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Received: 4 August 2023 | Revised: 17 November 2023 | Accepted: 21 January 2024

DOI: 10.1111/jan.16093

INTEGRATIVE REVIEW

Integrating nurse practitioners into primary healthcare to advance health equity through a social justice lens: An integrative review

Sue Adams[1] | Ebony Komene[1] | Cynthia Wensley[1] | Josephine Davis[1] | Jenny Carryer[1,2]

[1]School of Nursing, University of Auckland, Auckland, New Zealand

[2]School of Nursing, Massey University, Palmerston North, New Zealand

Correspondence
Sue Adams, School of Nursing, University of Auckland, Auckland, New Zealand.
Email: s.adams@auckland.ac.nz

Funding information
Health Research Council of New Zealand, Grant/Award Number: 21/1059/A

Abstract

Aim: To develop a framework to guide the successful integration of nurse practitioners (NPs) into practice settings and, working from a social justice lens, deliver comprehensive primary healthcare which advances health equity.

Design: Integrative review.

Methods: The integrative review was informed by the Whittemore and Knafl's framework and followed the Preferred Reporting for Systematic Reviews and Meta-Analyses guidelines. Quality was assessed using the Johns Hopkins Research Evidence Appraisal Tool. Findings were extracted and thematically analysed using NVivo. A social justice lens informed all phases.

Data Sources: Databases, including CINAHL, PubMed, Scopus and Web of Science, were searched for peer-reviewed literature published in English between 2005 and April 2022.

Results: Twenty-eight articles were included. Six themes were identified at the individual (micro), local health provider (meso), and national systems and structures (macro) levels of the health sector: (1) autonomy and agency; (2) awareness and visibility; (3) shared vision; (4) leadership; (5) funding and infrastructure; and (6) intentional support and self-care. The evidence-based framework is explicitly focused on the components required to successfully integrate NPs into primary healthcare to advance health equity.

Conclusion: Integrating NPs into primary healthcare is complex and requires a multi-level approach at macro, meso and micro levels. NPs offer the potential to transform primary healthcare delivery to meet the health needs of local communities. Health workforce and integration policies and strategies are essential if the contribution of NPs is to be realized. The proposed framework offers an opportunity for further research to inform NP integration.

Impact Statement:

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- Nurse practitioners (NPs) offer the potential to transform primary healthcare services to meet local community health needs and advance health equity.
- Globally, there is a lack of guidance and health policy to support the integration of the NP workforce.
- The developed framework provides guidance to successfully integrate NPs to deliver comprehensive primary healthcare grounded in social justice.
- Integrating NPs into PHC is complex and requires a multilevel approach at macro, meso and micro levels.
- The framework offers an opportunity for further research to inform NP integration, education and policy.

Summary Statement:

- *What problem did the study address*: The challenges of integrating nurse practitioners (NPs) into primary healthcare (PHC) are internationally recognized. Attempts to establish NP roles in New Zealand have been ad hoc with limited research, evidence-informed frameworks or policy to guide integration initiatives. Our review builds on existing international literature to understand how NPs are successfully integrated into PHC to advance health equity and provide a guiding framework.
- *What were the main findings*: Six themes were identified across individual (micro), local health provider (meso) and national systems and structures (macro) levels as fundamental to NP integration: autonomy and agency; awareness and visibility of the NP and their role; a shared vision for the direction of primary healthcare utilizing NP scope of practice; leadership in all spaces; necessary funding and infrastructure; and intentional support and self-care.
- *Where and on whom will the research have an impact*: Given extant health workforce challenges together with persisting health inequities, NPs provide a solution to delivering comprehensive primary healthcare from a social justice lens to promote healthcare access and health equity. The proposed evidence-informed framework provides guidance for successful integration across the health sector, training providers, as well as the NP profession, and is a platform for future research.

Reporting Method: This integrative review adhered to the Preferred Reporting for Systematic Reviews and Meta-Analyses (PRISMA) method.

Patient or Public Contribution: No patient or public contribution.

KEYWORDS

community care, health equity, integration, integrative review, nurse practitioner, organizational development, policy, primary healthcare, social justice, workforce policy

1 | INTRODUCTION

The nurse practitioner (NP) workforce is increasingly recognized as a pragmatic response to rising healthcare costs, disease burden, ageing populations, poor access to healthcare and the maldistribution of healthcare workers (Wheeler et al., 2022). While numbers of NPs continue to grow with more countries introducing NP roles, the implementation of the NP workforce remains ad hoc without national or state policy (Maier et al., 2018; Porat-Dahlerbruch et al., 2023). The dearth of knowledge and policy guidance to inform the integration of NPs into practice limits the opportunity to facilitate NPs' contribution to improving health outcomes (Porat-Dahlerbruch et al., 2023).

In New Zealand, there are now 700 registered NPs with approximately 60% working in broadly defined primary healthcare (PHC) settings including general practice, urgent care, community

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services and health providers serving Māori (the Indigenous population), and Pacific peoples (Adams & Carryer, 2023). The NP scope of practice is broad and permissive with NPs able to practice autonomously, prescribe medications, treat and refer to specialists, and access nationally available capitation funding to deliver primary care services in the same way as general practitioners (family physicians) (Adams & Carryer, 2023; Nursing Council of New Zealand, n.d.). However the dominance of biomedical healthcare structures together with persisting institutionally racist systems and processes, the New Zealand health sector has struggled to achieve universalism and advance health equity (Came et al., 2020; Goodyear-Smith & Ashton, 2019).

As with other countries, the burden of health disparity and preventable disease continues to unjustly fall on groups of people who experience systemic and structural injustices relating to, among others, race, ethnicity, colonization, sexual orientation, poverty and physical and mental ability (Braveman, 2014; Griffiths et al., 2016; Walter, 2017). This burden benefits and privileges others and is a considerable cost to society (Nixon, 2019; Reid et al., 2022). For Māori, the Indigenous people of Aotearoa (New Zealand), life expectancy is reduced by 6 to 9 years, and morbidity and mortality rates across the lifespan are generally two- to threefold greater for Māori compared with non-Māori (Gurney et al., 2020; Reid et al., 2022). The prevalence of health issues, such as mental health and addiction, long-term conditions, childhood illness and cancer rates, are all significantly higher for Māori (Gurney et al., 2020; Reid et al., 2022). Compounding Māori health equity is the underrepresentation of Māori nurses and NPs in the workforce who continue to face systemic racism and institutional barriers, impeding their capacity to deliver culturally safe and Indigenous models of care (Adams et al., 2022; Komene et al., 2023).

The World Health Organization (2021) describes PHC as being 'rooted in a commitment to social justice, equity, solidarity and participation' (para. 5) and the cornerstone of achieving universal health coverage (UHC). The NP role is well placed to work alongside communities, delivering unique and comprehensive PHC through a social justice paradigm (Browne & Tarlier, 2008; Carryer & Adams, 2017; Delvin et al., 2018; Grant et al., 2017; Porat-Dahlerbruch et al., 2022). As a team of Māori and non-Māori nurses, NPs and researchers, our interest lies in how we can enable the NP workforce to successfully integrate their roles in PHC to enable Māori to live, thrive and flourish as Māori (Ministry of Health, 2020) and improve health and wellbeing for other marginalized groups.

