A single case study: an evaluation of the impact of the implementation of the Primary Health Care Strategy on the primary health care nursing workforce in Tairawhiti.

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Abstract

In December 2000 the New Zealand Health Strategy was released closely followed by the Primary Health Care Strategy in February 2001. The Primary Health Care Strategy pledged a significant paradigm shift in health service funding and delivery and primary health care nurses were considered crucial to implementation. The intent of this study is to investigate the impact of implementation of the Strategy on primary health care nursing in Tairawhiti. Tairawhiti District Health Board (TDH) and the two Primary Health Organisations (PHOs) were central to the analysis.

For my overarching research framework I employed a qualitative interpretive design informed by constructionism. The diffusion of innovation theory seeks to explain how, why, and at what rate new ideas are spread through cultures and provided the theoretical lens to collect the data and analyse the findings. Using a single instrumental case study design, data were collected from multiple sources including relevant policy documents and strategic plans as available on the TDH, Ngati Porou Hauora and Turanganui PHO websites. Qualitative data were obtained using in-depth individual interviews with managers at middle and senior levels at TDH and the two PHOs. Focus groups were held with primary health care nurses.

The study concludes that investment in and the effective deployment of primary health care nurses in Tairawhiti did not occur as anticipated. A key finding was the lack of a whole of system strategic approach and poor diffusion processes meant widespread service change was undermined. The study also found that the Strategy met with multiple sources of resistance across the health sector, further exacerbated by existing structural barriers in the health system. This study brings together an increased understanding of the complexities that continue to disable a true primary health care approach and consequently restrict the potential gain the nursing workforce offers.

Acknowledgements

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Naku Noa
Heather Robertson

Preface

The assumptions inherent in this thesis are a product of the on-going changes in my understanding of what is important to me in research and how I understand knowledge to be produced and validated. Research is a progressive and dynamic process. Understanding is mixed with judgment and meaning is constructed rather than assumed from set truths about social reality. Researchers bring an understanding of the world with them to the research and the values and experiences of the researcher greatly influence the inquiry (Guba & Lincoln, 1989). Researchers are not able to set aside their own subjectivity and values cannot be ignored. It is therefore the task of the researcher to acknowledge their own intrinsic involvement in the research process and the part this plays on the results produced (Burr, 2005).

I was an insider researcher in a unique position to study the impact of the New Zealand Primary Health Care Strategy on primary health care nursing in Tairawhiti. This allowed me to draw on my prior knowledge and understandings from working as a primary health care nurse for more than 18 years. In that role I had the privilege of engaging in partnerships to work alongside families and communities. I worked with some of the most vulnerable families in Tairawhiti. Public health nursing taught me that to improve the health of people we must focus on reducing inequalities and improving access to health care. My workforce experience taught me the potential value of the Primary Health Care Strategy.

Districts such as Tairawhiti have the most to gain from a robust primary health care system including an effective primary health care nursing workforce. During the course of this research I was promoted to a position as nurse leader-primary and community for TDH. In the latter half of my research my professional role expanded to include a part-time position as health of older persons and disability portfolio manager. Both these positions proved useful to my understanding in the implementation of the Primary Health Care Strategy.

The release of the Primary Health Care Strategy in 2001 represented a significant paradigm shift in health service funding and delivery. The Minister of Health at the time identified that the nursing workforce was considered crucial to the implementation of the Strategy (Ministry of Health (MoH), 2001). Five years later while conceptualising this study, there had been pockets of innovation but no significant national change either in the way primary health care was delivered or in primary health care nursing. As an insider it was clear that opportunities were being missed due to limited philosophical change and subsequent service delivery.

It is acknowledged that health systems are both fragmented and complex and it can be arduous to measure the impact of policies, organisational change and public initiatives. Researching policy addresses issues that relate to discussion about services either directly by providing answers or indirectly by providing information that helps unravel a problem so that alternative solutions can be proposed (Starfield, 1978). I wanted to evaluate the impact of the implementation of the Primary Health Care Strategy on primary health care nursing in Tairawhiti. The research findings synthesised alongside the literature increased understanding of the influences of policy change on the nursing workforce.

It is highly probable that the findings will correlate with what has and is occurring in other districts in New Zealand. Therefore, the information from this research may also prove useful to other District Health Boards (DHBs) who have likewise struggled to utilise the primary health care nursing workforce effectively. The findings are time and situation specific but provide insights relevant to primary health care nursing both nationally and internationally as well as areas for further research.

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Chapter One: Setting the scene

1.1 Introduction

The New Zealand Primary Health Care Strategy was launched by the Labour-led coalition in 2001. The Strategy declared that a strong primary health care system was considered central to improving the health of New Zealanders and particularly for tackling inequalities (Ministry of Health (MoH), 2001). The Strategy also provided the opportunity for nursing to advance its contribution to primary health care (Carryer, 2005; Finlayson, Sheridan, Cumming, & Fowler, 2011; Hefford et al., 2010; Sheridan, 2005; Tully & Mortlock, 2005).

The Primary Health Care Strategy intended a fundamental change to the scope of the New Zealand public health system. The Expert Advisory Group on Primary Health Care Nursing (2003) stated: "Historical patterns of primary health care have not always provided the best service delivery, nor aligned it with health needs. Services have often evolved as a result of a mix of organisational and environmental factors, or funding and employment arrangements" (p.2). For a country to move toward a strong primary health care system, breaking down traditional barriers, professional boundaries and employment practices are necessary (International Council of Nurses, 2008a).

The Primary Health Care Strategy did not account for its potential effect or the reaction of existing institutions and structures (Gauld & Mays, 2006). Challenging traditional cultures can be difficult (Harvey & Broyles, 2010). The social dimensions of change and the characteristics of the people who make up that social system cannot be underestimated (Rogers, 2003). As this research will expose, bringing about the system wide shift that the Strategy required inevitably met with multiple sources of resistance.

The Primary Health Care Strategy explicitly identified nursing as holding a central role in fulfilling the goals of the Strategy. The goals seemingly intended that nurses were to become central and visible members of the

primary health care workforce in New Zealand. However, as the Expert Advisory Group on Primary Health Care Nursing (2003) identified, there was a great deal of work to be done to better align nursing service structures with community need.

The International Council of Nurses (2008b) has said that it is through the principles of primary health care that nursing has made 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). As a force in society's effort to tackle inequalities, nurses are poised in communities to actively effect social change and improve health outcomes for vulnerable people (Clarke, 2004; Cumming et al., 2005; Opalinski, 2006).

This thesis considers one area of New Zealand, that is, Tairawhiti District Health Board. Arguably Tairawhiti had some of the most significant levels of primary health care need. Through examining the implementation of the Primary Health Care Strategy in Tairawhiti, I considered whether nursing services had become more closely aligned with this need. This chapter provides the contextual background to the case under investigation beginning with the rationale and intent of this study. An overview of the New Zealand Health Strategy and the Primary Health Care Strategy is presented. The characteristics of Tairawhiti and significant health organisations are also explored. An overview of the thesis completes the chapter.

1.2 Rationale for the study

The launch of the Primary Health Care Strategy heralded a radical policy change to strengthen service delivery in primary health care (Workforce Taskforce, 2008). The Strategy document stated the proposed move towards greater population focus and emphasis on a wider range of services would increase the need for well-trained primary health care nurses. However, I believed that in the years since the release of the Strategy, little had changed for primary health care nursing as a specialty area of practice. I wanted to know why this was so and how it had occurred.

As a primary health care nurse I was not convinced that the primary health care nursing workforce was effectively deployed in Tairawhiti to improve the health of our most vulnerable communities. Neither was I persuaded that this workforce had developed as anticipated. I found it frustrating that opportunities to move the Primary Health Care Strategy and primary health care nursing practice forward were being missed. I identified a noticeable lack of a strong nursing leadership in primary health care and an absence of clinical career pathways. I observed that there was no nursing voice in the decision-making. I considered primary health care nurses to be under-utilised, undervalued and lacking in adequate resources to support their education, autonomy and skill development. The factors that created this situation were multiple and complex.

The principles of the Primary Health Care Strategy required change at an unprecedented level and that change was fraught with challenges. It required a move away from traditional relationships and presumed there would be no obstacles to nurses taking on a greater role. The role of women in society and the dominant and historical discourses of nursing and medicine have all in some way influenced and largely constrained the development of the current primary health care nurse role in Tairawhiti. The previously established and expected behaviour patterns defined the range of tolerable behaviours. This was aggravated by the nature of health policy, an entrenched biomedical philosophy of care, funding structures and District Health Board (DHB) decision-making. Changing behaviour is testing and changing a health care system is complicated given the way that they have evolved. Such factors supported the status quo, despite evidence that change was required.

1.3 The intent

This research evaluates the impact of the implementation of the Primary Health Care Strategy on the primary health care nursing workforce in Tairawhiti from 2001-2010. I make visible the factors that support or impede the nursing workforce in Tairawhiti from being full partners and participants in implementing this Strategy. Information was sought on the opportunities and barriers for primary health care nurses and on the factors that influenced

deployment. Aspects include structural determinants, norms of behaviour, primary health care nursing leadership, business models, DHB priorities, political intrusions and resistance to change.

I wanted to explore events and process in the local implementation of the Primary Health Care Strategy. I sought to understand to what degree it had influenced the role of the primary health care nursing workforce from the participant's perception. To begin, I formulated the following two questions in response to my national and local knowledge of primary health care nursing within the context of current literature:

1. What change has occurred within the primary health care nursing workforce in Tairawhiti since the implementation of the Primary Health Care Strategy, how and why did this come about?
2. What factors influenced the deployment of primary health care nurses in Tairawhiti?

I drew on several theoretical concepts to develop an overarching framework best suited to my research questions. Firstly, I drew on constructionism as an epistemological position underpinned with the constructs of the interpretive qualitative paradigm. This approach centres on how people methodically construct their experiences and their worlds. The construction process informs the mechanisms in which social forms are brought into being in everyday life (Holstein & Gubrium, 2008). Individuals and society are inseparable units. An understanding of one is not possible without the complete understanding of the other (Denzin & Lincoln, 2008). This is explored further in Chapter Four.

The process of planned change in health is complex (Greenhalgh, Robert, Bate, Macfarlane and Kyriakidou, 2004, 2005). Some innovations are readily accepted, where others are poorly supported. The research study was concerned with understanding this complexity by exploring and examining the situational and structural factors contributing to the implementation of the Primary Health Care Strategy in Tairawhiti. This in turn influenced the utilisation of nurses. To support this understanding, the diffusion of innovation

theory developed by Rogers (2003) and Greenhalgh et al., (2004, 2005) was used. The diffusion of innovation theory is discussed in Chapter Two.

For my methodology I employed case study investigation based on Stake's definition of a qualitative single instrumental case study. An instrumental case study is the study of a case to enhance understanding of a particular issue (Stake, 1995). The actual case is of secondary importance as it facilitates understanding of something else (Denzin & Lincoln, 2005; Simons, 2009). In this project the case is the impact of the implementation of the Primary Health Care Strategy on primary health care nursing.

Case studies allow incorporation of a wide range of information which fits well with finding out how or why a program has worked or not worked in order to improve action and make better decisions (Scholz & Tietje, 2002; Yin, 2003). The real value of case study research is in advancing the understanding of an issue or interest (Stake, 2006), its distinctiveness and particularity (Simons, 2009). It uncovers the manifest interactions of significant factors characteristic of a phenomenon and captures the "various nuances, patterns and more latent elements" (Berg & Lune, 2012, p.327). Case study as the research methodology is presented in Chapter Four. The broader context of the case under consideration is now provided.

1.4 Context of the case

A key point in case study research is defining the boundaries and determining what is deemed important in those boundaries (Stake, 2000). Boundaries determine the unit of analysis. In this case, the geography, population, health status and socio-economic status define the boundaries of Tairawhiti. The time period is from 2001 through to and inclusive of 2010. Primary health care nurses are the social group under investigation, as are the local health services employing them. The unit of analysis defines the focus of the case as illustrated in Figure 1.

