficiently flexible to meet identified gaps in a country with relatively small population.

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NZNO does not support further roll out of the PA role, particularly into primary care on the strength of a limited demonstration in a surgical context. However, as it appears the next PA 'pilot' will go ahead regardless, and will, again, not include a comparative study but rather "be more like a observational study of collaborative approach to primary care" (Tiwari, 2012), full and credible exploration of the following is essential if the intention is to genuinely pilot the role, rather than pursue a predetermined course of action:

- the costs of establishing and maintaining a PA education programme and the minimum numbers that would be required;
- comparison of position/role descriptions;
- identification of similarities and differences in patient allocation and management between the PA and the NP;
- referral rates to the GP; and
- the impact on practice nursing role, both in its scope and on inter-professional communication.

NZNO strongly urges HWNZ to engage widely with the sector on problem identification and discussion on the range of options to address these issues. Decisions on the future workforce need to take into account a full cost/benefit analysis of all the options to inform sensible decisions for the future health workforce mix; Aotearoa New Zealand is a small country and a sustainable and largely home-grown health workforce should be our aim in meeting future population health need.

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Mission statement

NZNO is committed to the representation of members and the promotion of nursing and midwifery. NZNO embraces Te Tiriti o Waitangi and works to improve the health status of all peoples of Aotearoa/ New Zealand through participation in health and social policy development.

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