1.1 | Background

The NP role bridges biomedicine with nursing, resulting in a broad hybrid scope of practice which has its roots within a social justice lens (Browne & Tarlier, 2008; Delvin et al., 2018; Rudner, 2021). There is ample evidence that NPs deliver healthcare similar to family physicians achieving equivalent or superior clinical outcomes, including for mental health and addiction issues, and higher levels of patient satisfaction (Barnett et al., 2022; Laurant et al., 2018; Turi et al., 2023). While comparative research has been necessary to demonstrate that NPs deliver safe and effective care, in many ways, this has fuelled the discourse of substitution where NPs are employed to fill gaps in physician shortages and deliver biomedical healthcare (Carryer & Adams, 2022). Rosa et al. (2020) state, 'descriptions such as 'physician extenders', 'task shifting' or 'mid-level providers' do little to instill patient trust nor do they empower NPs to provide optimal, autonomous and evidence-based care services' (p. 557). Given that the majority of PHC NPs work within mainstream health services dominated by physician-led care, the challenge is how we integrate NPs into health systems whereby they can deliver services that resonate with and enact the intent and possibilities of NP practice.

Social justice is considered by many nursing academics to be a critical concept central to nursing's disciplinary focus concerned with redressing unjust systems and processes to promote societal change and achieve health equity (Browne & Reimer-Kirkham, 2014; Dillard-Wright & Shields-Haas, 2021; Walter, 2017). The International Council of Nurses (ICN) (2021) positions social justice as an ethical concept where equity and fairness for all are deemed essential to fully recognize human rights, including universal access to healthcare. Social justice should be a 'way of being and responding to people in the context of everyday nursing practice' (Browne & Reimer-Kirkham, 2014, p. 30) and by engaging in social justice, practitioners draw attention to power and privilege, particularly white privilege, which, unless addressed, perpetuate oppressive social structures and disparities (Browne & Reimer-Kirkham, 2014; Nixon, 2019). A qualitative study in remote Australia concluded that nurses and NPs wanted to provide comprehensive services based within a social justice approach and empower communities (McCullough et al., 2021). Braveman (2014) states that 'at the heart of the concept of health disparities [are] concerns about social justice' (p. 6). However, given the potential for ambiguity in defining health equity (Braveman, 2014), we have chosen to explicitly frame health equity within a social justice perspective.

In New Zealand and elsewhere, there is no, or limited, workforce policy on the implementation of NPs into health services (Maier et al., 2018). Porat-Dahlerbruch et al. (2022) developed a conceptual model of NP integration across the health sector using evidence from 78 sources, identifying necessary processes and actions at the macro, meso and micro levels. The macro level, across nations or jurisdictions, may include legislation, regulations, policies, funding mechanisms and educational infrastructure; the meso level represents the organizations employing NPs, in our case local health providers, and includes management systems, local policies and procedures, governance, and clinic and service organization; and the micro level includes individual interactions of NPs with other local health workers, patients and communities (Porat-Dahlerbruch et al., 2022). Successful integration was essential if NPs were to provide a holistic approach for people with complex care needs (Porat-Dahlerbruch et al., 2022). Challenging traditional ideologies and

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facilitating health system transformation were identified as attributes necessary to enable NPs to function within an organizational care model to fill health service gaps and improve health outcomes (Porat-Dahlerbruch et al., 2022). Successful integration, therefore, enabled NPs 'to function to the full extent of their education, training, and scope of practice and contribute to patient, health system, and population needs' (Porat-Dahlerbruch et al., 2022, p. 1110). Our review intends to add to this body of knowledge, focusing on the integration of NPs into the PHC sector where they contribute to transforming healthcare to advance health equity through a social justice lens.

2 | THE REVIEW

2.1 | Aims

This integrative review aimed to develop a framework to guide the successful integration of NPs into practice settings and, working from a social justice lens, deliver comprehensive primary healthcare which advances health equity. The intent was to identify components from international literature that not only supported the integration of NP roles into practice settings but articulated a NP role which included elements of a social justice perspective. Such elements included for example, healthcare access, health outcomes and equity or inequality in relation to underserved, rural or Indigenous populations. From this evidence, our objective was to develop a framework to guide the integration of NPs in the local practice setting, which could be further refined and tested in the New Zealand context. We hoped the development of a framework would inform national health workforce policy and the education and training of NPs to address prevalent and persisting health disparities.

TABLE 1 Search strategy.

"Nurse Practitioner" OR "Advanced Practice Nurse"
AND
"Primary Health*" OR "Community Health*" OR "Family Health" OR Neighbourhood OR Family OR Primary OR District OR Community
AND
Integrate OR Implement* OR Introduc* OR Induction OR Internship OR Establish* OR Transition OR Novice OR "Organizational Climate"

2.2 | Design

An integrative review was conducted using the methods described by Whittemore and Knafl (2005) including clarification of problem and aim, systematic search and evaluation of the literature, data analysis and presentation of findings. The process was designed to enable the collection and synthesis of diverse literature on the integration of PHC NPs with a social justice focus. The integrative review adhered to the Preferred Reporting for Systematic Reviews and Meta-Analyses (PRISMA) method (Page et al., 2021).

2.3 | Search methods

Key concepts were informed by the research aim: nurse practitioner, primary healthcare and integration. Synonyms and alternative words were identified and supplemented with keywords from relevant existing literature (Table 1). Including 'social justice' and relevant terms in the search, such as 'equity' or 'disparity', limited results. Instead, we searched more broadly, focusing on integration and then screened titles and abstracts for indications of social justice elements.

Inclusion and exclusion criteria were developed at the outset and further refined as literature was identified (Table 2). The presence of social justice elements was identified to systematically apply inclusion criteria (Table 3).

2.4 | Search outcome

Electronic database searching was performed in Web of Science, PubMed, Scopus, CINAHL and the University of Auckland Library Catalogue on 6 April 2022. Relevant records from the database searches ($n = 3040$) were extracted into the Endnote X19 reference

TABLE 2 Literature inclusion and exclusion criteria.

Inclusion	Exclusion
English written publications	Specialist disease-state roles
Literature published between 2005 and April 2022	Undifferentiated advanced practice nurse (APN) roles (NPs and clinical nurse specialists)
Focus on how NPs are integrated into PHC and purposively concerned with social justice, improving access and equity to underserved, rural or Indigenous populations (see Table 3)	Undifferentiated roles of NPs and physician assistants
Primary research, discussion articles and literature reviews	Effectiveness and outcomes of NP work (without integration component)
	Planning the integration of NP(s)
	Evaluation of education or transition programmes
	Postgraduate theses, including PhDs

Abbreviations: APN, advanced practice nurse; NP, nurse practitioner; PHC, primary healthcare; PhD, Doctor of Philosophy.

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manager. Duplicates were removed leaving 1834 articles. An additional 96 articles were located by searching on international health ministry websites, research sites specializing in NP research, and citation mining via the reference lists (backwards) and citation searching (forward) using Scopus (Wohlin, 2014). Articles were uploaded into Covidence, a systematic review manager in preparation for screening. Two authors (SA and EK) independently screened all titles and abstracts and then full-text, with differences in opinion resolved through discussion. A third author (CW) was available to resolve disputes and clarify inclusion and exclusion criteria. In total, 199 full-text articles were reviewed, of which 28 met the inclusion criteria (Figure 1).

