DIFFUSION OF THE PRIMARY HEALTH CARE STRATEGY IN A SMALL DISTRICT HEALTH BOARD IN NEW ZEALAND

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Abstract

The Primary Health Care Strategy (2001) was launched in New Zealand by a Labour-led coalition. This paper reports the findings of a study examining aspects of the implementation of the Strategy on primary health care nursing in a small district health board in New Zealand and contributes new understanding on the depth of issues in the diffusion of the Strategy itself. The research approach was an instrumental case study informed by constructionism and underpinned by a qualitative interpretive design. Data were collected from multiple sources including relevant policy documents and strategic plans as available on organisational websites at the local district health board and primary health organisation level. Qualitative data were obtained using in-depth individual interviews with managers at middle and senior levels at the local district health board and two primary health organisations. Focus groups were held with primary health care nurses. Findings demonstrated that poor diffusion processes negatively influenced the deployment of primary health care nursing in this district; nurses did not understand the intent and potential of the Primary Health Care Strategy. We suggest that policy implementation must include robust diffusion processes in the design and be purposefully inclusive of nursing where relevant.

Keywords

Diffusion; innovation; primary health care (PHC); primary health care nursing

Introduction and Background

The Primary Health Care Strategy (PHCS) declared that a strong primary health care (PHC) system was considered fundamental to improving the health of New Zealanders and for tackling inequalities (Ministry of Health (MoH), 2001). The launch heralded a radical policy change to strengthen service delivery in PHC (Workforce Taskforce, 2008) and provided an opportunity for PHC nurses to engage fully with government and their employers in developing new nursing roles and responsibilities (MoH, 2005). It coincided with an international call for nursing innovation to produce a new form of health service delivery given an increase in health care demand from people with chronic conditions (Halcomb, Patterson, & Davidson, 2006; Temmnink, Francke, Hutten, van der Zee, & Abu Saad, 2000). Changes to service delivery, shorter hospital stays and an increased focus on population health and health promotion, meant that the responsibilities for nurses working in primary health care (PHC) had increased (MoH, 2005).

It was imagined that the extensive contribution nursing could make to reducing health inequalities, achieving population health gains and preventing disease,

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would be fully realised as a result of the PHCS (Expert Advisory Group on Primary Health Care Nursing, 2003). The expert advisory group reported that there was no nursing voice in decision-making, a noticeable lack of nursing leadership infrastructure in PHC settings and an absence of clinical career pathways. They also noted that PHC nurses lacked adequate resources to support their education, autonomy and skill development. This study thus explored and examined the situational and structural factors contributing to the implementation of the PHCS in a district health board (DHB) with a particular focus on the utilisation of nurses.

Background

There is an abundance of international literature that concentrates on the positive characteristics of PHC (Arford, 2005; International Council of Nurses, 2008; McMurray, 2007; Sloand & Groves, 2005; Starfield & Shi, 2007; Walker & Collins, 2009; World Health Organisation (WHO), 2008). A PHC paradigm privileges a broader remit than the provision of episodic care for ill health. It works toward the development of health by putting the emphasis on prevention, community involvement and working with sectors outside of health (Keleher, 2000; Sweet, 2010). The International Council of Nurses (2008) has said that it is through the principles of PHC that nursing can make an important contribution toward progress in the goal of "health for all" noting that nursing is considered the "very essence of primary health care" (p.7).

Much of the relevant published New Zealand literature focuses on the introduction of primary health organisations (PHOs) and funding models associated with the implementation of the PHCS but makes little mention about the impact on PHC nursing. The PHCS promised the effective deployment of nurses to make the best use of nursing knowledge and skills. It was about aligning nursing practice with community need and developing funding streams for service delivery that supported nurses adoption of an integrated approach to practice incorporating both population and personal health (Kent, Horsburgh, Lay-Yee, Davis, & Pearson, 2005; MoH, 2005).