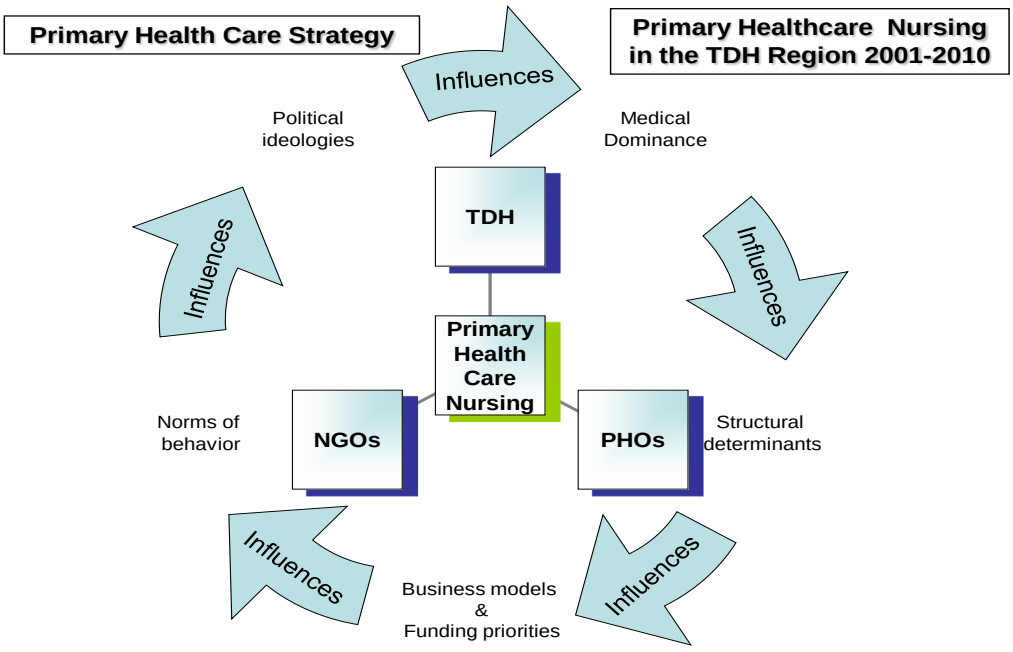

Figure 1. **Context of the case**

1.4.1 Primary health care nursing

Primary health care nurses are pivotal in promoting, improving, maintaining and restoring health through therapeutic relationships with individuals and communities. The Expert Advisory Group on Primary Health Care Nursing (2003) defined them as follows:

> Primary health care nurses are registered nurses with knowledge and expertise in primary health care practice. Primary health care nurses work autonomously and collaboratively to promote, improve, maintain and restore health. Primary health care nursing encompasses population health, health promotion, disease prevention, wellness care, first point of contact care and disease management across the lifespan (Expert Advisory Group on Primary Health Care Nursing, 2003, p.9).

Primary Health Care Nurses in Tairawhiti include public health nurses, tamariki ora (well child/plunket) nurses, practice nurses, district nurses, rural nurses, occupational health nurses, 'ear health' nurses, non-government

organisation nurses and nurses working with long-term conditions (identified as disease state management nurses in current contracts). The settings in which such nurses practice include people's homes, general practice, community clinics, schools, marae and workplaces.

The setting and ethnic/cultural grouping of the people determines the model of nursing practice (Expert Advisory Group on Primary Health Care Nursing, 2003). There are many nursing roles and a variety of titles in the primary health care context. Collectively there is a core body of knowledge and these groups have more commonalities than differences (Carryer, Dignam, Horsburgh, Hughes, & Martin, 1999; Expert Advisory Group on Primary Health Care Nursing, 2003; International Council of Nurses, 2008a). Notwithstanding this, Sheridan (2005) in her thesis that explored mapping a new future for primary health care nursing in New Zealand stated that there was "no commonly agreed core knowledge attributed to the specialty of primary health care nursing" (p.xviii).

The majority of nurses in New Zealand are employed in the public hospital with a comparatively smaller number employed outside of this setting. The distribution of nurses by their employer group in New Zealand is illustrated in Table 1 next.

Table 1. Distribution of nurses by employer group in New Zealand

Setting	*Education*	*Govt agency*	*Māori Health provider*	*Agency*	*Other*	*Primary Health care*
Number of nurses	1063	528	465	763	2831	6035
Setting	*Private hospital*	*Public Community service*	*Public hospital*	*Rest home*	*Self employed*	*Unknown*
Number of nurses	3449	4436	21457	3999	658	3768

(Source: Nursing Council of New Zealand, 2011).

A Nursing Council of New Zealand (2010) workforce survey identified there were 442 female and 31 male nurses registered as employed in Tairawhiti across a variety of settings. Practice nurses are the largest primary health care nursing group (Sheridan, 2005). They are employed to provide care to enrolled patients in a general practice setting (included in the above table under primary health care nurses).

A 2009 survey identified that in Turanganui Primary Health Organisation (PHO) there were 31 practice nurses, all were female with an average age of 46.3 years. Of these, 3 identified as Māori, 1 as Pacifica and 27 as other (Pinnacle Group Limited, 2010). A majority of the practice nurses worked part-time. The practice nurse population does not represent the population in terms of ethnicity or sex. Māori and Pacifica practice nurses remain significantly underrepresented across New Zealand. However, an annual workforce survey by Nursing Council New Zealand (2010) identified more Māori nurses specialising in primary health care throughout New Zealand. There is a drive nationally to recruit more Māori and Pacifica students into schools of nursing. This occurred in Tairawhiti with the introduction of a locally delivered nursing programme which significantly increased the number of new graduate Māori nurses. Next, the New Zealand Health Strategy as part of the contextual background is considered.

1.4.2 New Zealand Health Strategy

Changes in the policy context of health were indicated following the release of the New Zealand Health Strategy in 2000 and the Public Health and Disability Act 2000. The Act positioned population health at the forefront of the health and disability service decision-making and strengthened community input. The new look health policy intended to shift the way health services had previously been funded and delivered. The objectives included reforming primary health care, improving population health, and reducing inequalities once cost barriers for people accessing services were removed (Ashton & Tenbensel, 2010; MoH, 2001).

In 2001 the New Zealand Public Health Services Reform Act was introduced[1] that led to a number of significant changes within the health sector. This Act strengthened the government's authoritative decision-making ability with the introduction of the Ministry of Health (MoH) as the foremost agency responsible for policy advice (Quinn, 2009). In effect it was a more streamlined version of the Department of Health (Gauld, 2001). The Minister of Health was given overall responsibility for ensuring the health and disability system was effective for New Zealanders. The Minister worked through the Ministry to enter into accountability arrangements with DHBs and to set health and disability strategies. Most of the purchasing functions were transferred to 21 geographically based DHBs.

The underlying principles enunciated in the New Zealand Health Strategy include:

- Acknowledgement of the special relationship between Māori and the Crown under the Treaty of Waitangi[2]
- Promotion of good health and wellbeing for all New Zealanders throughout their lives
- Improvement in the health status of those currently disadvantaged
- Collaborative health promotion and disease and injury prevention with all sectors
- Timely and equitable access for all New Zealanders to a comprehensive range of health and disability services, regardless of their ability to pay
- A high-performing health system in which people have confidence
- Active involvement of consumers and communities at all levels (MoH, 2000).

The New Zealand Health Strategy formed part of the wider social aims of the Labour-led coalition (Minister of Health, 2006). Further priority areas were identified to ensure the health sector was directed to develop more equitable

[1] The same year as the release of the Primary Health Care Strategy
[2] The Treaty of Waitangi was signed in 1840 formalising British sovereignty.

policy and deliver the highest health benefits to the population (Barnett & Barnett, 2001). New Zealand research indicates a strong association between deprivation and health outcomes (Crampton, Salmond & Kirkpatrick, 2004; Howden-Chapman, 2005). This is consistent with international evidence that people in the lowest socio-economic groups have the poorest health (Daniels, 2004; Goldman, 2001; Graham & Power, 2004).

The New Zealand Health Strategy laid out 10 overriding goals and 61 population health objectives. Thirteen were defined as prime objectives for short to medium term implementation (Cordery, 2008). Five of these were service priorities for DHB purchasers once new funding became available. These five were:

1. Public health
2. Primary health care
3. Reducing waiting times for public hospital elective services
4. Improving the responsiveness of mental health services
5. Providing accessible and appropriate services for people living in rural areas (MoH, 2000).

The Primary Health Care Strategy and He Korowai Oranga (Māori Health Strategy, 2002) sat under the New Zealand Health Strategy, the overarching document. He Korowai Oranga was considered important for the improvement of Māori health and embraced the concept of whanau ora, validating Māori health models of holistic health care provision. In total, there were 30 health and disability strategies produced around that time (Adam, 2003). Each strategy supported the Labour-led government's social policy framework to reduce inequalities. Other more significant strategies included the Pacific Health and Disability Action Plan, New Zealand Disability Strategy, Health of Older People Strategy, Youth Health, Child Health and Te Tuhuru-Improving Mental Health 2005-2015.

This number of strategies is excessive for any government to produce and all were considered key documents in providing direction to DHBs. The linking

of these national strategies theoretically provided the platform for cohesion and integration (Sheridan, 2005). The strategies were produced with an expectation that each DHB would interpret them locally and develop their own strategic plans. The strategies, including the Primary Health Care Strategy, provided little practical guidance on how to translate them into practice (Ashton & Tenbensel, 2010). As a result, each DHB developed its own interpretation of each strategy.

1.4.3 Primary Health Care Strategy

The Primary Health Care Strategy was said to be "arguably the single most significant change for the scope of New Zealand's public system of health care since the 1940s" (Mays & Cumming, 2004, p.49). It was considered pivotal to meeting the principles, goals and objectives of the New Zealand Health Strategy (MoH, 2000). The release of the Primary Health Care Strategy signalled a change in thinking about health service delivery in New Zealand. It was more in line with the World Health Organisation's (WHO) conviction that primary health care should be an integral part of a country's health system. The WHO (2008) stated that primary health care is an effective response to health challenges that supports the values of equity, solidarity, and social justice.

Primary health care was defined in the Primary Health Care Strategy as "essential health care based on practical, scientifically sound, culturally appropriate and socially acceptable methods that are:

- "Universally accessible to people in their communities
- Involves community participation
- Integral to and a central function of New Zealand's health system
- The first level of contact with our health system" (MoH, 2001, p.1).

Primary health care covers a broad range of health improvement and preventive services such as health education and counselling, disease prevention and screening**,** generalist first-level services, mobile nursing services, community health services and pharmacy services. It includes first-

level services for maternity, family planning, sexual health, dentistry, or those using particular therapies such as physiotherapy, chiropody and osteopathy, traditional and alternative healers. Not all of these services are government funded (MoH, 2001).

Over a five to ten year period people were to be part of local primary health care services that were easy to get to and where their on-going care would be coordinated (MoH, 2001). A strong focus was on actively working to reduce health inequalities and ensuring the public health role of the primary health care workforce was fully realised. To achieve this, six key directions for primary health care were identified:

1. Working with local communities
2. Identifying and removing inequalities
3. Offering access to comprehensive services to improve, maintain and restore people's health
4. Co-ordinating care across service areas
5. Developing the primary health care workforce
6. Continuously improving quality using good information (MoH, 2001).

The Primary Health Care Strategy was intended to have a significant influence on the "number, mix, distribution, and education of the primary health care workforce" (MoH, 2001, p.22). This had previously been largely unplanned and the ratio of practitioners to clients did not necessarily match the needs of the population. It was not about the development of nursing, medicine or any other health occupational group (MoH, 2001). It was about the ability to respond to large areas of unmet need and significant areas of inefficiency in the delivery of disease prevention, health promotion and delivery of first level health service in New Zealand (Carryer, 2004).

The key priorities in the Primary Health Care Strategy for early action were to reduce barriers for groups with the greatest health needs and to improve access for first contact services. This was to be achieved through the development of Primary Health Organisations (PHOs) and the facilitation of a smooth

transition from the current state. A multidisciplinary approach to service provision and decision-making was emphasised, as was the development of Māori and Pacifica providers (MoH, 2001). Table 2 demonstrates the difference between the old approach and the new vision of primary health care.

Table 2. Differences between the vision of the primary health care approach and the old approach

Old	New
Focuses on individuals	Look at health of populations as well
Provider focussed	Community and people-focussed
Emphasis on treatment	Education and prevention important too
Doctors are principal providers	Teamwork-nursing and community outreach essential
Fee for service	Needs-based funding for population care
Service delivery is monocultural	Attention paid to cultural competence
Providers tend to work alone	Connected to other health and non-health agencies

(Source: MoH, 2001, p.6).

To summarise thus far, the launch of the Primary Health Care Strategy heralded a radical policy change to the service delivery in primary health care (Workforce Taskforce, 2008). It epitomised a new way of thinking and promised a new way forward for health service delivery in New Zealand. It had implications for the professional and business autonomy of general practice (Mays & Cumming, 2004). The Strategy signalled a bold intention to redesign the financing and delivery of primary health care service consistent with the priorities of the 1978 Alma Ata Declaration (Hefford, Crampton, & Foley, 2005) and incorporated social models of health.