TABLE 3 Examples of terms identified during screening and full-text review demonstrating elements of a social justice approach to guide inclusion.

Address health disparity; improve health equity; healthcare access; concern with socio-economic determinants of health; poverty
Responsive to population health, or local community health need; address gaps in service provision
Indigenous health improvement; services for high needs, disadvantaged, Indigenous, underserved or marginalized groups; services to redress colonizing practices
Transform services; flexible care delivery; innovative models of care; intersectoral or interagency collaboration; community networks; co-design

2.5 | Quality appraisal

The Johns Hopkins Research Evidence Appraisal Tool was used to assess evidence strength, quality and relevancy of a variety of qualitative, mixed methods and quantitative research as well as non-research literature (Dang et al., 2022). Using the evidence guide, each article was assigned a level of evidence strength from Level I (e.g., randomized controlled trial) to Level III (e.g., qualitative study) for research and Level IV to Level V for non-research evidence. Each article was then graded as high quality, good quality and low quality according to relevance to the research question, research design, findings and conclusion of research information. Articles were independently evaluated by two authors (SA and EK). Any discrepancies were discussed and consensus was reached. All 28 articles were retained (Table S1).

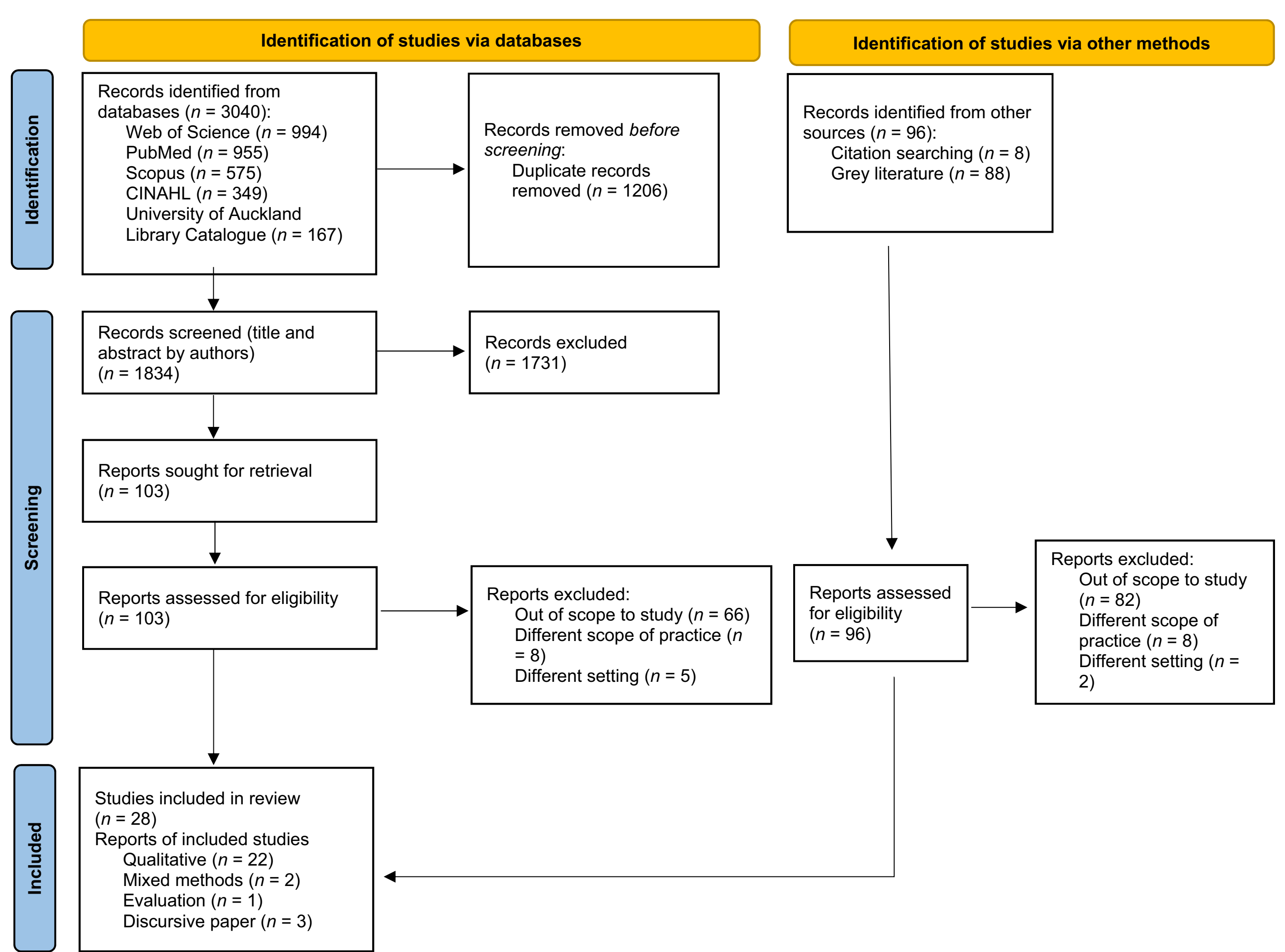

FIGURE 1 Preferred reporting for systematic reviews and meta-analyses (PRISMA) diagram.

2.6 | Data abstraction and synthesis

Study characteristics including year, country of publication, participant demographics and study design were extracted and tabulated. All the results and findings from each article (n=28) were extracted as full-text, coded and thematically analysed (as outlined by Braun et al. (2018)) using NVivo V1.7. Throughout the analysis, the authors (SA, EK and CW) maintained a social justice lens, searching for integration strategies and actions which aligned with the purpose of the review to enable NPs to deliver comprehensive PHC to advance health equity. Themes arising were discussed, reviewed and refined in discussion with the team. It was evident that the themes generated could be further categorized at individual (micro), local health provider (meso) and national systems and structures (macro) levels (Whittemore & Knafl, 2005). Table S1 provides a summary of the articles including aims, research approach, key findings and quality appraisal.

3 | RESULTS

Twenty-eight articles of good to high quality (Dang et al., 2022) were included in the final review. The majority of articles were qualitative (n=22; 78.6%); with others being mixed methods (n=2; 7.1%; Lowe et al., 2017; Wilson et al., 2021); an evaluation of an NP integration process (n=1; 3.6%; Bourque et al., 2020); and discursive papers (n=3; 10.7%; Browne & Tarlier, 2008; Chulach & Gagnon, 2016; Marceau et al., 2021). Over half of the articles were from Canada (n=15; 53.6%), and the remainder sourced from the United States (n=5; 17.9%), New Zealand (n=4; 14.3%), Australia (n=2; 7.1%) and Scotland (n=1; 3.6%).

Analysis of the data revealed that there were six key themes, or components, identified as being relevant and important to support the integration of NPs where they were enabled to deliver comprehensive PHC to advance health equity through a social justice lens. We identified that these components were required across all levels of the health sector: individual (micro), local health provider (meso) and national systems and structures (macro). The six components for integration were as follows: (1) autonomy and agency; (2) awareness and visibility; (3) shared vision; (4) leadership; (5) funding and infrastructure; and (6) intentional support and self-care. These components were strongly interrelated, for example, autonomy and agency relied on both the awareness of the NP scope of practice alongside the required funding and infrastructure to support their practice. A summary and evidence of these components identified for each level of the health sector are presented in Table 4.