There is emerging evidence that primary health care nurses do improve health outcomes and should be utilised accordingly (Cumming et al., 2005; Laughlin & Beisel, 2010; Finlayson, Sheridan, & Cumming, 2009; International Council of Nurses, 2008; McMurray, 2007; Nelson, Connor, & Alcorn, 2009; Sheridan, 2005). There is also evidence of the nursing potential to reduce inequalities in health between the social groups (Hoare, Mills, & Francis, 2012; International Council of Nurses, 2008; Marshall, Floyd, & Forrest, 2011). The conceptualisation of primary health care is also in harmony with the philosophy of nursing.

Nonetheless, a WHO (2008) report on PHC identified impatience with the inability of health services internationally to deliver levels of national coverage to meet changing health and societal need. In New Zealand, while there may have been small pockets of change, overall primary health care development has been disappointing and many of the features of health services have remained unchanged (Ashton & Tenbensel, 2010; Gauld, 2009). Despite the PHCS now having nearly a 15 year history, the opportunity for real change for nursing has been obstructed by misaligned policy levers and also by custom and practice issues (Carryer & Yarwood, 2015). Greenhalgh, Robert, Bate, Macfarlane and Kyriakidou (2005) argue the process of planned change in health is complex. Some innovations are readily accepted, whereas others are poorly supported.

Research Design

Aim

To enhance understanding of the impact of the implementation of the PHCS on PHC nurses in a small DHB in New Zealand.

Methodology

A qualitative interpretive design informed by constructionism was employed. The diffusion of innovation theory offered by Rogers (2003) and Greenhalgh et al. (2005) provided the theoretical lens to collect the data and analyse the findings. This theory offered conceptual clarity in designing and measuring the impact of change in a health setting. It facilitated locating the meaningful components to expose the reasoning that underpinned the complex adoption process.

Method

Using a single instrumental case study, documentation data were collected from multiple sources including relevant policy and strategic plans as available on the local DHB and PHO websites. A total of 42 people participated in the qualitative data collection that took place over a 20 week time period in 2010. In-depth individual interviews were held with ten managers at middle and senior levels at the DHB and two PHOs. Five focus groups were held with 32 PHC nurses that included practice nurses, public health nurses, tamariki ora nurses, rural nurses, sexual health nurses and Iwi based nurses. While representation was sought from all primary health care nursing groups, no district nurses or occupational health nurses participated in the focus groups.

Thematic analysis was used as the process for identifying, analysing and describing themes or patterns within the qualitative data. This enabled the communication of findings and interpretation of meaning and provided crucial insight into what was known by research participants. Integrity of the research was strengthened through individual interview participant checks and audio taping of the interviews and focus groups. All processes were described in full, personal biases were acknowledged and enhanced by self-critical reflection on author preconceptions that had potential to affect the research.

Ethical approval was granted after submitting a detailed ethical application to the Massey University, Northern Campus Human Ethics Committee. Advice from the National Coordinator, Health and Disability Ethics Committee identified application to a regional ethics committee was not required as this piece of research did not involve patients and the risk of harm to participants was considered minimal. As an employee of the DHB of study, the principle researcher (HR) sought approval from the chief executive and clinical board. The researcher also obtained permission from the chief executives of other organisations involved. All ethical requirements were met.

The diversity of different groups as part of the investigation was considered as central. Cultural considerations were of high importance and Māori input was actively sought in each step of the research process.

Findings

The organisational and individual diffusion of the Strategy in this local DHB negatively impacted on the intended development of the PHC nursing role. Key themes included: local strategy, local knowledge and impacts on understanding.

Local strategy

There were notable failings in the communication channel around the purpose, function and impact of the whole of Strategy intent. The DHB 2002/2003 District Annual Plan (Tairawhiti District Health, 2002a) clearly identified that planners and funders understood that there was a MoH requirement to implement the PHCS. The MoH directed each DHB to develop a local strategic plan to provide direction in working toward the Strategy objectives. This plan was to have local meaning, local buy in and local support.