The recognition of inequalities and disparities in health meant those living in lower socio-economic environments were a priority (Hefford et al., 2005). This was particularly important for Māori, the indigenous people of New

Zealand. There was also the intent to move from a fee-for-service mind-set toward a population based approach. At the same time, multidisciplinary and multisectoral collaboration was expected between numbers of stakeholders: primary and secondary care services, primary and public health services, primary and disability support services, primary and mental health service and for specific population groups (Expert Advisory Group on Primary Health Care Nursing, 2003). This approach might include nurses, doctors, pharmacists, physiotherapists, health promoters, psychologists, social workers, midwives, dieticians and community health workers (Workforce Taskforce, 2008).

The Primary Health Care Strategy is examined in greater detail in Chapter Three. Next, Tairawhiti as the case study site is discussed.

1.4.4 Tairawhiti

Tairawhiti is a unique region of New Zealand and is geographically remote, situated on the East Coast of the North Island of New Zealand. It is one of the most isolated parts in New Zealand. The boundary extends from Potaka in the north, to the Wharerata range in the south. Tairawhiti enjoys high sunshine hours and has many fine beaches enabling a relaxed outdoor lifestyle. Major industries are centered on horticulture, wine production, farming and forestry, fishing and related services. Whilst this seems idyllic, the reality for the majority of Tairawhiti residents is quite different as the following illustrates.

a. Population

Tairawhiti is the most sparsely populated area of the North Island, with a population density of 5.3 people per square kilometre (TDH, 2011). The region has 1.1% of the New Zealand population; the majority live in Gisborne city. Data from the 2006 census indicate that 44,496 people live in Tairawhiti with a relatively high Māori population of 47.3% (Statistics New Zealand, 2006). This is three times higher than in the total New Zealand population and the highest proportion of Māori for any DHB (TDH, 2011). The main Iwi tribal groups of the Tairawhiti district are Ngati Porou on the East Coast, and

Te Aitanga a Mahaki, Rongowhakaata and Ngai Tamanuhiri. These tribal boundaries are situated within the Turanganui a Kiwa/Poverty Bay district.

Māori in Tairawhiti have a younger population than non-Māori due to the higher birth rate and lower life expectancy, as is consistent throughout New Zealand. This population is expected to increase 6.9% in the next 10 years. The region has a small but growing population of Pacifica people (1.1%) and a relatively large percentage of older people and people aged 45-65 years compared with New Zealand overall (TDH, 2011).

b. Health status

Tairawhiti has a significantly higher overall mortality rate and lower life expectancy when compared with other parts of New Zealand (MoH, 2009). Māori males and females have the lowest life expectancies in the Midland region and the highest age standardised rate for all causes of mortality out of all DHBs (TDH, 2011). Māori also have the highest health needs of any ethnic group for this region.

Analysis of the health needs of people in Tairawhiti has indicated that mortality and morbidity is comparative to preventable lifestyle factors including tobacco consumption and obesity (TDH, 2011). The New Zealand Health Survey[3] undertaken annually by the Ministry of Health identified that in 2011/2012, 25.10% of children and 37.03% of adults in Tairawhiti are recorded as obese compared with 10.8% and 29.10% nationally. In Tairawhiti the number of people still smoking is 36.1% compared to 19.3% nationally and similarly there are 35.2% daily smokers compared to 17.1%.

The most common cause of death is from high rates of cardiovascular and cerebovascular disease accounting for over 40% of deaths. At the same time, there is a large and disproportionate burden of diabetes and disease of the respiratory system (including bronchitis and asthma). However, cancer is the second most common cause of death (25%) and there are high rates of mental

[3] http://www.health.govt.nz/nz-health-statistics/national-collections-and-surveys/surveys/current-recent-surveys/new-zealand-health-survey

illness. The rural population in particular has higher health needs; the overall burden of disease is far greater for Māori than non-Māori. Tairawhiti also ranks second highest in the country equal with Whanganui in terms of hazardous drinking patterns (23.7% of respondents). For the year ended December 2012, Tairawhiti recorded the highest ambulatory sensitive hospitalisations (ASH) rates in the country in the 0-74 age group[4]. Of these ASH rates, cellulitis is a significant issue for children under five years.

c. Socio-demography

The people of Tairawhiti experience the highest rates of socio-economic deprivation nationally (TDH, 2011). In the region 49% of people aged 15 years and over have an annual income of $20,000 or less, compared with 43% of people for New Zealand as a whole (Statistics New Zealand, 2006).

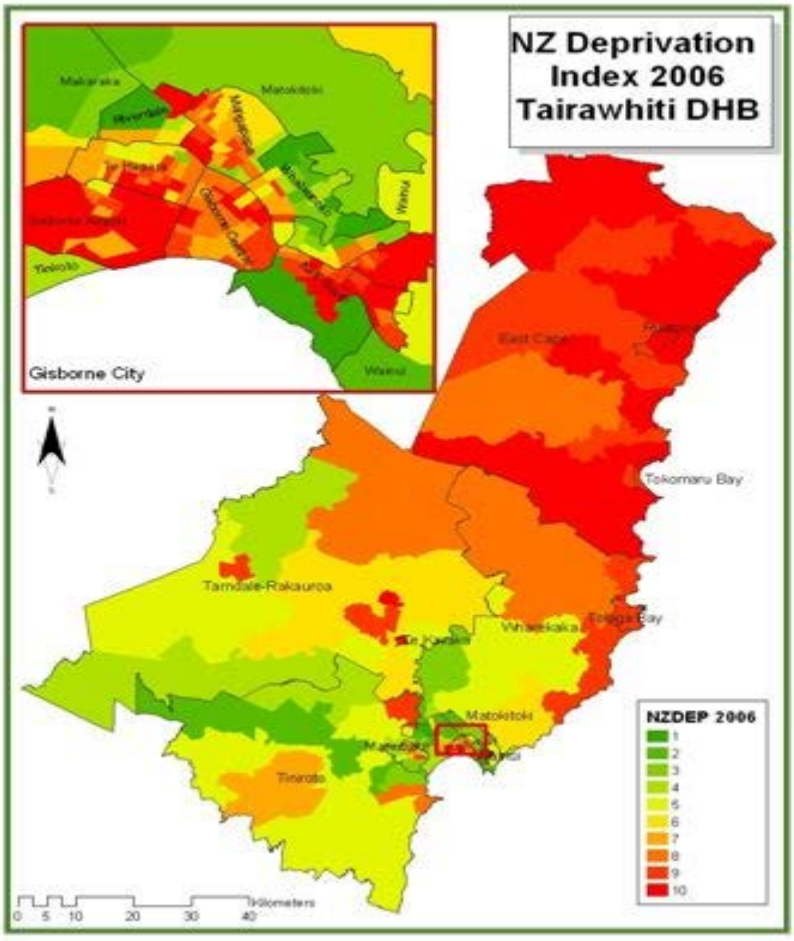

Figure 2. **Deprivation map of Tairawhiti**

[4] http://www.nsfl.health.govt.nz/apps/nsfl.nsf/pagesmh/485?Open

The Tairawhiti region has lower levels of education, lower average incomes, higher unemployment rates and higher benefit use (TDH, 2011). People in Tairawhiti are less likely to own their own home, more likely to be in a solo parent household, live in overcrowded conditions and less likely to have access to a phone or vehicle when compared to the New Zealand average. Deprivation is spread throughout the district although it is more marked in some areas. This is illustrated clearly on the deprivation map in Figure 2. Rural isolation with transport and communication difficulties and a relative lack of health services compound the complexity.

Failure to honour the Treaty of Waitangi and subsequent land confiscations has had a significant negative impact on the present socio-economic status and poor health patterns for Māori (Howden-Chapman, 1999). The tenets of the Treaty include three key principles: participation, protection and partnership. Largely ignored until the 1970s, these three principles were to become pivotal to health policy and service delivery in New Zealand (Ashton & Tenbensel, 2010).

Māori have a significant place in the New Zealand health system, not only as a Treaty of Waitangi partner, but as a population of people with distinct health needs (Durie, 2005; Love, 2003; Manaia, 2002; National Health Committee, 2002). Health inequalities are evident with Māori and Pacifica people having the poorest health (Durie, 2005; Manaia, 2002; MoH, 2010; TDH, 2012). Māori living in deprived areas live on average nine years less than those in the least deprived areas (Hefford et al., 2005). Those in deprived areas have twice the probability of being admitted to hospital for conditions that are usually amenable to early primary health care intervention (Crampton, et al., 2004; Hefford et al., 2005; Howden-Chapman, 2005; MoH, 2010; TDH, 2012).

Other significant socio-economic factors affecting health include education, knowledge, literacy, health beliefs, ethnic concordance between professional and patient, as well as professional attitude and bias (National Health Committee, 2000). The relatively high Māori population, poor health status

and low social-demographic makeup of Tairawhiti suggest this population has high primary health care need.

1.4.5 Tairawhiti District Health (TDH)

Located in Gisborne New Zealand, TDH is a crown entity established as a DHB on 1 January 2001 under the Public Health and Disability Act. TDH is responsible for funding most publicly funded health and disability support services in the Tairawhiti district as well as for locals who need these services out of the district. Central government provides the funding and the guidelines. However, it is up to each DHB to determine what health and disability support services are required and how to fund these to best meet the health and disability need of the population.

TDH's role is threefold, namely owner/governance, funder and provider of public health and disability services. TDH Board and statutory advisory committees hold responsibility for overall governance and direction of the DHB. The government set the national frameworks within which the Board must govern. The funding arm of the DHB is called Te Puna Waiora. Te Puna Waiora is responsible for assessing and undertaking appropriate service planning, funding health services according to the level of need. As a provider TDH supplies health and disability services for a large area of the East Coast of the North Island of New Zealand. Services are provided from Gisborne Hospital, the Healthy Environments/Healthy Population team, Community Mental Health facilities and rural health facilities, as well as directly to people in their homes.

TDH Board has endorsed organisational bi-cultural and Treaty of Waitangi policies which demonstrate its commitment to the needs of Māori. TDH has a governance relationship with local Iwi through Te Waiora O Nukutaimemeha (TWON). The purpose of this Māori health advisory committee is to provide guidance and direction on all aspects of Māori health within Tairawhiti. TDH has Memorandums of Understanding with Te Runanga[5] O Ngati Porou, Te

[5] Māori governing council/administrator of Māori Hapu or Iwi

Runanganui O Turanganui-A-Kiwa and the Pacific Island Community Trust.

TDH funds primary health care services and community-based care delivered through providers such as PHO, non-government organisations (NGOs), Māori health providers and disability support providers. At the time of data collection TDH owned and operated a rural nursing service and a general practice. This has since transferred to Te Hauora o Turanganui a Kiwa (Turanga Health) in April 2011. Two PHOs cover the population of Tairawhiti as outlined in the next section.

1.4.6 Turanganui PHO

During the period of data collection Turanganui PHO was one of over 90 in New Zealand. Turanga Health and Pinnacle Incorporated owned Turanganui PHO, a not-for-profit company. With an estimated enrolled population of 33,244, Turanganui PHO included six Gisborne general practices, as well as the Iwi based provider Turanga Health. The PHO provided a number of management services locally. It also purchased PHO and general practice network management services from Pinnacle Group Limited. In 2010 Turanganui PHO became part of the Midland Health Network. This followed the amalgamation of five PHOs within the Midland Region into one larger PHO.

1.4.7 Midland Health Network

Midland Health Network was established in 2010 in response to the current Health Minister's campaign 'Better, Sooner, More Convenient'[6] primary health care. The Network is made up of a team of primary health care professionals delivering primary health care to nearly 500,000 people in the central North Island. This includes Gisborne, Coromandel, Waikato, Taupo-Turangi, and Taranaki. Partners to the network include Pinnacle Incorporated, Taranaki Primary Health Provider Incorporated, Tui Ora and Turanga Health.

[6] In 2009 a new direction in health policy was introduced called 'Better, Sooner, More Convenient' (MoH, 2011).

1.4.8 Te Hauora O Turanganui A Kiwa (Turanga Health)

In 1985, Te Runanga O Turanganui-A-Kiwa (TROTAK) was established with the support and mandate of three Iwi of Turanganui-a-Kiwa: Rongowhakaata, Ngai Tamanuhiri and Te Aitanga-a-Mahaki. In the 1990s TROTAK entered into an arrangement with the then Midland Regional Health Authority (RHA) to purchase health services for Iwi and Māori in the Tairawhiti region. TROTAK established a separate health company under the name of Turanga Health to provide these services.

Turanga Health is a limited liability company with charitable trust status. The three Iwi of Turanganui-A-Kiwa are the principal shareholders. Turanga Health offers a number of services to the local community including smoking cessation, disease state management, tamariki ora (well child) and a kaumatua (older persons) programme. In 2010 they were successful in a tender to own and operate the Western rural health services, subcontracting the general practice service to an existing Gisborne based practice within the Midland Health Network. This transition was completed in July 2011.