3.1 | Autonomy and agency

Independent decision-making and responsibility for patient care in NPs' everyday role and scope of practice are necessary for autonomous practice if NPs are to prioritize the NP-patient relationship and meet patient health needs (Faraz, 2019; Owens, 2021; Poghosyan et al., 2013; Weiland, 2015; Wilson et al., 2021). Agency (defined as the ability to act and fulfil the role of a NP) and autonomy are constrained by biomedical and physician-dominated primary care models, which then limits the contribution of NPs in PHC to address local health need (Chulach & Gagon, 2016; Poghosyan et al., 2013). Within physician-led primary care, the support of the physician to facilitate NPs' autonomous practice was a necessary component (Poghosyan et al., 2013). When genuinely autonomous practice was enabled at an individual level, NPs delivered healthcare differently to improve access aimed at social benefit and improving the community's capital (Kirkman et al., 2018; Wilson et al., 2021). At the local health provider level, autonomy and agency required supportive organizational processes, to provide flexibility of healthcare delivery modes to improve appropriate access; deliver outreach services to homes and communities, including Indigenous communities; and enable straightforward billing and referral process with an effective patient management system (Black et al., 2020; Burgess et al., 2011; Poghosyan et al., 2013; Wilson et al., 2021). Local policy, governance, leadership and teams that promoted models of care where the NP scope of practice was fully utilized improved integration (Poghosyan et al., 2013). Health system funding, regional leadership and national policy that supported independent practice are required for NPs to deliver on improving patients' healthcare access and equity (Bourque et al., 2020; Burgess et al., 2011; Chulach & Gagnon, 2016; Poghosyan et al., 2013; Strachan et al., 2022).

3.2 | Awareness and visibility

Visibility of the NP role, particularly in relation to NPs' experience, clinical knowledge and decision-making capabilities, enabled health providers to realize the full potential of NPs within their service and community offering alternative ways of working (Chulach & Gagnon, 2016; Faraz, 2019; Poghosyan et al., 2013). The establishment of trusting relationships between the NP and their patients, local teams and communities, however, requires an understanding of the NP role and takes time to develop before care delivery could be optimized (Burgess & Purkis, 2010; Kirkman et al., 2018; Poghosyan et al., 2013; Sangster-Gormley et al., 2013; Sullivan-Bentz et al., 2010). At the micro level, taking time to build relationships with patients raised confidence in and acceptance of the NP role, enabling both the patient and NP to determine whether the NP was the appropriate health professional to address their healthcare needs (Burgess & Purkis, 2010; Sangster-Gormley et al., 2013). Raising awareness of the NP was also particularly important for the autonomy and independence of mental health patients (Sangster-Gormley et al., 2013). Making visible NPs' contribution to patient health outcomes through, for example, referrals, documentation and billing codes further distinguished how NPs improved access and equity in physician-dominated settings (Burgess et al., 2011; Burgess & Purkis, 2010; Poghosyan et al., 2013; Sullivan-Bentz et al., 2010). Consensus in health and workforce policy is required to promote the

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TABLE 4 Mechanisms to successfully integrate nurse practitioners into primary healthcare settings to promote social justice, including healthcare access and equity.

Key theme, summary and source	Evidence at individual (micro), local health provider (meso), and national systems and structures (macro) levels
Autonomy and agency are genuine when NPs can exercise decision-making and fully utilize their scope of practice to innovatively meet the social justice, equity, and access needs of patients and communities (Adams & Carryer, 2019; Black et al., 2020; Bourque et al., 2020; Burgess & Purkis, 2010; Burgess et al., 2011; Chouinard et al., 2017; Chulach & Gagnon, 2016; Contandriopoulos et al., 2015; Faraz, 2019; Kirkman et al., 2018; Lowe et al., 2017; MacLellan et al., 2016; Marceau et al., 2021; Owens, 2021; Poghosyan et al., 2013; Rioux-Dubois & Perron, 2023; Sullivan-Bentz et al., 2010; Strachan et al., 2022; Weiland, 2015; Wilson et al., 2021).	**Individual (micro)** *Recognition of NP autonomy*: Acceptance of the NP role by their team supports NPs to work independently and within a social justice focus. This includes taking services outside the clinic boundary to where services are needed in the community. *Agency inherent to the role*: For NPs to meet community needs requires team understanding and enabling of NP agency as inherent to the NP scope of practice (SOP) and role progression. **Local health provider (meso)** *Organizational climate*: Health and social systems, governance structures, regulations, guidelines, billing practices, funding, and decision-making all impact NP autonomy and agency. *Governance*: Local nursing leaders contribute towards policy that enhances NP SOP which inherently supports their ability to work differently towards access and equity. *Collaboration*: Intersectoral and interagency collaboration sustains NP autonomy and supports the quality of patient care models being socially just. *Models of care*: NP-centric models of care require support with opportunities for NPs to be innovative in their collaboration and care delivery, particularly in traditionally physician-centric practices. Equitable health outcomes directly relate to NP practice and are evidence of NP agency. **National systems and structures (macro)** *Interorganizational planning*: Consensus on NPs as agents for social justice from a regional and national perspective formalizes their agency in health planning and decision-making at a governance level. *Regional presence and leadership*: A NP community of practice enhances NP autonomy and agency facilitating regional and national conversations that promote socially informed changes for PHC. *Funding and policy arrangements*: Policies that regulate NP funding, referrals, remuneration and practice management systems recognize NPs as independent practitioners.
Awareness and visibility of the NP and NP role build trust, and acceptance, and further integrate the NP as an enabler of social justice to meet patient and community needs (Browne & Tarlier, 2008; Burgess & Purkis, 2010; Burgess et al., 2011; Chouinard et al., 2017; Chulach & Gagnon, 2016; Faraz, 2019; Kirkman et al., 2018; Lowe et al., 2017; O'Rourke et al., 2016; Officer et al., 2019; Poghosyan et al., 2013; Sangster-Gormley et al., 2013; Sullivan-Bentz et al., 2010; Strachan et al., 2022).	**Individual (micro)** *Trusting relationships*: Time in the form of extended appointment times develops visibility and therefore trust, knowledge, and acceptance of the NP role and their capabilities. *Maintaining visibility and awareness*: Evaluation of NP care and functions ensures their knowledge and expertise related to social justice remains visible and useful. Time for NPs to engage in research alongside collaboration with researchers and evaluators maintains their visibility. **Local health provider (meso)** *Visual recognition and contribution*: Organizational policies, regulations, and key leaders require awareness of NP as socially informed care providers and make visible their contribution to patient access and equity outcomes. Visibility further supports healthcare accountability to patients and communities. *Community promotion*: Local health providers that promote the role of the NP within their communities ensure improved role clarity, acceptance and awareness. This includes highlighting their SOP as bridging medicine and nursing and offering innovative service delivery models to improve healthcare access and equity. *Maintaining visibility*: The contribution of NPs to innovative models of care and health outcomes is evaluated and promoted. Tools are developed to measure and capture NP contributions by intentional collaboration with researchers and evaluators. **National systems and structures (macro)** *Conscious and consistent awareness*: Public awareness campaigns increase overall public recognition, understanding and confidence in the focus of the NP role as holistic health providers. *Intersectoral consensus*: Collaborating with government, employers, educators, regulatory colleges and professional organizations, including interprofessional taskforces, supports a broad-based awareness and understanding of NPs contribution to social justice. *Strategic visibility*: Nurse leaders promote national visibility, including influencing systems and health and workforce policy.