A local PHC discussion document was developed and

identified the why, who, and the what, of the PHC plan although there was little mention of nursing in this document. In November 2002, the draft document was presented to the community and public health advisory committee for endorsement (Tairawhiti District Health, 2002b). At this meeting it was confirmed that once agreement around the discussion document was reached, it would then become the local strategy and guide recommendations for funding decisions going to the Board. The document was never finalised into a local strategy. This notable absence of a local strategy was confirmed by one manager:

> *I understood that there was going to be a [DHB] primary health care strategy … and seven years on there still hasn't been a strategy. (I.5, p.5)*

We found no evidence of a planned local communication approach. No district annual plans articulated how information of the Strategy was to be communicated, or how all the stakeholders, including nurses, were to be engaged. As a result, nurses and other health professionals were alienated from the local development process and unable to gain certainty about the cause and effect of the Strategy. Consequently there were differences in meaning and understanding of PHC/primary care implications of the Strategy between the managers interviewed and the nurses who participated in the focus groups confirmed this locally.

Local knowledge

Knowledge of the Strategy by the managers ranged from basic understanding through to in-depth comprehension:

> *I like its focus in terms of population health…I like its attempt to try and integrate services and health professionals in a way that it hasn't before. (I.10, p.1)*

Conversely, only four of the thirty-two PHC nurse participants had any awareness of the PHCS as the following excerpt illustrates:

> *May I ask what is the Primary Health Care Strategy? Can we get that right in my head. (FG.1, p.1)*

We found this knowledge gap puzzling initially, especially as one of the managers firmly believed that information regarding the Strategy had been widely distributed across the district:

> *I think you would have had to have had your eyes shut if you were around at that time. (I.8, p.2)*

There was evidence that one cohort of nurses had greater appreciation of the PHCS than others. From the focus groups it became apparent that public health nurses employed at the local DHB had opportunity to engage in conversations around the PHCS, both at the time the Strategy was launched, and in the years that followed:

> *When I was at public health, I was more aware of it because we talked about it and a lot of the programmes were based around initiatives … (FG.4, p.1)*

Public health nurses were not only provided information, but actively discussed the Strategy and looked at opportunities for public health nursing to contribute to its principles. The irony is that public health nurses were largely excluded by the singular national focus on the general practice environment. Whereas nurses in general practice under the auspices of newly formed PHOs, or in the non-government organisation sector, showed minimal awareness of the Strategy.

Impacts on understanding

Disseminating information on the PHCS to PHC nurses was significantly compromised by the lack of PHC nursing leadership across the study DHB. Two managers confirmed this was the case:

> *What we need is to have nurse leaders but we do not have the funding to do that. (I.1, p.5)*

> *… advancing primary care nursing from a leadership perspective and a collective perspective from the ground up is not equitable and quite variable. (I.5, p.13)*

Further, no key person or cluster of people stood out as driving the PHCS forward across the study region. This is supported by the following comment by one of the managers who was a leading player in PHC at the time the Strategy was released:

> *They have relied on the structures to circulate that information. Without having the one message deliverer you have got multiple deliverers all having a take on health. (I.9, p.3)*

Multiple messangers allowed for multiple interpretations of the PHCS with personal values and biases added to information. Another manager suggested that communication regarding the Strategy was less than meaningful engagement:

> *I suspect that it was more lip service than engagement. (I.2, p.2)*

Poor engagement suggests there was very little likelihood of shared understanding across the district. Inactivity of Strategy communication and implementation caused several participants to suggest it was an academic document or a document that sat on the shelf rather than a genuine blueprint for change:

> *I don't think the Strategy, like many of the strategies that we've seen enlighten the life of the health sector, have become really live working documents. It is become another nice to have that I go and find in the library and refer to if I'm doing academic papers. (I.6, p.2)*

In order to reach a point of effectiveness there first needed to be a shared understanding of the terminology. Both the MoH and DHB in this research continually struggled with this. The term primary care was frequently used interchangeably with PHC in the district annual plans and other strategic documents. The Strategy was frequently referred to as the primary care strategy (Tairawhiti District Health, 2002a, p.7 & 52). Further, the MoH website directs readers to their PHC publications which are predominantly primary care related documents.