1.4.9 Ngati Porou Hauora PHO

Ngati Porou Hauora was recognised by District Health Boards New Zealand (DHBNZ) (2009) as a leader in community health services. The whanau (family) and hapu (sub-tribe) of Ngati Porou established Ngati Porou Hauora, a process that began in 1994. The key drivers for the establishment included rural isolation, the strong desire for self-determination and the need to ensure services were appropriate to the people (DHBNZ, 2009). The health facilities and assets were transferred from the then Area Health Board (AHB) to Ngati Porou Hauora in 1999. Ngati Porou Hauora became a PHO in 2002 and is one of two PHOs in Tairawhiti. Fortunately it required little structural change in the transformation to a PHO as its philosophical underpinnings were congruent with the Primary Health Care Strategy (DHBNZ, 2009). Ngati Porou Hauora holds special area doctor status which means there was no charge for health services on the East Coast, although a fee is required for attendance at the two Gisborne-based clinics.

1.4.10 Non-government organisations (NGOs)

An extensive range of health and social organisations have developed in New Zealand (New Zealand Parliament, 2009). Most NGOs are non-profit organisations that actively fundraise to support the functioning of their organisation to provide services. They are a valuable contact within the community and

> have a special role in identifying and resisting the capture by vested interests of regulatory bodies charged with protecting the public interest. By contracting with the voluntary sector, government may achieve health gains which may not be possible through direct state intervention (Crampton, Hoek, & Beaglehole, 2011, p.66).

NGOs have a complementary role to the government sector and cater for minority populations as well as representing a vehicle for indigenous self-determination. A number of NGOs in New Zealand are Iwi based organisations and partner to a PHO as in the case of the previously mentioned Turanga Health. The NGOs of significance for this study are those where primary health care nurses are employed. These include Plunket, Cancer society and Gisborne Stroke. The next section outlines the structure of this thesis.

1.5 Structure of the thesis

Chapter One: A brief introduction situates the thesis before outlining the rationale and intent of the study. A précis of the theoretical constructs is presented as well as the methodology. The context and background to the study is discussed with reference to the New Zealand Health Strategy, a brief introduction to the Primary Health Care Strategy, and an overview of Tairawhiti as the case site.

Chapter Two: The chapter presents the diffusion of innovation theory (Rogers, 2003; Greenhalgh et al., 2004, 2005). This theory seeks to explain

how, why, and at what rate new ideas are spread through cultures and it provided a model that enabled me to make sense of data collected during the investigation.

Chapter Three: This chapter critiques selected literature on primary health care before exploring the nursing fit within the Primary Health Care Strategy. The tensions associated with the Strategy are articulated. External factors that influenced implementation were examined including the shift in political preferences following the 2008 national elections and biomedical influences. The chapter concludes with a summary of the Strategy's implementation.

Chapter Four: The thematic research schema is provided in this chapter and includes the epistemological, ontological and philosophical location of the thesis. Case study, as the methodology, is also presented.

Chapter Five: In this chapter the investigative processes employed to undertake this research are described. Insider research, ethical issues, cultural considerations, data collection and analysis, trustworthiness of the data, and the intention to disseminate the results are explained.

Chapter Six: This is the first of three chapters that discusses the findings emerging from analysis of the interview, focus groups and document audit data. At the heart of this chapter is examination of the attributes of the Primary Health Care Strategy. The chapter examines themes of the local propensity to act, the development of a local primary health care plan, the Strategy as the innovation and local diffusion processes.

Chapter Seven: Multiple layers of resistance are explored in this chapter. The resistance was both covert and overt across all levels of the health sector including resistance from organisations and general practitioners (GP). Limited engagement by nurses and reform weariness was examined.

Chapter Eight: The focus of this chapter is examination of the changes that occurred for primary health care nursing in Tairawhiti. I use the five goals

identified in the *Investing in Health* document provided by the Expert Advisory Group on Primary Health Care Nursing (2003) as the framework. The drivers behind the changes and the barriers that prevented the full utilisation of the primary health care nurse workforce in Tairawhiti form the basis of this chapter.

Chapter Nine: This concluding chapter discusses the findings in relation to current literature and critical reflections on the Primary Health Care Strategy implementation. Limitations of this research and opportunities for further research are included, as are recommendations for moving forward in primary health care.

1.6 Concluding statement

The purpose of this chapter was to position the thesis. It began with a brief introduction that was followed by the rationale and intent of the study and conceptualisation of the research questions. The context of the case was described in detail and boundaries identified. Primary health care nursing was defined along with a snapshot of Tairawhiti and its people. An overview of the DHB and local primary health care providers was then provided. To conclude, a synopsis of the following chapters was presented. The background to this study is now complete. The next chapter explores information on the diffusion of innovation theory that underpinned my guiding framework.

Chapter Two: The diffusion of innovation theory

2.1 Introduction

The previous chapter provided the background and context to the case under investigation. The diffusion of innovation theory is now presented as the conceptual framework informing this research. This framework facilitated the location of the meaningful components of the impact of the Primary Health Care Strategy's implementation on the nursing workforce in Tairawhiti. The principle underpinning the diffusion of innovation theory is explanation of how, why, and at what rate new ideas are spread through cultures. The diffusion of innovation theory has seldom been used by nurse researchers.

Traditionally, innovation has been defined as a linear process (Cameron, 2011). This simplified view does not take into account the complexities of the social system when introducing new policy. This is particularly so for policy requiring a significant paradigm shift as was the case following the release of the Primary Health Care Strategy. The diffusion of innovation theory highlights the complexities involved when an organisation adopts a particular innovation. In health systems, each organisation has its own political, social, cultural, technological and economic characteristics (Greenhalgh et al., 2005). It was these complexities I wanted to understand in order to determine the barriers to, and opportunities for, the effective deployment of primary health care nurses in Tairawhiti.

The chapter begins with the rationale for the use of the diffusion of innovation theory followed by a brief history before an overview of the theory is presented. Detail is then provided on innovation, communication, time, and the social system as the four main elements identifiable in every diffusion research study. This is followed by an exploration of adopter categories before discussion of potential consequences of innovation adoption. My guiding framework is then presented as the approach informing this study informed by

both Rogers (2003) and Greenhalgh et al. (2004, 2005). The chapter concludes with disadvantages in using this theory.

2.2 Rationale for diffusion of innovation theory

In conceptualising this thesis I considered using feminist theory and critical social theory as my theoretical lens given well documented gender inequalities in nursing and multiple layers of dominant discourses in the health system (Blue & Fitzgerald, 2002; Gough & Richards, 1998; Harvey, 2011; Mills & Hallinan, 2009; Piji-Zieber, 2013). I also explored organisational theory on formal social organisations and their interrelationship with the environment in which they operate. These theories did not provide for in-depth analysis of the complexities involved in implementing a significant paradigm shift expected by the Primary Health Care Strategy.

I then considered Lewin's Theory on the change process in human systems. Conceptualised as having three components (unfreezing, moving and refreezing), change consists of altering the driving and resisting forces that facilitate movement to a new equilibrium (Burnes, 2004). However, this theory did not explain what influenced each component. Complexity theory on the other hand, considers organisation as complex systems that operate on the edge of chaos and respond to changes in the environment through self-organising change.

Both theories had a limited focus on the attributes of the innovation and would not have supported finding answers to the questions I posed. The rationale being that structures, processes, and patterns associated with innovation in other industries are more supportive of creative generation of improvement ideas than are those in health care. The introduction of innovations to health care requires insight into determinants that may facilitate or impede the introduction, in order to design an appropriate strategy for introducing the innovation (Fleuren, Wiefferink & Paulussen, 2004). Multiple elements shape the speed, intensity, and types of innovation impacts since health care presents high degrees of complexity (Cucciniello & Nasi, 2014). However, without change, current health care delivery will remain constant (Block, 2013).

I then decided to explore the foundational element of diffusion and the term innovation. Innovation has become increasingly popular and is a key component of policy and strategy (Shafique, 2013) and a quintessential feature of commercial, political, economic, and business development (Courvisanos, 2009). It also "continues to be a driver of economic growth at the societal level and a performance differentiator at the industry and firm level" (Gianiodis, Ettlie & Urbina, 2014, p.88). However, not all organisations are oriented towards innovation, especially in organizations structured to reward people for occupying their post rather than thinking creatively about how to improve it (Morris, 2013). Innovation can also mean different things to different people and organisations; it is challenging to provide a single definition covering all its aspects, concerns and objectives (Akenroye, 2012).

There are different classifications and taxonomy of innovations leading to confusion between different types (Abayomi, 2011). Innovation can mean improving products and services, often referred to as continuous or incremental innovation and reinforces benefits of prior significant innovation with minimal new investment (Courvisanos, 2009). Radical and disruptive innovations are distinct types of innovation (Govindarajan, Kopalle, & Danneels, 2011). A radical innovation is one that requires a major breakthrough or discovery or transformation and makes a significant impact on the entire organisational structure (Akenroye, 2012). Disruptive innovation theory helps describe innovations that improve a product or service or understanding the concept of the value network (Hwang & Christensen, 2008). It is a term used to describe innovation that is of a highly discontinuous or revolutionary nature, the opposite of evolutionary or incremental innovation (Thomond & Lettice, 2002).

Christensen's disruptive innovation originally focussed on disruptive technologies (Markides, 2006) and expanded to include disruptive business models. Markides (2006) states disruptive business models redefine an existing product or service provided to the customer. In contrast, a sustaining innovation does not create new markets or value networks but rather only evolves existing ones with better value. Sustainability is defined as the

innovative and potentially transformative activities that generate more sustainable technological and institutional systems, as well as processes (Larson, 2000., Foxon & Pearson, 2008). Other innovations might be referred to as rupture, breakthrough, or discontinuous thus seeking to make products and services dramatically different and better, or to establish new standards (Morris, 2013).

As the Primary Health Care Strategy had the potential to redefine a service it was potentially an example of a disruptive business model. Despite this, I decided on the use of the diffusion of innovation theory as it provided a clearer identification of the multiple factors that affect the diffusion process. The diffusion of innovation theory also embraced the social-construction element allowing for exploration of the complexities of social dimensions of change. The potential to provide greater understanding of motivations for adoption or non-adoption of all or parts the Strategy was appealing. It was also important for me to appreciate attributes of the strategy from the participant's perspective as well as how information on the proposed change was diffused across the health sector. Taking into account system antecedents, the diffusion of innovation theory was able to answer my what, how and why questions. Examination of this theory begins with its historical beginnings as followed next.

2.3 Historical beginnings

Rogers (2003) traced the beginnings of diffusion theory to Europe over a century ago at a time when sociology and anthropology were emerging as new social sciences. Frenchman Gabriel Tarde, a forefather of sociology and social psychology, observed certain characteristics associated with the adoption of innovations that he called "the laws of imitation" (Rogers, 2003). Tarde (1962) believed it was important to learn why, out of a hundred innovations conceived, only 10 will be adopted and the other 90 will be forgotten. Tarde introduced the S shaped curve as illustrated in Figure 3 (p.29), as well as the concept of opinion leadership. Although Tarde did not specify or clarify key diffusion concepts, his insights affected the development of many social science disciplines such as geography, economics and anthropology.

Forty years later the infamous Ryan and Cross 'hybrid corn study' was researched (cited in Rogers, 2003). Rogers (2003) considered this the most influential of all diffusion studies. There were a number of diffusion studies completed in the 1920s and 1930s but it was this seminal study of the hybrid corn seed in 1941 that "influenced the methodology, theoretical framework and interpretations of later students" (Rogers, 2003, p.55). The 'hybrid corn study' investigated the social factors in the economic decision-making that influenced Iowa famers to adopt a new corn hybrid known to increase the harvest yield. One of the first qualitative approaches to data collection in diffusion research, the investigation sought information as to why, despite the obvious advantages, some farmers began using this seed and others not up until four years later. Rogers (2003) contends this study left an indelible mark on the history of all diffusion research that encouraged future researchers to consider other variables relating to innovation.

Over the years, the scope of diffusion research broadened as more disciplines became involved and as the theory was applied to studying a broader range of innovations. Some of the key areas of development were in rurality, medical sociology, communication, marketing, technology and economic specialties (Greenhalgh et al., 2005). Greenhalgh et al. (2004, 2005) especially, contributed significantly to diffusion of innovation in health service delivery.

2.4 Overview of the diffusion of innovation theory

Diffusion of innovation means different things to different groups of scholars (Greenhalgh et al., 2005). Rogers (2003) stated classical diffusion of innovation research is a body of knowledge that demonstrates people in a social system have a consistent pattern of adoption of new ideas over time. At its most elementary form, the diffusion process involves:

1. An innovation
2. An individual or unit of adoption that has the knowledge or experience in using that adoption
3. Another individual who does not have that experience or knowledge
4. A communication channel connecting the two units (Rogers, 2003).