(Continues)

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TABLE 4 (Continued)

Key theme, summary and source	Evidence at individual (micro), local health provider (meso), and national systems and structures (macro) levels
Shared vision and goals for transforming PHC by developing health services to meet community health need and improve health access and equity provide direction for integrating NPs into PHC (Adams & Carryer, 2019, 2021; Burgess & Purkis, 2010; Chouinard et al., 2017; Contandriopoulos et al., 2015; Contandriopoulos et al., 2016; Faraz, 2019; Lowe et al., 2017; Marceau et al., 2021; Officer et al., 2019; O'Rourke et al., 2016; Rioux-Dubois & Perron, 2023; Strachan et al., 2022; Wilson et al., 2021).	**Individual (micro)** *Agents of change*: NPs are acknowledged as health innovators with the ability to transform PHC services to meet population needs. NPs as individuals are committed to equity and are adequately empowered to change the delivery of healthcare services that continue to meet needs accordingly. *Community networking*: NP capacity is supported to work alongside the community, developing networks and models of healthcare delivery. **Local health provider (meso)** *Team engagement*: Early engagement and team discussions of a shared vision centres on matching community health needs with NP service delivery. *A clear vision*: Careful planning and management of the NP integration process with team and community engagement requires legitimate and purposeful leadership. *Sustainable vision*: Local health providers and community stakeholders have knowledge and commitment to the vision leading to local sustainability and benefit to the community. *Advancing the vision*: Coordinated alliances with regional health provider organizations support decision-making power for local providers to integrate NPs into practice. **National systems and structures (macro)** *Collective vision*: Coordinating a socially just vision of NP integration requires systemic support across management structures, professional nursing organizations, local and regional health provider organizations. *Building confidence in the vision*: Rebuilding and giving effect to equity and access within PHC requires a supported policy context and government action for a renewed PHC vision, with NPs as part of the solution. *Beyond the national vision*: The development of an international-level NP pan-collaborative network (such as the ICN) can support NP workforce development using international collaboration to identify issues, priorities and goals for integration.
Leadership is critical to ensure a vision for NP integration and social justice is enacted (Bourque et al., 2020; Burgess et al., 2011; Burgess & Purkis, 2010; Chouinard et al., 2017; Contandriopoulos et al., 2015; Faraz, 2019; Lowe et al., 2017; MacLellan et al., 2016; Officer et al., 2019; O'Rourke et al., 2016; Owens, 2021; Poghosyan et al., 2013; Rioux-Dubois & Perron, 2023; Sangster-Gormley et al., 2013; Strachan et al., 2022).	**Individual (micro)** *Daring to lead*: Politics is inherent to nursing development, and NPs, as leaders of a different way of delivering equitable care to communities, are prepared to manoeuvre within the political foray. *Assuming leadership*: NPs are autonomous providers of care and take on such leadership roles that promote equitable and accessible patient outcomes. **Local health provider (meso)** *Sharing the lead*: NPs contribute to modelling shared leadership and willingly share, mentor, and exchange knowledge with team members and other allies to support healthcare improvements. *Strategic leadership*: NPs lead the way by influencing others to act collectively, ensuring allies are clear in their roles and responsibilities within their local communities to enhance social justice. *Stepping into the foray*: Strong NP leadership requires courage, perseverance and consistent support to foster the emergence of transformative models. **National systems and structures (macro)** *Intentional leadership*: Leadership approaches reflect a solid understanding of the NP role and its potential to deliver on equity. Health authority leaders induce collective action and develop the necessary infrastructure. *Power, equity and required authority*: Leadership at regional and national levels with authority, budget and policies give effect to social justice to legitimize NP autonomy, agency and leadership of patient and community care.

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TABLE 4 (Continued)

Key theme, summary and source	Evidence at individual (micro), local health provider (meso), and national systems and structures (macro) levels
Funding and infrastructure require a sustainable and flexible shift from traditional to transformative for NP to maintain a social justice focus when integrating (Adams & Carryer, 2019, 2021; Black et al., 2020; Browne & Tarlier, 2008; Chouinard et al., 2017; Contandriopoulos et al., 2016; Faraz, 2019; Kirkman et al., 2018; Lowe et al., 2017; MacLellan et al., 2016; Marceau et al., 2021; Officer et al., 2019; Owens, 2021; Poghosyan et al., 2013; Rioux-Dubois & Perron, 2023; Sangster-Gormley et al., 2013; Strachan et al., 2022; Sullivan-Bentz et al., 2010; Weiland, 2015; Wilson et al., 2021).	**Individual (micro)** *Pay parity*: Pay relative to an NP's workload, performance, autonomy and responsibility requires a vested interest in parity. *Innovative funding*: NPs require an understanding of the relationship between financial imperatives, political drivers and responsiveness to socially just community health needs. *Financial viability*: NPs are fully informed and engaged in decision-making over their financial contribution, income generation and long-term health benefits. NPs working in a NP-centric model are likely to yield greater community benefits. **Local health provider (meso)** *Competitive contracting environments*: Neoliberal competitive contracting environments are unsupportive of providers developing models of care to achieve equitable health outcomes and improve access. Alternative PHC funding models are required. *Commensurate remuneration*: Salary scales and remuneration packages need to reflect NPs' accountabilities, skills and services delivered within their SOP. Employment, contractual and business practices are designed to optimize the NP role. *Funding models*: Physician-centric funding models restrict NPs' work to a substitutive model. Instead, NP-centric funding models enable NPs to deliver holistic care within collaborative teams, while maintaining financial sustainability. *NP social entrepreneurship*: Demonstration of NPs' ability to generate income strongly influences providers' decisions to employ NPs. Options outside the business-as-usual models recognize the NP role as innovative and concerned with social improvement. **National systems and structures (macro)** *NP-specific funding mechanisms*: Health policy and legislation support socially just models of care. NPs are recognized as delivering long-term, sustainable and comprehensive PHC services. Employment opportunities and conditions, fair compensation and funding formulas are compatible with collaborative approaches to care and value preventative and promotive healthcare. *Funding availability and sustainability*: Sustainable funding is required to develop the NP workforce, including investing in the education and training of NPs and their transition into practice on registration as NPs.
Intentional support and self-care for NP integration is required at all levels to sustain the transformation of a socially just healthcare system (Adams & Carryer, 2019, 2021; Black et al., 2020; Bourque et al., 2020; Browne & Tarlier, 2008; Burgess & Purkis, 2010; Burgess et al., 2011; Chulach & Gagnon, 2016; Chouinard et al., 2017; Contandriopoulos et al., 2015; Contandriopoulos et al., 2016; Gonzales et al., 2022; Kirkman et al., 2018; Lowe et al., 2017; MacLellan et al., 2016; Officer et al., 2019; O'Rourke et al., 2016; Owens, 2021; Poghosyan et al., 2013; Sangster-Gormley et al., 2013; Strachan et al., 2022; Weiland, 2015).	**Individual (micro)** *Self-care*: Work-life balance and job satisfaction promote NP well-being, integration and retention, and as a result support patient satisfaction and health outcomes. *Mentorship*: Receiving mentoring from other NPs within or external to the organization is critical for successfully developing a NP model of care that optimizes the NP SOP. *Feeling valued*: Mutual trust and acceptance of the NP and their role increases NPs' perception of being valued. *Ongoing professional development*: NPs require and value opportunities for professional development and career progression with NPs and medical colleagues, including conferences and workshops. **Local health provider (meso)** *Collaborative environment*: Working in a collaborative team environment, with peer and collegial support strongly supports successful integration of the NP. *Value-add of NP practice*: Maintaining NPs' unique value requires a reorientation from physician-centric models of patient care towards the introduction of NPs as a legitimate autonomous nursing role. As medical-nursing hybrids, NPs' work is different from the medical model, drawing on relational and social justice models. Protecting NPs' time is required for NPs to integrate into the practice and community and deliver a transformative model of care. **National systems and structures (macro)** *Role development*: NP workforce strategies need to include funding for mentorship and ongoing professional development to both deliver innovative and transformative healthcare and develop their clinical skills and knowledge. *Leadership, education and research*: NPs are encouraged and supported into positions of influence, including policy, nursing and NP education and training, research, and health leadership. Funding is required to release NPs from clinical practice to fulfil such positions. NPs' ability to work innovatively and become socially and politically astute towards improving health equity requires accessible knowledge and training.

