Profiling the South African private nurse practitioner

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Although private practice has existed in South Africa since the 19th century, the difference between private practice and the private sector continues to confound, and the role that private nurse practitioners fulfil is the subject of many myths. The Society of Private Nurse Practitioners of South Africa (SPNP) recently undertook a survey to determine the profile and characteristics of private nurse practitioners in South Africa. This survey included professional nurses or midwives registered with the SA Nursing Council and known to be a private nurse practitioner, or in possession of a practice number from the Board of Healthcare Funders of Southern Africa (BHF). The provisional results of the survey describing the characteristics of private nurse practitioners in South Africa are presented.

At the time of developing the survey, the literature provided no specific definition of “private practice”. Descriptions varied between nurse entrepreneurs, duty (or agency) nurses and those of private practice primarily in the USA as we understand it. Evidence of private practice in the UK and Australia is beginning to emerge. The focus is on nurses, not midwives. The key distinction is the difference between nurses undertaking entrepreneurial activities through business ventures and self-employed nurse practitioners. In a recently published review, Currie, Chiarella and Buckley evaluated private nursing practice models internationally, and identified economic independence as the defining characteristic of private practice, whereby nurses charge a fee for a service, paid by the patient or a relevant third party.

There is limited understanding of private practice in the South African setting. A common misconception is that private nurse practitioners work in private hospitals or agencies, or are only midwives. According to Charlotte Searle, nurses have been in private practice since the 18th and 19th centuries. The introduction of the hierarchical nursing structures, based on the British model following the South African War from 1899-1902, resulted in nurses forfeiting their independence and their collaborative relationship with medical practitioners. While many midwives continued to function as private practitioners, nurses became part of nursing establishments in hospital and community settings.

Although there have been individual nurses in private practice, the expansion of the private health sector and medical schemes in the 1980s began to drive demand for private nurse practitioners. Advancing technology and specialisation, reduced community nursing services, shorter hospital stays and a growing cohort of recently retired nurses provided an impetus for the return to private practice. The BHF, representing medical schemes, administers the Practice Code Numbering System (PCNS) which facilitates the payment of healthcare providers for services rendered to patients, and is currently the only known database of private practitioners.

Challenges

In 2012, the BHF allocated 2,950 PCNS numbers to professional nurses. These included private nurse practitioners, i.e. nurses who are in full-time employment in hospitals, pharmacies and nursing agencies. The actual number of nurses who are self-employed is not known, and this hampers attempts to effectively define the private nurse practitioner.

Enquiries from private nurse practitioners indicate that in spite of having extensive experience and appropriate qualifications in the field of primary health care, authorities are unwilling to give authorisation to these practitioners to function at a level that would enable them to diagnose and treat common conditions in areas that are poorly serviced.
by medical practitioners. This is partially owing to their independent status, and partially because of the incomplete nature of the regulatory framework for nursing. Private nurse practitioners successfully provide basic nursing care or advanced nursing practice as collaborating members of the healthcare team.

The absence of research-based information has limited the ability of the SPNP to adequately represent members, leading to the commissioning of this survey.

**Purpose**

The primary purpose of the survey was to profile private nurse practitioners in South Africa, their practice structures, services and qualifications and distribution, in order to better understand how the SPNP can address the needs of its members.

The premise was that a private nurse practitioner was a registered professional nurse or midwife, reimbursed directly or indirectly by the patient, and who practised autonomously within his or her scope of practice.

**Method**

The survey was undertaken by means of a questionnaire, distributed in two phases. In the first phase, invitations to participate were distributed by e-mail through Medpages, a national commercial database, as well as the SPNP and the South African Society of Occupational Health Nursing Practitioners (SASOHN) membership lists, with an e-mail reminder to participate four weeks later. The commercial database was selected as it lists 34 000 nurses who have had practices or held practice numbers previously. We were unable to obtain consent to access the only other comprehensive database, i.e. that of the PCNS.

The second phase is currently underway, making use of SMS invitations to ensure that persons with cellular telephones, but no listed e-mail addresses, are also invited to participate.

The first-phase 1 700 invitations were sent out by e-mail. Four hundred and ninety-two responses were received, of which there were usable data on 478. This translated to a response rate of 28.1%. The questionnaire was designed using LimeSurvey®, and the data were analysed using Excel ®.

**Results**

The initial analysis is reported in terms of the profile, including practice numbers, source of income, reporting structures, legal status of the practice, and the ownership of infrastructure and the geographical setting. The second cluster provides information on the nursing services being provided.

The qualifications and experience of the practitioners is considered in the third cluster. Mapping of the services in relation to the qualifications is in process, and will be reported on in due course.

**Practice profile**

The majority of the respondents (64.9%) had a PCNS number, while 20.8% did not, and details were not recorded for 14.7%.

With respect to sources of income, it was determined that 36% were reimbursed directly by or on behalf of the patient, 32.8% received a salary for full-time employment, 10.8% received part of their income from agencies or companies, and the source of income was unknown for 9%. Some respondents selected more than one category.