The central tenet of the diffusion of innovation theory is that the adoption of a new idea follows a predictable pattern. Most innovations have an S shaped rate of adoption with variations in the slope of the S. At first only a few individuals adopt the innovation in each time period, that number then climbs as more individuals adopt. The curve accelerates to a maximum until half of the individuals in a system have adopted the innovation. Eventually, the trajectory of the rate of adoption begins to level off as fewer individuals remain who have not yet adopted the innovation. Finally the S shaped curve reaches its asymptote and the diffusion process is finished. The propensity to act is high initially but decreases as the majority of people adopt an innovation (Robinson, 2009). This is illustrated in Figure 3.

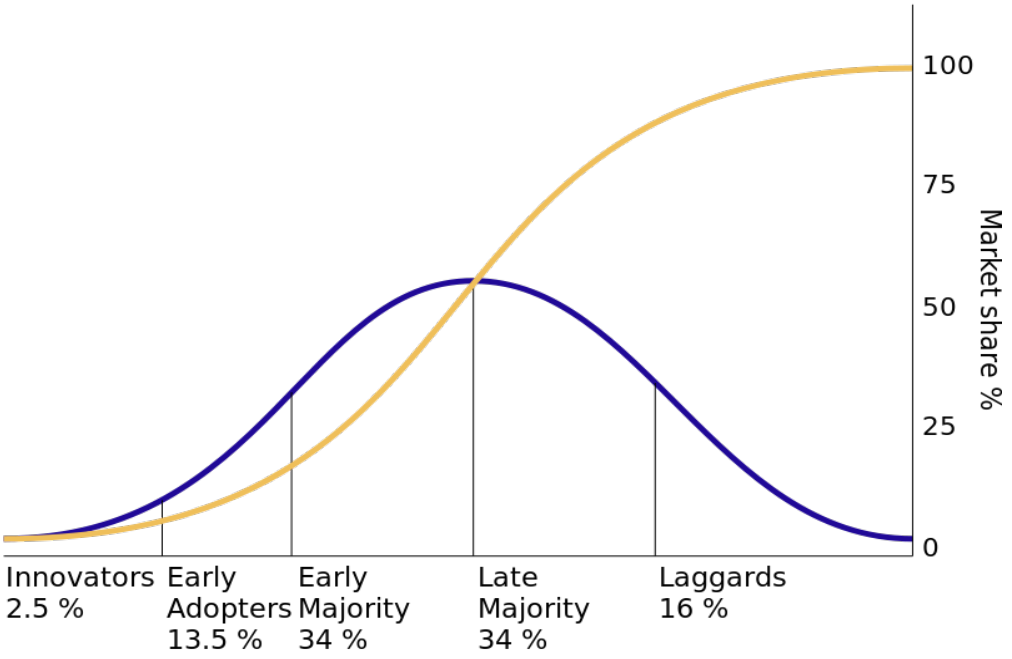

Figure 3. **Bell shaped curve with adopter categories (**Source: http://en.wikipedia.org/wiki/Diffusion_of_innovations, n.d.)

A crucial concept in understanding the social nature of the diffusion process is the critical mass in the number of people adopting the innovation. It is the point after which further diffusion becomes self-sustaining (Rogers, 2003). Rogers and Shoemaker (1971) called this the diffusion effect or the cumulative increasing degree of influence upon an individual to adopt or reject an innovation in a social system.

The assumptions of the diffusion of innovation theory are based on the nature of growth in a closed system where the population is fixed and the influence of the population stays constant over time. When there is a rapid population turnover, an infusion of new people, loss of former members, or a change in the market or value of the innovation, the shape of the curve will change (Rogers, 2003). Natural growth is sufficient to describe the shape of the adoption curve but it does not tell us why some people adopt an innovation early, while others adopt it much later or never at all (Greenhalgh et al., 2005). The complexity of process-based innovations in a service organisation should not be over generalised.

Marred with setbacks and surprises along the way, organisations move back and forth between the initiation, development, and implementation of an innovation (Greenhalgh et al., 2004). An innovation is successfully diffused when large numbers of people using the innovation make fundamental changes to the way they practice (Szabo, 2002). Sustainability is a term rarely used in the mainstream literature on diffusion of innovations as it presupposes implementation and implies resistance to further innovation in that area (Greenhalgh et al., 2005). Instead, an organisation moves through a period of equilibrium when the best way of operating becomes more widely accepted (Hayes, 2007). However, not all innovations reach a stage of action and the reasons are neither recognised nor explored (Sarason, 2004).

According to Greenhalgh et al. (2005), dictating the adoption of an innovation is not necessarily conducive to adoption. Implementation of the Primary Health Care Strategy for example, was a directive from the MoH, the principal agency responsible for health policy (Quinn, 2009). This is what Rogers (2003) termed an authoritative innovative decision where the choice whether to adopt or not is made by a few individuals who possess the power status and expertise in a system.

There is little knowledge of the way all the components of decision-making are combined to progress though the diffusion process (Cameron, 2011). Likewise, Sarason (2004) stated that information is not depicted on what

components of the adoption process are successful. Consequently, Cameron (2011) argued that we need "to explore, understand and debate this process to allow for replication of the successful processes" (p.26). It is this information that may assist in informing future work on policy implementation.

2.5 Four main elements

Rogers (2003) identified four main elements identifiable in the diffusion process: innovation, communication, time, and the social system.

2.5.1 Innovation

Greenhalgh et al. (2005) defined innovation in health service delivery as a "novel set of behaviours, routines and ways of working, which are directed at improving health outcomes, administration efficiency, cost-effectiveness or the user experience, and which are implemented through planned and coordinated action" (p.20). The authors recognised that this definition is not perfect as it implies the innovation is an event rather than a process of continuous change. The intent of any innovative course of action is to discontinue previous practice through increasing administrative efficiency, being more cost effective, improving the user's experience, or improving outcomes (Greenhalgh et al., 2005).

The perceived newness of the idea for an individual determines their reaction to it (Rogers, 2003). The innovation may have been known to a person for some time, but they had not yet developed a favourable or unfavourable attitude. The "newness of an innovation may be expressed in terms of knowledge, persuasion, or a decision to adopt" (Rogers, 2003, p.12). Olatokun and Igbinedion (2009) labelled this as an attitude construct or the degree to which a person has a favourable or unfavourable appraisal of an innovation.

Not all innovations are equivalent units of analysis (Rogers, 2003). Instead, Rogers (2003) offered the following five characteristics of an innovation that are the most important in explaining the different rates of adoption: relative advantage, compatibility, complexity, trialability and observability. Individual

perceptions of innovations with greater relative advantage, compatibility, trialability, observability and with less complexity are more likely to be adopted. Relative advantage is the degree to which an innovation is perceived as being better than the idea it superseded. The greater the perceived relative advantage of an innovation, the more rapid the adoption rate will be. However, relative advantage on its own does not guarantee widespread adoption (Greenhalgh et al., 2004; Rogers, 2003).

Compatibility refers to the measure of which an innovation is perceived as being consistent with the existing values, past experiences and needs of potential adopters (Rogers, 2003). Innovations that are compatible with the values and norms of a social system are more likely to be adopted than innovations that are incompatible. Complexity on the other hand, is the degree to which an innovation is perceived as difficult to understand and use (Rogers, 2003). Members of a social system comprehend some innovations as being more complicated and therefore adopt them more slowly. Practical experience, demonstration and/or when an innovation is broken down into more manageable parts can reduce perceived complexity (Greenhalgh et al., 2004).

The term trialability is used when an innovation is modified and experimented with. When an innovation is trialled it represents less uncertainty to the individual who is considering it for adoption. Alternatively, observability is the extent to which results of an innovation are visible to others. The easier it is for an individual to see the results of an innovation, the more likely it will be adopted (Rogers, 2003).

Reinvention was eventually added to the list of characteristics (Greenhalgh et al., 2005). Initially it was assumed that an innovation "was an invariant quality that did not change as it diffused" (Rogers, 2003, p.17). Rogers (2003) defined reinvention as the degree to which the user changes or modifies an innovation. Reinvention increases the likelihood that the innovation will be adopted more easily. Some innovations, such as corn seed cannot be reinvented, whereas others, such as the Primary Health Care Strategy, are more flexible in nature.

Other attributes have been added to the list of characteristics that support or impede adoption. These include fuzzy boundaries, risk, task issues, the knowledge required to use the innovation and augmentation or support (Greenhalgh et al., 2004). Complex innovations in service organisations have what Greenhalgh et al. (2004, 2005) termed “fuzzy boundaries”. They are made up of a hard core, or the irreducible elements of the innovation itself. There is also a soft periphery, or the organisational structures and systems required for the implementation of the innovation. The soft periphery links with the aforementioned concept of reinvention. “System fit” is an important feature which signals an innovation is ready to be adopted.

There is an amount of risk or uncertainty in adopting an innovation. If the individual identifies the risk as high, it is less likely that the innovation will be adopted (Greenhalgh et al., 2004). Additionally, if an innovation improves task performance it also increases the chance of adoption. Task issues are those with relevance to a person’s work. When an innovation can be codified and transferred from one context to another, then the innovation will be adopted more easily. Greenhalgh et al. (2004) identified this as the knowledge required to use the innovation. Augmentation includes the notion that an innovation will be adopted more easily if support such as training is provided.

2.5.2 Communication

Communication must take place if the innovation is to spread. Diffusion is a particular type of communication in which the message content that is exchanged is concerned with new ideas and is spread to the members of a social system (Rogers, 2003). Diffusion focuses on bringing about overt behaviour change in the adoption or rejection of a new idea as opposed to changing attitudes. As discussed earlier, in its most elementary form the diffusion or communication process involves:

1. An innovation
2. An individual or unit of adoption that has the knowledge or experience in using that adoption
3. Another individual who does not have that experience or knowledge

4. A communication channel connecting the two units (Rogers, 2003).

Sanson-Fisher (2004) suggested that diffusion communication is usually more effective when there is a high degree of professional resemblance between those people attempting to introduce the innovation and the recipient. For example, doctors introducing an innovation to other doctors. The different conceptual and theoretical bases for the spread of innovation in service based organisations are illustrated in Figure 4.

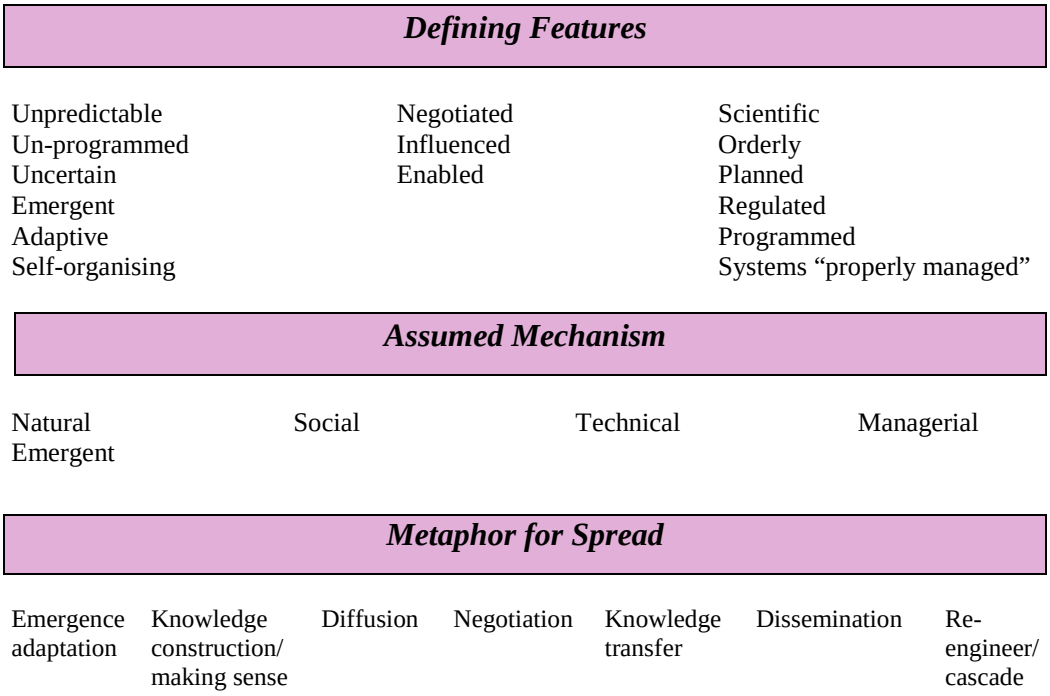

Figure 4. **Different conceptual and theoretical bases for the spread of Innovation in service organisations** (Source: Greenhalgh et al., 2004, p.593).