Abbreviations: ICN, International Council of Nurses; NP, nurse practitioner; PHC, primary healthcare; SOP, scope of practice.

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NP workforce, emphasizing NPs as agents of social justice and catalysts of change in the PHC sector (Browne & Tarlier, 2008; Burgess et al., 2011; Chouinard et al., 2017; Officer et al., 2019; Poghosyan et al., 2013).

3.3 | Shared vision

Central to the NP role is to deliver healthcare that meets local community health needs, improving healthcare access and outcomes (Adams & Carryer, 2019; Chouinard et al., 2017; Contandriopoulos et al., 2015; O'Rourke et al., 2016). Creating a shared vision within a local health provider requires NPs to be acknowledged as health innovators with the ability to transform PHC services to meet population need (Burgess & Purkis, 2010; Contandriopoulos et al., 2015; O'Rourke et al., 2016; Rioux-Dubois & Perron, 2023; Wilson et al., 2021). Recognizing NPs' decision-making capacity and capability in physician-dominated settings supported model of care development (Chouinard et al., 2017; Contandriopoulos et al., 2015; O'Rourke et al., 2016). Matching community health needs with NP service delivery supported a shared vision and integration activities at local health provider and national systems and structures levels (Adams & Carryer, 2021; Burgess & Purkis, 2010; O'Rourke et al., 2016; Wilson et al., 2021). With the support of workforce and policy strategies, a national vision for PHC transformation could be better coordinated, sustained and developed (Adams & Carryer, 2019, 2021; Chouinard et al., 2017; Marceau et al., 2021; Strachan et al., 2022). Where access and equity were prioritized at the national level, activities to determine health outcome-based goals ensured the best opportunities for integrating NPs (O'Rourke et al., 2016).

3.4 | Leadership

NPs are identified as capable leaders to promote healthcare access and equity (Bourque et al., 2020; Burgess & Purkis, 2010; MacLellan et al., 2016; Owens, 2021; Sangster-Gormley et al., 2013). Politics is an inherent component of the NP role and NPs, as leaders, must be prepared to manoeuvre within local and national political environments (Burgess & Purkis, 2010; MacLellan et al., 2016). The benefits of NP leadership in patient healthcare delivery when compared with traditional physician-centric leadership are evident (Burgess et al., 2011; Burgess & Purkis, 2010; Contandriopoulos et al., 2015; Sangster-Gormley et al., 2013). Preservation of NP leadership at macro and meso levels requires policy, capacity (direct supervision and shared leadership among local leaders) and motivation (championing of the NP role by NPs and doctors) to lead teams to deliver care differently (Burgess et al., 2011; Burgess & Purkis, 2010; Contandriopoulos et al., 2015; Officer et al., 2019; Sangster-Gormley et al., 2013). For leadership to be intentional about equity, access and social justice requires endorsement in policies, budgets and legal and professional authority (Bourque et al., 2020; Burgess & Purkis, 2010; O'Rourke et al., 2016). Relationships with nursing associations and health authority leaders, alongside opportunities for NPs to become strategic leaders supported their integration and ensured a collective vision for PHC transformation (Bourque et al., 2020; Burgess & Purkis, 2010; Chouinard et al., 2017; O'Rourke et al., 2016; Strachan et al., 2022).

3.5 | Funding and infrastructure

The relationship between financial imperatives and political drivers influenced NP power to negotiate and practice outside of a physician substitute model (Adams & Carryer, 2019; Contandriopoulos et al., 2016; Kirkman et al., 2018; MacLellan et al., 2016). The imperative to generate income and grow the business at the local health provider level impacted NP integration (Black et al., 2020; MacLellan et al., 2016). Competitive contracting and lack of NP-specific funding mechanisms at the macro level highlighted the tension between cost-effectiveness and value-for-money with NPs' goals for social justice (Adams & Carryer, 2021; Black et al., 2020; Lowe et al., 2017; Marceau et al., 2021; Officer et al., 2019). Short-term pilot funding impacted the flexibility and sustainability of NP practice (Black et al., 2020; Marceau et al., 2021; Sullivan-Bentz et al., 2010). Innovation using NPs was limited by policy, tradition, power and politics rather than evidence (Kirkman et al., 2018). NP-specific funding pools and pathways are necessary for NP integration and practice, providing opportunities for NPs to showcase their work (Black et al., 2020; Browne & Tarlier, 2008; Lowe et al., 2017; MacLellan et al., 2016; Marceau et al., 2021; Officer et al., 2019; Sullivan-Bentz et al., 2010; Weiland, 2015). Working outside of the business income model was beneficial, allowing different service models, including outreach, leading to reduced costs for patients and communities (Kirkman et al., 2018; Wilson et al., 2021).

3.6 | Intentional support and self-care

Supporting NPs to work to their full scope of practice and move beyond simply shifting medical workloads onto NPs requires a commitment and intentional support (Adams & Carryer, 2019; Officer et al., 2019; Strachan et al., 2022). Intentional support included the provision of mentoring (by NP and physician colleagues), peer and team support, and a focus on professional development and career progression (Adams & Carryer, 2019; Browne & Tarlier, 2008; Burgess & Purkis, 2010; Owens, 2021; Poghosyan et al., 2013; Weiland, 2015). Establishing NPs into positions to deliver models of care in partnership with patients, communities and local teams supported successful NP integration (Adams & Carryer, 2021; Black et al., 2020; Bourque et al., 2020; MacLellan et al., 2016). A collaborative environment with ongoing mentorship and strong teamwork fostered role integration and promoted NP well-being (Black et al., 2020; Burgess et al., 2011; Burgess & Purkis, 2010; Chouinard

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et al., 2017; Gonzales et al., 2022; Kirkman et al., 2018). Such environments noted the benefits of supporting NP well-being and encouraging self-care including improved quality of work (Black et al., 2020; Burgess & Purkis, 2010; Faraz, 2019; Lowe et al., 2017). Ensuring support is available for NPs in their local setting requires a commitment to national workforce planning and funding as well as at local health provider levels (Adams & Carryer, 2019; Poghosyan et al., 2013).