In a similar vein, the definition of PHC nursing was not well understood across the sector. It could be argued that there was a shared degree of ignorance about the place, role and contribution of PHC nurses. This was confirmed by the significant number of participants who struggled to articulate the fundamental ideology of PHC nursing. The limited appreciation of the role and the difficulty in articulating the depth was illustrated by managers and nurses alike. The implications of the wrong use of the terminology continued to shape communication processes and the decision-making and propensity to act at all levels of the health system in the study area.

Discussion

The Strategy was a directive from the MoH, the principal agency responsible for health policy. However, the operational decision-making for implementation of the Strategy rested locally with newly formed DHBs and resulted in variability in each DHB's response across New Zealand (Cumming et al., 2005; Finlayson, Sheridan, Cumming, & Fowler, 2011;

Gauld, 2008; Primary Health Care Advisory Council, 2009). This suggests a failure to successfully engage all potential significant stakeholders, including nurses, at both a national and local level in articulating a shared vision or common purpose to support the roll out of the Strategy.

Diffusion

The poor diffusion process of the PHCS reduced the chance for successful adoption in this local DHB. Greenhalgh et al. (2005) argue adopters of innovations must first ascribe meaning to it and it is their understanding and belief about an innovation that predisposes their reaction and subsequently directs actions in response. Numerous innovations require a lengthy period of years from the time the innovation becomes available to the time it becomes widely adopted (Rogers, 2003). Even so called "evidence based innovations undergo a lengthy period of negotiation among potential adopters, in which their meaning is discussed, contested, and reframed" (Greenhalgh Robert, Bate, Macfarlane, & Kyriakidou, 2004, p.594).

Political drive can increase an organisation's predisposition to implementing an innovation. Rogers (2003) concurs that mandated change or authoritative decisions are usually associated with a higher rate of diffusion and the adoption of an innovation. Greenhalgh et al. (2005) also assert that dictating the adoption of the innovation is not necessarily conducive to acceptance and implementation. The authors argue the impact of political directives can divert implementation activity away from the innovation toward organisations second guessing what they were required to do rather than concentrating on local priorities.

Successful dissemination and assimilation of an innovation depends on the ability of an organisation to be able to manipulate structures and activities in place, as well as the ability of the stakeholders to understand the new conceptualisation that accompanies the diffusion process (Greenhalgh et al., 2005). The authors concur that the complexity of organisations especially those with fragmented internal and external structures constrains innovativeness and making it happen requires an orderly, planned and regulated approach, with all systems 'properly managed' in order to mainstream the innovation within the organisation. As this research identified, the PHCS required a formulated approach, that involved nursing, to drive the expected changes forward.

Understanding the role communication plays in innovation should not be underrated (Leeuwis, 2011). Leeuwis also argues the everyday communication among stakeholders is critical for the re-ordering of social relationships and the emergence of space for change in networks. In this study the place of employment impacted on access to information and meant that different people knew different things at different times.

The magnitude of organisations having the capacity to absorb new knowledge and be receptive and ready to change cannot be underestimated (Smith, McDonald, & Cumming 2008). The change process deserves greater attention in health care settings (Chreim, Williams, Janz, & Dastmalchian, 2010). Having a dedicated PHC project manager in each DHB to lead implementation would have been beneficial at the outset. This may have led to the identification of common values required, engagement and constructive conversations to increase mutual understanding, respect and commitment to shared gains in personal and population care (Buetow, 2008).