The factors that influence the spread of communication are on a continuum between pure diffusion and active dissemination (Greenhalgh et al., 2004). Greenhalgh et al. (2005) defined pure diffusion as the spread of an innovation that is usually peer mediated, unplanned, informal, and decentralised. Alternatively, active dissemination is planned, formal, centralised and most likely to occur through vertical hierarchical structures. In other words letting it happen, helping it happen, or making it happen. The results are determined by the effort put into the dissemination process.

2.5.3 Time

One of the strengths of diffusion research is the measurement of time (Rogers, 2003). Diffusion scholars recognised that an individual's decision about an innovation is not an instantaneous act but that it is a process that occurs over time and consists of a series of different actions. The time dimension involved in the diffusion process can involve three components:

a. The innovation decision process
b. Innovativeness
c. An innovation's rate of adoption (Rogers, 2003).

a. The innovation decision process

This is the process through which an individual passes from receiving their first knowledge of an innovation to the formation of an attitude as to whether to adopt or reject the use of a new idea through to the acceptance of the innovation. Rogers (2003) conceptualised these processes in five phases: the knowledge, the persuasion, the decision, the implementation and the confirmation.

The knowledge phase occurs when an individual/unit is exposed to an innovation and gains an understanding of how it functions. Within the knowledge phase there are three types of knowledge: "awareness" knowledge, "how to knowledge" and "principles" knowledge (Rogers, 2003). The persuasion phase is attitude formation and change on the part of an individual/unit, as opposed to communication with the intent to induce attitude change. In this phase people seek innovation evaluation information that might reduce some of the uncertainty about expected outcomes. The decision phase takes place when an individual/unit engages in activities that lead to the adoption or rejection of the innovation. Rejection can be either active or passive and represents quite different types of behaviour. Rogers (2003) states it is active when an individual considers using the innovation but then decides not to use it, or passive when they did not consider using it in the first place.

The implementation phase occurs when an individual/unit puts a new idea into practice. Confirmation then eventuates when an individual/unit seeks reinforcement of an innovation-decision already made. When the benefits of the innovation are recognised, it is integrated into on-going routine as well as being promoted to others (Rogers, 2003). The five stages in the information decision process are illustrated in Figure 5.

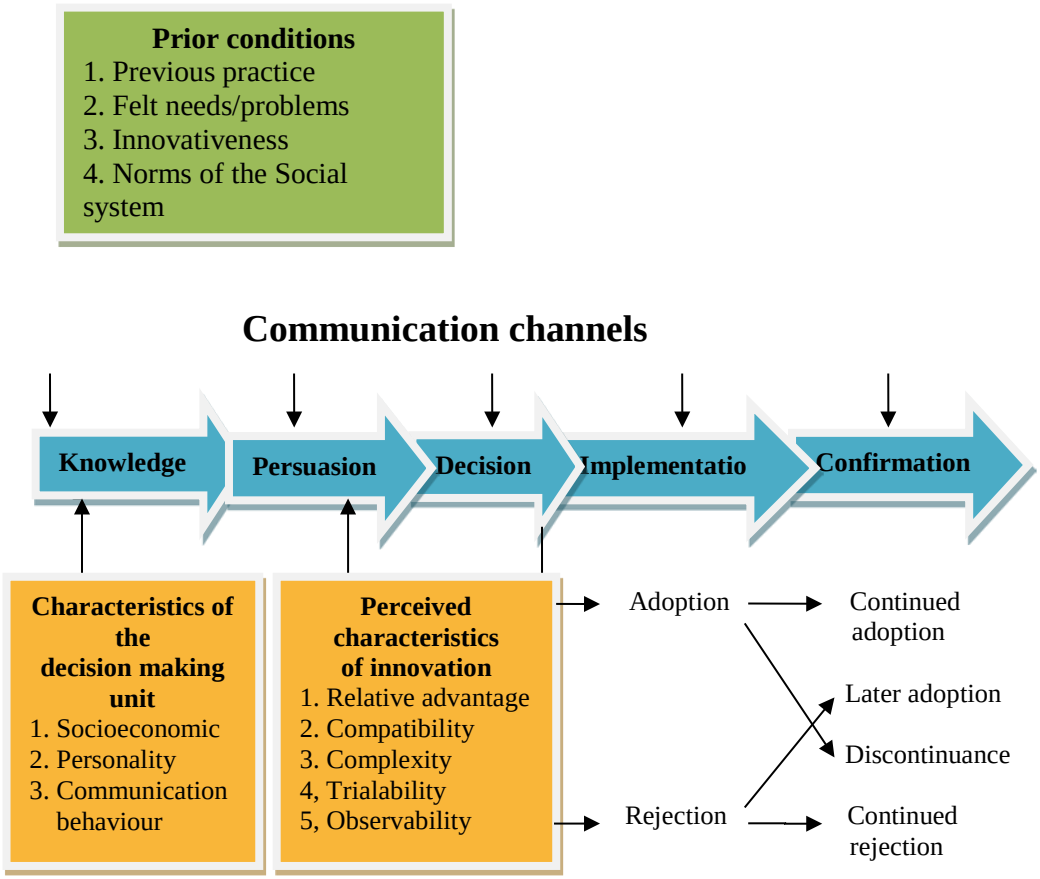

Figure 5. **A model of five stages in the information decision process (**Source: Rogers, 2003, p.170).

b. Innovativeness

Not all individuals or organisations adopt an innovation at the same time. Greenhalgh et al. (2005) identified determinants of organisational innovativeness or system antecedents rather than individual innovativeness. The authors include the size of the organisation, structural complexity, leadership, receptive context for change and initiatives to enable and support

knowledge manipulation. Greenhalgh et al. (2005) reiterated this is not a comprehensive list, but represents the determinants most widely studied as illustrated in their conceptual model illustrated in Figure 6 (p.40).

Alternatively, Rogers (2003) wrote of individual innovativeness which he defined as the degree to which an individual adopts a new idea compared with other members within a system or organisation. The author stated adopters have distinct characteristics depending on their socio-economic status, personality, communication, behaviour and so forth. This allows individuals to be classified into adopter categories on the basis of when they first began using the new idea: innovators, early adopters, early majority, late majority and laggards. These adopter categories were illustrated in the bell shaped curve in Figure 3 (p.29).

Innovators are venturesome people whose interests in new ideas tend to lead them out of a local circle of peer networks into what Rogers (2003) termed "more cosmopolite social relationships" (p.282). As risk takers, innovators are important for launching new ideas. They must be able to cope with a degree of uncertainty about an innovation at the time he or she adopts and must be willing to accept the occasional setback that inevitably happens.

Early adopters follow innovators in the uptake of innovations and are more integrated into their local social system than innovators. Respected by their peers, early adopters have the highest degree of opinion leadership in the majority of social systems. Potential adopters look to these early adopters for advice and information about an innovation and serve as role models. They decrease uncertainty about the innovation through adoption then convey a subjective evaluation of the innovation to peers through interpersonal networks. The early adopters thus put their stamp of approval on new ideas (Rogers, 2003).

The early majority adopt new ideas before the average member of a social system and interact frequently with their peers. However, they seldom hold positions of opinion leadership in a system. Because of where they sit, the

early majority are an important link in the diffusion process and provide interconnectedness in the system's interpersonal networks. They make up one third of all members of a system (Rogers, 2003).

The late majority make up another third of the members of a system. The late majority do not adopt new ideas until after most others in a system have already done so. They tend to be sceptical and cautious, requiring pressure from peers to motivate their adoption (Rogers, 2003). Most of the uncertainty must be removed before a late majority feels that it is safe to adopt. The late majority are not the last people in a system to adopt, laggards are.

Laggards are well behind with awareness of an innovation in a system. The innovation-decision process is lengthy for the laggards who tend to be suspicious of innovations as well as change agents. Resistance to innovation is rational from the laggard's viewpoint as their resources are usually limited. Laggards need to be certain an innovation will not fail before proceeding (Rogers, 2003). With no opinion leadership, laggards generally interact primarily with people with traditional values.

However, Greenhalgh et al. (2004) disagreed with the adopter categories proposed by Rogers (2003). The authors argued there is little empirical evidence to support these "stereotypical, value laden terms" (p.598). Further, the categories fail to acknowledge the adopter as an individual who interacts purposely and creatively with an innovation: "people are not passive recipients of an innovation" (Greenhalgh et al., 2004, p.598). Instead, the authors suggest that people seek out innovations, experiment with them, evaluate them, find or fail to find meaning in them, challenge them, develop feelings about them either positively or negatively, modify them and so forth.

Greenhalgh et al. (2004) propose seven aspects of adopters and the adoption process: general psychological antecedents, context specific antecedents, meaning, the adoption decision, concerns in preconception stage, concerns during early use, and concerns in established users. General psychological antecedents or individual traits are those associated with the propensity to try

out and use innovations, for example tolerance, motivation and learning styles. Greenhalgh et al. (2005) suggest these characteristics should be examined more as researchers largely ignore them.

Context specific antecedents include the notion that where a person is motivated to use a particular innovation, they are more likely to adopt it. The meaning of an innovation to the intended adopter influences their adoption decision and is not independent from other decisions. If the meaning to an individual matches that of management, stakeholders and services users, then it is more likely that the innovation will be assimilated. As mentioned previously, authoritative approaches or dictating the adoption of an innovation is not conducive to assimilation. The decision is more of a process rather than an event (Greenhalgh et al., 2005).

Concerns in the pre-adoption stage relate to the awareness of an innovation, having sufficient information about the innovation, being clear on how to use it and understanding how it may affect the adopter personally. Concerns in the early implementation phase include the notion that successful adoption is more likely when there is sufficient access to information, training and support. Greenhalgh et al. (2004) stated successful adoption is more likely if adequate feedback is provided to intended adopters about the consequences of adoption. Adoption is further increased when there is autonomy and support to adapt and refine the innovation to improve its fittingness. Figure 6 illustrates the determinants of diffusion, dissemination and implementation of an innovation in health service delivery.

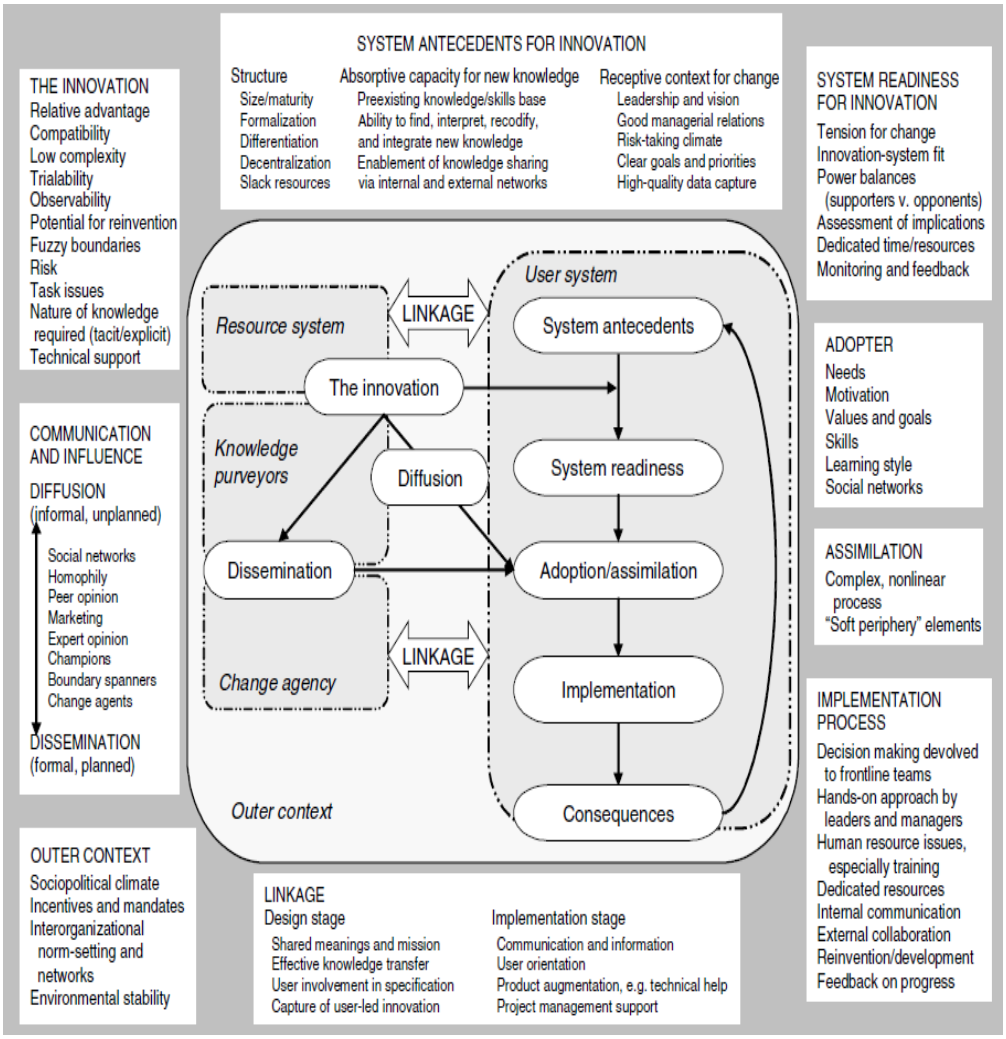

Figure 6. **Conceptual model for considering the determinants of diffusion, dissemination and implementation of innovations in health service delivery and organisations** (Source: Greenhalgh et al., 2004, p.595).