4 | FRAMEWORK FOR NURSE PRACTITIONER INTEGRATION INTO PRIMARY HEALTH CARE

Our premise, throughout this review, has been that NPs have the capability and potential to transform PHC service delivery to advance health equity working within a social justice lens. The intention was to develop a framework to guide the integration of NPs into PHC to achieve this transformation. The framework (Figure 2) developed uses the six components identified through the literature and found to be required across all levels of the health system: individual (micro), local health provider (meso), and national systems and structures (macro) levels.

The literature identified the integration of NPs to be highly complex and multi-faceted. This aligns with knowledge of innovation in the PHC sector, which is contextually laden, complex and dynamic (Ploeg et al., 2019). For example, some components could already be in place depending on the local health provider's funding or business model, the existing engagement with the community, or the number of other health practitioners (including physicians) available. There is no one particular place to start, with the intent that the framework enables the consideration of contextual factors organically and iteratively.

Centred in the framework (Figure 2) is the NP, where they are enabled to deliver transformational PHC for the patient and community with a focus on equity and access as elements of a social justice approach. This central position of NP, patient and community emphasizes the reciprocal relationships, influence and power of stakeholders crucial to co-design of health service delivery to meet local health need (Strachan et al., 2022). Progressing outwards, the middle ring depicts the six components required for successful NP integration, with the arrows demonstrating the interrelated and dynamic nature of these fundamental components of transformational PHC. The outer ring highlights the individual, local health provider, and national systems and structures levels where all components interact. Actions required for each component at each level to integrate NPs necessarily require consideration of social justice, if health equity is to be achieved.

We recognize that the framework needs to be tested and will require adaptation and refinement, particularly for NPs working with specific communities, for NPs working with Indigenous communities and for Indigenous NPs.

5 | DISCUSSION

This integrative review explored international literature to identify what is required to guide the successful integration of NPs into

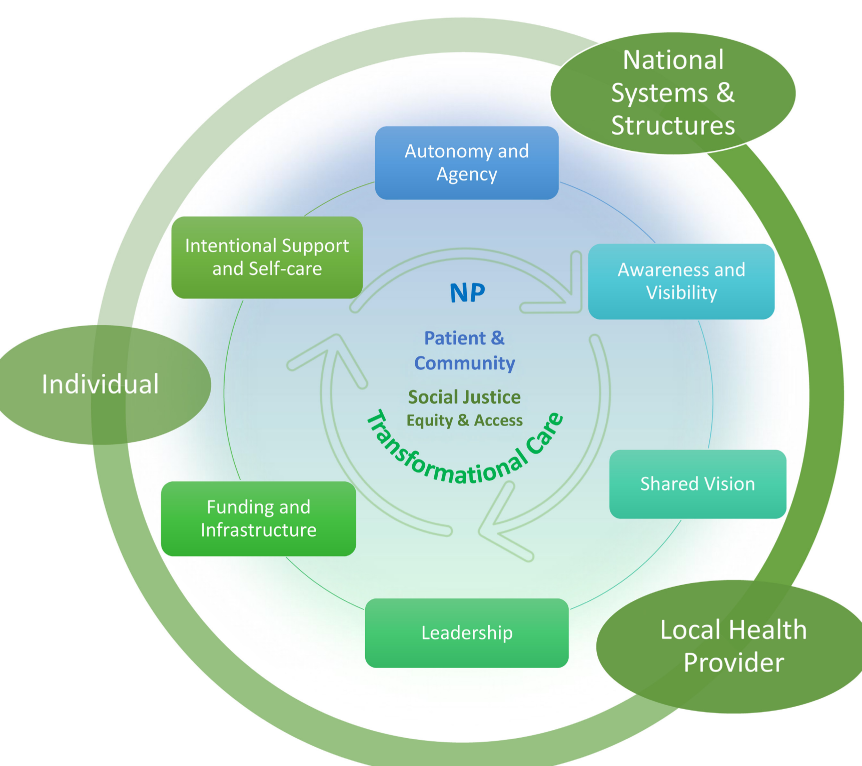

FIGURE 2 Guiding framework for integrating nurse practitioners (NPs) into primary healthcare settings to deliver healthcare through a social justice lens.

PHC where they can advance health equity, working within a social justice lens. Our interest stemmed from an imperative to improve health outcomes for communities experiencing persisting health inequities both in New Zealand and globally (Gurney et al., 2020; Rosa et al., 2020). The broad NP scope of practice ideally positions NPs to deliver comprehensive, culturally appropriate PHC to meet local health needs aligned with the World Health Organization global goals for universal health coverage and equity (Rosa et al., 2020; Scanlon et al., 2022). From the review, a proposed framework (Figure 2) was developed to guide the integration of NPs into PHC settings at the individual (micro), local health provider (meso) and national systems and structures (macro) levels. Thematic analysis revealed six key components and multiple possible actions to support NP integration (Table 4).

From the 28 articles included in the review, mechanisms were identified at all levels of the health, academic, regulatory, legislative and professional sectors to ensure the NP workforce can be optimally grown, supported and integrated into practice with the intention to improve health outcomes and equity. Multiple and complex barriers and facilitators exist for the implementation of NPs into PHC settings (Torrens et al., 2020). Porat-Dahlerbruch et al. (2022) have proposed a conceptual framework for integrating NPs across the health sector; and additionally argued for the necessity of research and policy guidance for integration (Porat-Dahlerbruch et al., 2023). The results of our review have added to this body of knowledge, further highlighting the complexity of integrating the NP workforce into established PHC practice settings and the necessity for careful planning, consultation, community engagement and attention to supporting multi-disciplinary, intersectoral and collaborative practice (Lowe et al., 2017; Strachan et al., 2022; Wilson et al., 2021). While such work needs to happen locally, the majority of articles reviewed identified the importance of regional, and national policy, sustainable funding mechanisms and commitment to the NP workforce in PHC (Contandriopoulos et al., 2016; Marceau et al., 2021). The onus is too often placed on the NPs themselves to advocate for their role and challenge dominant (and often disparaging) discourse in the face of systems which render their work invisible (Adams & Carryer, 2021; Delvin et al., 2018; Thompson & McNamara, 2022).

Visibility and valuing the NP role is a central feature to achieving a positive practice environment for NPs in PHC (Poghosyan et al., 2013). Our review found that achieving a shared vision requires strong leadership at local and national levels to inform NP education and training and support the PHC sector to employ and integrate NPs (Chouinard et al., 2017; Strachan et al., 2022). Across the globe, there is evidence of multiple, alternate NP health service delivery models demonstrating the opportunity to improve health access and outcomes, particularly for underserved and priority populations (Carthon et al., 2022; Grant et al., 2017). NPs are hybrid practitioners, working alongside local populations to promote social capital and community capacity as well as delivering appropriate biomedical primary care (Chulach & Gagnon, 2016; Delvin et al., 2018; Kirkman et al., 2018; McCullough et al., 2021; Wilson et al., 2021). Facilitating NPs through education and practice to work in ways that are both patient-centred and population-focused aligns with the intent of the NP scope of practice, World Health Organization goals for equity and social justice, and sees NPs as health practitioners adding value to the PHC workforce (Carryer & Adams, 2017; Plasse & Peterson, 2023; Rosa et al., 2020; Wilson et al., 2021).