The legal status of the practitioners (n = 320) indicated that 43.7% of the respondents who had registered with the tax authorities as a sole proprietor, 28% had registered companies, partnerships, or belonged to an NGO or cooperative, and 15% reported that they were not currently in private practice.

The practices (n = 371) were situated in residential areas in 57.6% of instances, business districts or malls in 27.5%, industrial areas in 7.8%, rural towns or areas in 4.0%, informal settlements in 2.3%, and 1.0% was ‘other’ or ‘not indicated’. The majority of the residentially based practices provided home- or hospital-based care.

**Autonomy and licensing**

Essentially, private nurse practitioners are autonomous, with 72% practicing in an independent setting, and not accountable to another professional or manager. Of the 28% of respondents who worked in a structure with professional supervision, 14.0% reported to other nurses, 7.8% to pharmacists, 3.7% to medical practitioners, and 1.1% to other healthcare practitioners or laypersons.

It was indicated that 52.5% of respondents who had completed a qualification which enabled them to apply for a dispensing licence from the Department of Health (n = 118) had a Section 22(c ) licence, while 37.0 had been refused a licence, and 13.0% were awaiting a response to their application. Successful applicants worked in the field of occupational health.

Professional indemnity was provided predominantly through Denosa (44%), SASOHN (13%) and Indemnus (5.8%). Nineteen per cent indicated other insurers, and 18.5% indicated no indemnity insurance. There appeared to be confusion between general liability cover and professional indemnity in the category of “Other”.

**Services offered by private nurse practitioners**

The type of nursing care provided by practitioners was clustered, with many practitioners offering a range of
services. In most instances, private nurse practitioners offered more than one service, depending on their field of expertise or the needs of the community.

These can be divided into four main clusters, with childbirth-related care, excluding midwifery, being the most common.

Infant immunisation was provided by 27.8% of the respondents, 17.5% offered childbirth education, and 17.4% provided antenatal or postnatal care. Only six respondents (1.7%) were midwives who actively assisted with births, either at home or in hospital.

While 20.5% provided reproductive health, two thirds of the respondents did so as part of occupational health nursing (30.5%). General home-based care (11.0%), wound care (basic and advanced) (30.4%), human immunodeficiency virus-related services (8.9%) and psychiatric services (3.2%), accounted for the general and primary health-related services. Specialisation areas included diabetic educators, stomatherapists and lymphoedema drainage.

Discussion

The data derived from the first phase of the survey targeted registered nurses on the database with known e-mail addresses and Internet access. The response rate was within an acceptable level of response to an electronic survey, as reported in the literature.

The figure of 2 950 private nurse practitioners, based on PCNS-allocated numbers, was the most common figure quoted when entering into discussions on the size of the sector, particularly with respect to how it affects national policy and planning for healthcare services. The SPNP continues to challenge this number, particularly if it is taken into consideration that respondents are persons with an interest in private practice, and of these, 37% had full- or part-time employment. Further studies are needed in order to determine an accurate figure.

The data relating to source of income and autonomy as two characteristics which could define private practice are insufficient at this stage. The second round of data collection should enable a more definitive conclusion to be drawn.

The scope of the services and the setting in which private nurse practitioners practice supports the SPNP’s view that private practice is not restricted to any one economic or population group. Further analysis and geomapping using postal codes should provide the additional information required when liaising with the authorities, or collaborating with funders.

There appears to be a definite decrease in the number of private nurse practitioners providing midwife-led births, and while there is local research in this arena, particularly that relating to Caesarean section rates and the cost of health care, it is essential that further studies are carried out to understand the effects of this scarce resource and maternal choice.

Conclusion

The initial analysis supports the concern that the number of nurses with PCNS practice numbers does not reflect the true number of private nurse practitioners practising for their own account as 25% of the respondents are in full-time employment.

The source of income remains the primary defining characteristic, although 12% of respondents had sessional appointments in pharmacy clinics or occupational health services. Such appointments may be the practitioners’ primary source of income, or they may provide economic stability and support private practice. Autonomy of practice is linked to source of income. The legal status of practice was predominantly sole proprietorship in this survey.

A key area of concern was the issue of professional indemnity insurance, whereby private nurse practitioners assumed that the cover provided by their sessional employer was adequate. It has been highlighted that employment-based cover does not offer the necessary protection for any services beyond the stated position, even when management has granted permission for outside work. The SPNP believes that each private nurse practitioner must obtain individual indemnity insurance to protect him- or herself and his or her dependents.

Although additional data and further analysis are required to establish what constitutes private practice against the suggested criteria of economic and professional autonomy, the initial information obtained from this survey provides a foundation for future discussions with the regulatory authorities and funding organisations.

The initial survey data provide the first available information on private nurse practitioners, and will enable the SPNP to speak with greater clarity in discussions with authorities and funders. In addition, insight has been provided into those areas which require in-depth research, as well as aspects on which the SPNP needs to focus when planning member education.

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Bibliography