The model was developed from Greenhalgh et al.'s, 2004 systematic literature review of the diffusion of service innovations. It combines a large amount of diverse literature into a unifying model and demonstrates the complexity of implementing innovations in health service organisations. It validates strong links among the determinants of diffusion, dissemination and implementation. Numerous parts of this model are utilised in my guiding framework as discussed later in this chapter. A number of the factors may be predictable and can be planned for. Equally so, there are numerous influences that are difficult to foresee and are not considered prior to the implementation process.

c. Rate of adoption

Innovations diffuse at a slow rate from the time they become available to the time they are adopted (Rogers, 2003). Rogers (2003) defined the rate of adoption as the speed with which members of a social system adopt an innovation. It is generally measured as the number of individuals who adopt a new idea in a specified period. The perceived attributes of the innovation explain the rate of adoption. The more people involved in making the innovation adoption decision, the slower the rate of adoption will be. As was illustrated in Figure 2, when the cumulative number of adopters is plotted the result is the distribution on an S shaped curve.

In addition, Greenhalgh et al. (2005) identified inner and outer context determinants as influencing an organisation's rate and spread of adopting an innovation. Within the inner context there is a hard medium of visible and measurable organisational structures and a soft medium of culture and ways of working. The outer environments also influence organisational innovativeness, taking into account the extent and quality of the external organisational networks and linkages. The fourth and final element identifiable in diffusion research is the social system and is discussed next.

2.5.4 Social system

Social systems are complex and classified as a set of interrelated units engaged in joint problem solving to accomplish a common goal (Rogers, 2003). Different organisations have varying contexts for innovations and while amenable to innovations, they may not be ready or willing to assimilate a particular innovation. It is the culture within a social system that determines system readiness to adopt an innovation (Greenhalgh et al., 2005; Rogers, 2003). Flat hierarchical structures and strong leadership committed to effective change, enable systems to respond more easily and quickly to an innovation (Sanson-Fisher, 2004). Sanson-Fisher (2004) further stated that bureaucratic health systems with their hierarchical configurations and separate organisational arrangements for each professional group tend to be a hindrance to rapid change.

Diffusion research suggests that most individuals do not evaluate an innovation on the basis of scientific study but are influenced more by the opinion from other individuals like themselves who have already adopted the innovation (Greenhalgh et al., 2004; Rogers, 2003). This suggests that at the heart of the diffusion process is potential adopter modelling and initiation of network partners who have also previously adopted. Therefore, individual innovativeness is affected "both by an individual's characteristics and by the nature of the social system in which the individual is a member" (Rogers, 2003, p.26). This is illustrated by the resistance to the diffusion of medical and health technologies or different modes of service delivery (Stanton, 2002). Stanton (2002) stated resistance is often not based on the claim of 'evidence', but on what the professionals have to say about the innovation.

The transfer of ideas occurs most frequently between two individuals who are similar or homophilous (Rogers, 2003). Homophily occurs when individuals belong to the same groups, live and/or work near each other and share similar interests. The attributes of similarity include beliefs, education, culture, gender, and socio-economic circumstances. When people "share common meanings and mutual subcultural language, and are alike in personal and social characteristics, the communication of new ideas is likely to have greater effects in terms of knowledge gain, attitude formation and change, and overt behaviour change" (Rogers, 2003, p.19).

Homophily can also have the opposite effect and act as a barrier to the rapid flow of innovations, essentially slowing down the rate of diffusion. New ideas usually enter an organisation through individuals with a higher status and if a high degree of homophily is present, then these elite individuals may only interact with each other. As a consequence, the innovation is spread horizontally rather than vertically throughout an organisation (Rogers, 2003). For example, doctors usually have a higher status and do not necessarily pass the innovation information down to nursing staff. Alternatively, opinion leaders provide advice and information to many individuals in a social system.

Rogers (2003) defined opinion leadership as the "degree to which an individual is able to influence other individual's attitudes or overt behaviour informally in a desired way with relative frequency" (p.27). Opinion leadership is earned and maintained through an individual's competence, social accessibility and conformity to a systems norm (Rogers, 2003). In order for opinion leaders to spread messages about an innovation they must have extensive interpersonal networks and be at the centre of the communication network (Grimshaw et al., 2006). At a basic level, opinion leaders serve as models for the followers.

Opinion leaders can positively encourage adoption or negatively slow down diffusion and prevent adoption if that innovation is considered undesirable (Greenhalgh et al., 2004). Because of their influence, the authors warned against failing to identify the true opinion leader. Greenhalgh et al. (2005) also distinguished between the monomorphic opinion leader (influential for a particular innovation only) and the polymorphic opinion leader (influential across a wide range of innovations). Grimshaw et al. (2006) identified that the more specialised the group, the more likely the effectiveness of the monomorphic opinion leader. There can be problems with recruiting opinion leaders to implement research findings because they tend to be more monomorphic.

Rogers (2003) differentiated opinion leaders from change agents. Rogers stated opinion leaders exert their influence as part of the social system. He considered a change agent as external to the social system and as an "individual who influences client's innovation-decisions in a direction deemed desirable by a change agency" (p.27). Change agents may use opinion leaders to lead their diffusion activity.

2.6 Consequences of innovations

When new ideas are invented, diffused, and adopted or rejected, they lead on to certain consequences which then result in change to the structure and functions of a given social system (Rogers, 2003). Rogers (2003) put forth the

following three dimensions of consequences: desirable versus undesirable, direct versus indirect and anticipated versus unanticipated.

2.6.1 Desirable versus undesirable

Desirable versus undesirable consequences depend on whether the effects of an innovation in a social system are functional or dysfunctional as determined by how the innovation affects the potential adopter. Most innovations cause both desirable and undesirable consequences (Rogers, 2003). An innovation may be functional for a system or organisation but might not be functional for an individual. For example, PHO formation was thought to be functional for implementing the intent of the Primary Health Care Strategy, but it was not necessarily functional for each individual GP within the PHO structure.

2.6.2 Direct versus indirect

Direct consequences "are the changes to an individual or social system that occur in immediate response to adoption of an innovation" (Rogers, 2003, p.445). Conversely, indirect consequences occur as a result of the direct consequences, are often unknown and therefore difficult to plan for. Change in one part of a system from the direct consequences of an innovation, often initiates a chain reaction of indirect consequences. For example, while capitated funding included the practice nurse subsidy, it also meant that some general practice owners have overlooked or forgotten this and have come to view nursing costs as an overhead to be minimised (Hefford et al. 2005).

2.6.3 Anticipated versus unanticipated

Anticipated consequences are changes due to an innovation that are intended (Rogers, 2003). On the contrary, Rogers (2003) stated unintended consequences represent a lack of understanding, not only about how an innovation functions, but also not recognising the internal and external forces at work in a social system. For example, did the Primary Health Care Strategy take into account the effects of the social system in its design and implementation? Next, I present my guiding framework informed by the diffusion of innovation theory.

2.7 Guiding framework

The implementation of the Primary Health Care Strategy set up complex demands that required the introduction of new ways of working, thinking, believing and behaving. A range of theorists offered valuable insights into exploring this process of change. Robinson (2009), in commenting on diffusion theory, suggested that it allows us to explore the qualities that make an innovation spread successfully, the importance of peer-peer conversations, peer networks and the value of understanding the needs of different user segments. Having determined the value of the diffusion of innovation theory for this research, a guiding framework was developed based on a selection of constructs drawn from both Rogers (2003) and Greenhalgh et al. (2004, 2005). This would help locate answers to my two research questions:

1. What change has occurred within the primary health care nursing workforce in Tairawhiti since the implementation of the Primary Health Care Strategy, how and why did this come about?
2. What factors influenced the deployment of primary health care nurses in Tairawhiti?

Understanding the motivations for adoption was considered essential. The framework developed aligned with my constructionist perspective that we all look at the world from a particular perspective. The framework also allowed for the social dimensions of change and therefore meaning in an attempt to address the processes by which the Primary Health Care Strategy was implemented in Tairawhiti. This supported the recognition of individual differences, thoughts and beliefs, as well as the interaction between the innovation and the intended adopters. It facilitated the teasing out of the intricacies and interactions that case study methodology demands. This framework is illustrated in Figure 7. While presented somewhat as a linear framework, each component is interrelated and represents numerous interactions.

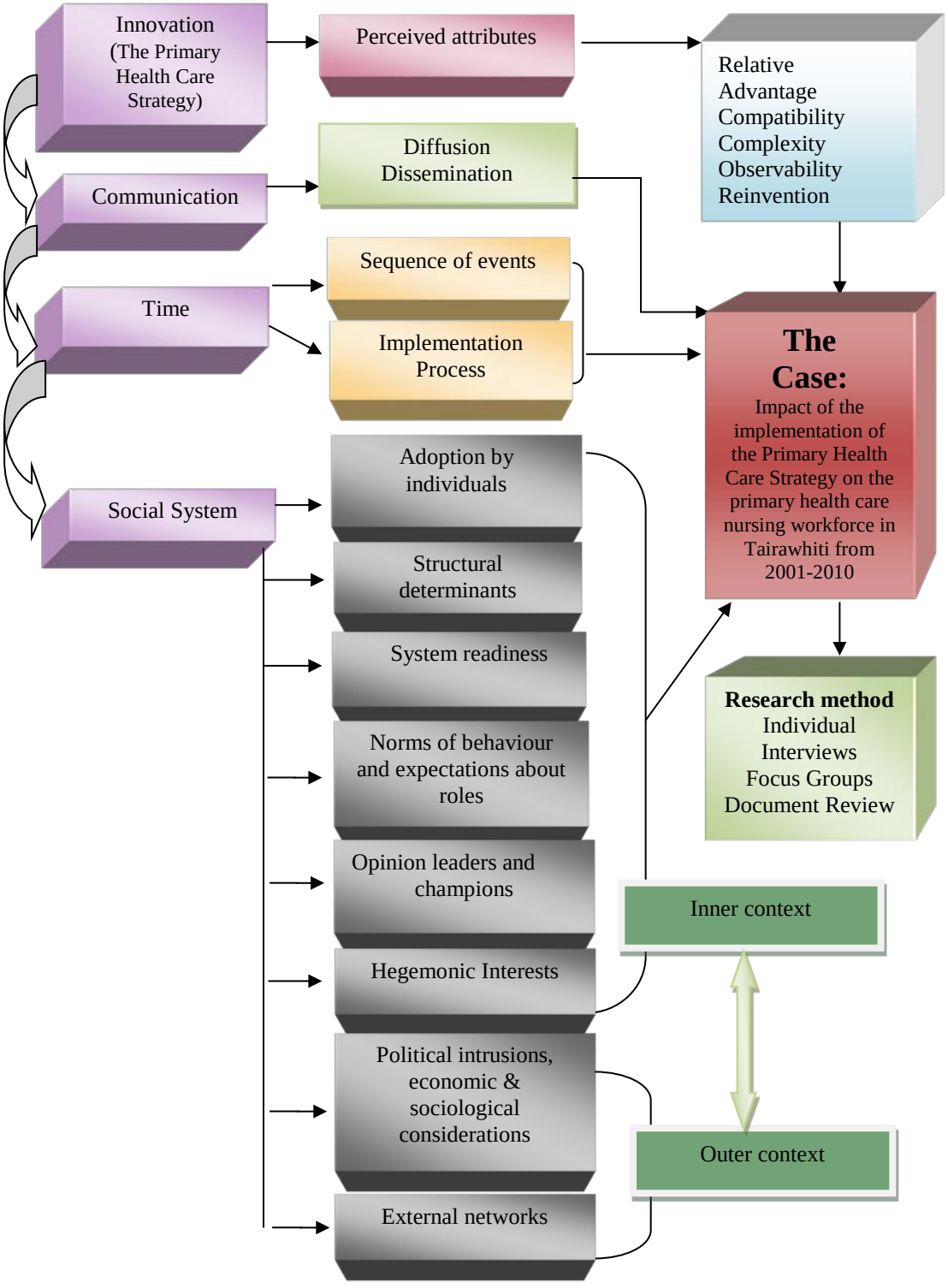

Figure 7. **Guiding framework based on the diffusion of innovation theory models of Rogers' (2003) and Greenhalgh et al.' (2004, 2005).**

The guiding framework has all four attributes that Rogers (2003) considered identifiable in every diffusion research study: innovation, communication,

time, and the social system. Five of the six perceived attributes of an innovation Rogers (2003) offered were utilised in the framework: relative advantage compatibility, complexity, observability and reinvention. I chose not to include trialability as the Primary Health Care Strategy was a policy change that assumed adoption.