Being able to practice autonomously is essential for an NP in PHC to deliver health services that offer the potential to transform care (Chulach & Gagnon, 2016; Kirkman et al., 2018; Weiland, 2015). Creating productive and collaborative practice environments reduces burnout and NPs' intent to leave and improves job satisfaction, and NPs' perceived quality of care (Abraham et al., 2021; Chouinard et al., 2017; Poghosyan et al., 2017; Wilson et al., 2021). However, too often NPs find themselves in organizations where their agency to enact the NP role and scope of practice is limited with multiple barriers experienced (Poghosyan et al., 2013; Torrens et al., 2020; Weiland, 2015). Removing regulatory and legislative barriers together with the inclusion of the NP workforce in health policy and PHC reform are fundamental shifts required at national levels (Maier et al., 2018; Schadewaldt et al., 2016). Internationally, consensus on the NP scope of practice will improve understanding between jurisdictions, support understanding of NP work and contributions, enable movement of NPs between jurisdictions and facilitate the synthesis of evidence.

The literature highlighted that evaluation is an important tool to measure NP value in a physician-centric setting and make visible the different ways of working across a nursing and medical boundary (Burgess et al., 2011; Porat-Dahlerbruch et al., 2022). Research has tended to focus on equivalence between general practitioners and NPs and as such perpetuates a discourse of substitution (Carryer & Adams, 2022). While we explicitly sought literature that identified NPs as delivering healthcare from a social justice lens, all included articles moved beyond the definition of NPs as substitutes for medical practitioners. Instead, NPs were identified as offering the potential to be innovative and transformational (Carryer & Adams, 2017; Chulach & Gagnon, 2016; Kirkman et al., 2018; Strachan et al., 2022). Incorporating social justice learning into NP curricula increases awareness of unjust and oppressive systems and structures and facilitates NPs to 'treat the downstream health effects of social inequity' (Plasse & Peterson, 2023, p. 119).

All of the articles in the review, except one, originated from colonized countries. Knowledge of how to support the Indigenous NP workforce was significantly lacking. In New Zealand, 17% of the population are Māori, yet only 8% of all NPs are Māori (Adams et al., 2022). Indigenous populations require health services delivered by health workers who reflect their culture and ethnicity if health outcomes are to be improved (Brockie et al., 2023). Ensuring Indigenous frameworks are available to inform workforce policy and education is a crucial next step if we are to redress disparities (Komene et al., 2023).

5.1 | Limitations

This integrative review addressed several gaps in the international literature by identifying the components required for the successful

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integration of NPs into PHC with a social justice focus. Strengths of this review are the comprehensive search conducted in four electronic databases and the systematic processes for study selection, data extraction and quality assessment conducted independently by two review authors. A limitation is that articles only in the English language were included. Furthermore, the authors have assumed that NPs already have the skills to engage with their communities and translate equity, access and social justice into practice. Therefore, NP preparation, training and education needs to be considered from a social justice perspective. The developed framework has yet to be tested and applied to a range of contexts.

5.2 | Implications for practice and policy and future research

The proposed framework (Figure 2) has been designed from the literature to support the integration of NPs into PHC settings where they can optimize their scope of practice and deliver healthcare services that improve healthcare access and health outcomes to achieve equity. This framework now needs to be tested in practice in a range of settings and adapted to meet the local context, community need and the NP workforce capabilities. Particularly, there is an imperative to expand the framework to support the development of the Indigenous NP workforce and NPs working with Indigenous and priority population groups. The development of a toolkit to inform and support the integration of NPs would provide practical actions required for NPs, local health providers, educators and policy-makers and funders.

As hybrid practitioners, there is a need to describe and evaluate the work of NPs in PHC that is not simply a comparison with physicians. Research demonstrating the value-added component of NP practice and their collaborative capacity is required to raise the visibility of the NP workforce, particularly for communities. Working with communities and co-designing health service delivery with other health and social agencies is critical if local community health needs are to be met and disparities eliminated.

Given the abundance of policy documents in New Zealand and elsewhere, which refer to equity, there is an urgent need to ensure consistent definitions of equity and disparity are used and framed within the context of unjust social systems, structures and processes. Research exploring the contribution of NPs within this space will support the clarification of terms and will highlight NPs' contribution to achieving health equity.

NP education in New Zealand has become increasingly medicalized, with little space in the curriculum for content including equity, social justice, ethics, philosophy of practice, leadership and policy. Regulatory authorities who audit NP education (in our case, the Nursing Council of New Zealand) and tertiary institutions need to review curricula to ensure that the health and well-being of local communities, Indigenous and other marginalized communities are prioritized through authentic relationships with these communities.

Finally, considerable political activity is required to ensure the NP workforce is recognized in health policy and health workforce planning. In July 2023, Te Whatu Ora (2023) published a national health workforce plan which included, for the first time, the training of NPs in New Zealand. The next step is to ensure the implementation plan follows, not only for training, but also for integrating NPs into practice settings. As identified in our review, successful integration is highly complex and requires commitment and policy development at national and local levels with strong collaborative relationships across the sector and with tertiary education.

6 | CONCLUSION

Through an integrative review, we have developed a framework to guide the integration of NPs into PHC. Central to this framework are key components which identify mechanisms and activities required at all levels of the health system to enable NPs to deliver PHC services in ways that are transformational and advance health equity for local individuals and communities. Further work is necessary to test and adapt this framework in practice, particularly by working with those who are in some way marginalized and experience socio-economic and health disparities, including communities, local health providers and NPs. Critical for the advancement of equity is that such a framework does not further promote power and privilege for the mainstream and white population, but instead is used to address oppressive and racist social and health structures and to achieve equitable health and well-being. Deliberate and concerted action at all levels of the political, health and education sectors is required to ensure the successful integration of NPs to deliver comprehensive PHC to meet the health needs of local communities.

AUTHOR CONTRIBUTIONS

All authors have agreed on the final version and meet at least one of the following criteria: (1) substantial contributions to conception and design, acquisition of data or analysis and interpretation of data; (2) drafting the article or revising it critically for important intellectual content.

FUNDING INFORMATION

This work has been supported by a Health Delivery Research Activation Grant (21/1059/A) from the Health Research Council of New Zealand.

CONFLICT OF INTEREST STATEMENT

No conflict of interest has been declared by the authors.

PEER REVIEW

The peer review history for this article is available at https://www.webofscience.com/api/gateway/wos/peer-review/10.1111/jan.16093.

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DATA AVAILABILITY STATEMENT

Data openly available in a public repository that issues datasets with DOIs.

ORCID

Sue Adams https://orcid.org/0000-0001-7374-2062
Cynthia Wensley https://orcid.org/0000-0002-6224-7514

TWITTER

Sue Adams DrSueAdamsRN
Ebony Komene EbonyKomene
Cynthia Wensley Brown_Acre
Josephine Davis Josephi97402545
Jenny Carryer Jennifercarryer

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How to cite this article: Adams, S., Komene, E., Wensley, C., Davis, J., & Carryer, J. (2024). Integrating nurse practitioners into primary healthcare to advance health equity through a social justice lens: An integrative review. *Journal of Advanced Nursing*, *00*, 1–16. https://doi.org/10.1111/jan.16093

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