Impacts on understanding

Strong leadership and good strategic vision enables systems to respond more easily and quickly to innovation and secure the necessary influence

(Greenhalgh et al., 2005; Hamer, 2010; Martin, Weaver, Currie, Finn, & McDonald, 2012). Numerous authors argued for a director of PHC nursing to be based within each DHB (Carryer, 2004; Expert Advisory Group on Primary Health Care Nursing, 2003; Finlayson et al., 2009). The paucity of nursing leadership was validated by the majority of nurses who remain unaware of the PHCS nationally with regional diversity and varied investment in PHC nurse leadership roles (Sheridan, 2005).

Many nurses in this study attempted to contribute meaningfully to PHC development but at the same time there were and are those who remain content to accept delegated nursing tasks (Docherty, Sheridan, & Kenealy, 2008). Without shared governance and collective leadership the ability to impact on planning and funding decisions or influence their own practice, allocate resource, or bring about significant change was unlikely (Adamson et al., 2005; Attree, 2005; Calverley, 2012; Carryer, 2004; Chreim et al., 2010; Expert Advisory Group on Primary Health Care Nursing, 2003; Nelson, Wright, Connor, Buckley, & Cumming 2009; Robertson-Malt & Chapman, 2008).

Terminology confusion

The defective diffusion process was aggravated by a lack of common understanding of the terminology. PHC in New Zealand continues to be regarded as largely synonymous with general practice (National Health Committee, 2000). Primary care is defined as the first point of entry into a health system, usually within general practice, whereas PHC has a broader more comprehensive remit (Adamson et al., 2005; Carryer, 2004; Docherty, 2004; Holdaway, 2002; Keleher, 2001). If the terminology is not well understood then invariably barriers are created that impede the implementation of the Strategy's intent (Carryer, 2004).

This particular perception has been at the heart of the challenges experienced, aggravated the perceived complexity of the Strategy and contributed to the difficulty in articulating a shared vision with common purpose across a range of stakeholders, including nurses. Previous research undertaken in the DHB of this study, identified PHC nurses did not understand PHC terminology (Adamson et al., 2005) and we found that this had not changed in the 5 years following. This was concerning given the Strategy explicitly recognised the significance of nursing's contribution to PHC (Expert Advisory Group on Primary Health Care Nursing, 2003).

Limitations

This was a single case study and is thus viewed by some as a less desirable form of inquiry (Flyvbjerg, 2004; Griffiths, 2004; Yin, 2003). Perceived limitations are overridden by the fact that this methodology allowed the capturing of multiple realities to provide evidence transferable to other PHC nursing settings. Opinions were confirmed, where ever possible, from supporting literature which was important in mitigating this risk.

Recommendations

One of the least studied aspects of policy change is knowledge on how and why social structures, internal and external influences, and diffusion processes affect the adoption of policy driven innovations in health. These factors are powerful predictors of whether an innovation will be adopted or not. Policy development must include in its design, programmes that are congruent with the values and goals of all major stakeholder groups including nurses. If this is not achieved, then effort must be made towards reaching a common understanding.

Conclusion

It was very clear that the PHCS promised so much, but delivered so little. Despite the directive to implement the Strategy in a region with high levels of deprivation, very little had changed for service delivery and PHC nursing during the study period (2010-2014 years).

There was little evidence of actions taken in moving toward a state of readiness. The flawed diffusion process was one of the most significant factors in the poor implementation results. This was evidenced by the gap in understanding by various DHB staff, nurses and other stakeholders as intended adopters of the Strategy. This had a negative effect on the adoption decision-making process across the district and the substantial lack of nursing engagement.

Implementing the Strategy required engagement, discussion and debate until a common understanding was reached. Instead ineffective diffusion and dissemination resulted in limited stakeholder understanding. As a consequence there was no shared vision across the health sector. Therefore, this research reinforces the importance of a planned approach to change, early attention to detail and the necessity for purposeful and meaningful engagement of all stakeholders, including nurses, following policy change or when strategic documents are released.

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