I considered the communication processes of the implementation of the Primary Health Care Strategy in Tairawhiti an essential component of the framework and have included both dissemination and diffusion. Time constructs included a sequence of events as well as the implementation process. The social system incorporated the structural determinants, system readiness and norms of behaviour, expectations about roles and identification of opinion leaders as part of the adoption process. I have also included hegemonic medical interests as influential in the decision-making in implementing the Strategy.

I utilised both the inner and outer context constructs put forward by Greenhalgh et al. (2004). The inner context included both hard and soft mediums. The outer environment took into account the extent and quality of the external organisational networks and linkages including political, economic and sociological factors. This framework provided a guide only. Offered next are criticisms of the diffusion of innovation research that must be considered.

2.8 Criticisms of diffusion of innovation research

Diffusion research has made important contributions to understanding behaviour but has a number of weaknesses. Pro-innovation bias is the most serious consequence in that there is an expectation that an innovation should be diffused and adopted, that it should be diffused rapidly and that the innovation should be neither re-invented nor rejected (Rogers, 2003). Rogers (2003) suggested this leads diffusion researchers to potentially “ignore the study of ignorance about an innovation, to underemphasise the rejection or discontinuation of innovations, to overlook re-invention ... and to fail to study

antidiffusion programs designed to prevent the spread of 'bad' innovations" (p.107).

Pro-innovation bias in diffusion research is a failure to learn about certain but very important aspects of diffusion (Baumann & Martignoni, 2011). To reduce pro-innovation bias, the researcher "should investigate the broader context in which an innovation diffuses" (Rogers, 2003, p.115). Considering this, the framework I developed specifically explored and examined the broader context of the Primary Health Care Strategy implementation in Tairawhiti. This is discussed in detail in Chapter Five.

Individual blame biases can also be of concern where the individual within the system is blamed for the failure to diffuse an innovation as opposed to a system failure (Rogers, 2003). The source of the innovation might be at fault for not providing adequate information, inappropriate promotion of the innovation, or for failing to engage those who need the most support.

There are also concerns in determining causality in being unable to answer the "why" questions. Rogers (2003) stated the "why" questions have seldom been probed effectively to increase understanding of the motivations for adopting an innovation. This author postulated that "rejection, discontinuation, and reinvention frequently occur during diffusion and that such behaviour might be appropriate from the individual's point of view" (p.114).

Time is considered one of the strengths of diffusion of innovation research but can also present a problem with inaccuracy in measuring the adoption (Rogers, 2003). The weakness lies with the dependence on the individual's ability to accurately recall the date they decided to adopt the innovation. Hindsight is not accurate and dependent on the individual being able to look back and reconstruct the past. The use of multiple sources of evidence to determine time lines can counteract this weakness. This research was less concerned with exact dates and times, choosing instead to focus more on the implementation process.

In addition, the notion of static and endurable attributes of innovations in an organisational setting is inherently flawed (Greenhalgh et al., 2005). These authors suggested that the next generation of diffusion research should be theory driven, process orientated, and recognise the reciprocal interaction between the programme and the wider setting in which it takes place. Multidisciplinary and multiple methods should be employed while common definitions, measures and tools, are standardised to allow comparison. Therefore, the research must be meticulously detailed to enable future researchers to produce more useful research questions to increase the validity of the findings for both practitioners and policy makers. Theoretical constructs and research processes for this thesis are detailed in Chapters Four and Five.

Finally, Greenhalgh et al. (2005) contend that classical diffusion of innovation theory takes little or no account of the complex process of adoption and that any search for features that can be built into innovations to make them spread more readily is fruitless. Notwithstanding this statement, having knowledge of potential issues and putting processes in place to combat each issue should increase the likelihood of adoption.

2.9 Concluding statement

This chapter detailed the diffusion of innovation theory and began with the rationale for the use of the diffusion of innovation theory followed a brief historical account. Following a general overview of the theory, the four main elements were presented. Adopter categories were noted before a discussion on the consequences of adopting an innovation was explored. My guiding framework developed from the diffusion of innovation theory was then presented. The chapter concluded with an overview of the disadvantages of this theory. What this chapter demonstrated was that understanding system antecedents, system readiness and the outer context or external influences are important in making sense of the implementation process in the eventual success or failure in the adoption of innovations. The next chapter critiques the literature on the Primary Health Care Strategy, articulating the tensions associated with its implementation.

Chapter Three: Primary Health Care Strategy in context

3.1 Introduction

The aim of this single instrumental case study was to enhance understanding of the impact of the implementation of the Primary Health Care Strategy on primary health care nurse deployment in Tairawhiti. To facilitate this, chapter three draws on existing literature and documentation relevant to the Strategy as the innovation. The intent is to present an analytical and critical appraisal of the factors that influenced Strategy adoption and the deployment of primary health care nurses.

There is an abundance of international literature that concentrates on the positive characteristics of primary health care (Alford, 2005; International Council of Nurses, 2008a; McMurray, 2007a; Sloand & Groves, 2005; Starfield, 1998; Starfield & Shi, 2007; Thomas, 2006; Walker, & Collins, 2009; WHO, 2008). However, the literature is relatively silent on the rationale for the mediocre and protracted adoption of proven primary health care principles. Much of the relevant published New Zealand literature focuses on the introduction of PHOs and funding models associated with the implementation of the Primary Health Care Strategy. Despite the Strategy being in existence for over 10 years, the literature makes little mention about the impact on primary health care nursing.

It proved important to selectively review literature to provide the best possible understanding of the context which underpinned the launch of the Primary Health Care Strategy in New Zealand, and in Tairawhiti. To some extent the literature was treated as data and examined using the lens of the diffusion of innovation theory. This enabled a more focused use of literature. I begin this review with the primary health care agenda which links primary health care and the Primary Health Care Strategy with nursing. I then focus on a range of contextual issues with the Strategy, including PHO formation and service

change. The external environment is also explored specifically as it related to funding, shifting political grounds and biomedical influences. A summary of the implementation of the Strategy completes the chapter.

3.2 Primary health care agenda

A WHO (2008) report on primary health care identified impatience with the inability of health services internationally to deliver levels of national coverage to meet changing health and societal need. The report clearly indicated the necessity for a renewal of primary health care systems as an alternative to the "quick fixes currently touted as cures for the health sector ills" (p.xiii). A primary health care 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 significance of primary health care to the health of individuals and communities was declared at the Alma Ata conference (1978). This conference called for urgent action and for "all governments, all health and development workers, and the world community to protect and promote the health of all the people of the world" (WHO, 1978, p.1). Primary health care was defined as

> essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination (WHO, 1978, p.1).

As an integral part of the country's health system, primary health care brings health care as close as possible to where people live and work. It constitutes the first element of a continuing health care process.

The Alma Ata Declaration suggested a paradigm shift by providing a set of primary health care principles and challenging the way communities and health professionals perceived health and ill health (Holdaway, 2002; MoH, 2001; Sheridan, 2005; Thomas, 2006; WHO, 1978, 2008). The Declaration identified the need for health care to focus on the prerequisites of health and the basic elements of health care. It reaffirmed health as a fundamental human right and asserted that people had a right to be active participants in planning and implementing their health care. Three key principles were identified that underpin an effective primary health care system:

1. Equity
2. Promoting good health
3. Multisectoral cooperation

The diffusion of innovation theory proposes that the objective benefits of an innovation on their own do not guarantee widespread adoption. What matters more is the degree to which it is perceived as advantageous by those making the adoption (Rogers, 2003). Undeniably the WHO faced significant obstacles when trying to operationalise primary health care following Alma Ata (Thomas, 2006). The application of the principles proved internationally inconsistent (Neuwelt & Crampton, 2005). Despite clear evidence to encourage the benefits of providing primary health care (Abel, Gibson, Ehau, & Tipene Leach, 2005; MoH, 2001; Starfield, 2006; WHO, 2008), western governments did not begin acknowledging the social determinants of health, health inequalities, or the strengths of community involvement until the 1990s (International Council of Nurses, 2008a). In New Zealand, it took twenty five years for the language of primary health care to make its way into New Zealand health policy (Neuwelt & Crampton, 2005).

The diffusion of innovation theory argues that many 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 et al., 2004, p.594). Despite delays in operationalising a primary health care approach, there is a renewed commitment to invigorating the public health agenda internationally so that primary health care is firmly at the centre of health care delivery (McMurray & Cheater, 2004; Thomas, Reynolds & O'Brian, 2006). Growing awareness of the importance of health promotion and disease prevention juxtaposed with increasingly scarce health care resources has activated this commitment (Bailey, Jones & Way, 2006; Jerden, Hillervik, Hansson, Flacking & Weinehall, 2006; WHO, 2008).

In the New Zealand context significant policy change was signalled in 1999 when a change of government saw the left-wing Labour Party form a coalition with the Alliance Party (1999-2008). The coalition's health policy agenda was concerned with building patient confidence in the health system with a strong focus on patients. It signalled a move away from a targeted approach of supporting primary health care to certain groups of the population, toward a universal approach where all New Zealanders were eligible for government funding for primary health care (Cumming & Gribben, 2007). It emphasised local decision-making by democratising service governance while orientating health policy and services toward upstream public health goals (Gauld, 2009a). Upstream approaches in public health seek to understand cause of disease and preventable disability so that the source can be addressed through prevention rather than treatment (Royal College of Nursing, 2012).

In 2001 the government released the Primary Health Care Strategy as a stimulus for primary health care development in this country. The Strategy outlined the most significant proposed change to the scope of New Zealand's public health system and concurrently provided the opportunity for nursing to advance its contribution (Carryer, 2005; Finlayson et al., 2011; Hefford et al., 2010; Sheridan, 2005; Tully & Mortlock, 2005).

3.3 Primary health care nursing - Strategy alignment

It was explicitly stated in the Primary Health Care Strategy that nursing was crucial to Strategy implementation (MoH, 2001). The presence of this statement provided an opportunity for primary health care nurses to engage

fully with government and their employers in developing new nursing roles and responsibilities in order to nurture and develop their professional partnerships with clients and communities (MoH, 2005). The Strategy 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 adopting an integrated approach to practice incorporating both population and personal health (Kent, Horsburgh, Lay-Yee, Davis & Pearson, 2005; MoH, 2005). The move to a wider range of services would require well educated primary health care nurses with generalist knowledge and skills, as well as those with advanced skills in particular areas of professional practice.

The release of the Primary Health Care Strategy coincided with an international call for nursing innovation to produce a new form of health care given that current western health care policy was anticipating 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 had increased (MoH, 2005). For the first time in New Zealand's health history there appeared to be an opportunity for primary health care nurses to be recognised for their professional contribution.

It was imagined that the extensive contribution nursing could make to reducing health inequalities and achieving population health gains, as well as preventing disease, would be fully realised (Expert Advisory Group on Primary Health Care Nursing, 2003). Nurses were to have an essential role in achieving primary health care improvements that were affordable, accessible, acceptable and participatory by providing high quality health education, prevention, promotion, and treatment services in the community.

Nursing practice is the very essence of primary health care given nursing's education, experience and the settings where they work (Carryer et al., 1999;

Expert Advisory Group on Primary Health Care Nursing 2003; Holdaway, 2002; International Council of Nurses, 2008a). As providers of first-line services, nurses share generalist knowledge and skills as well as advanced skills in particular areas of professional practice. Primary health care nursing when fully utilised, involves complex roles such as health education, prevention, problem solving, empowerment of people, and working in partnership with families.

There is emerging evidence that primary health care nurses do improve health outcomes and should be utilised accordingly (Baker Laughlin & Beisel, 2010; Cumming et al., 2005; Finlayson, Sheridan, & Cumming, 2009; International Council of Nurses, 2008a; McMurray, 2007a; MoH, 2004; Nelson, Connor, & Alcorn, 2009; Primary Health Care Nurse Innovation Evaluation Team, 2007; Sheridan, 2005). Substantiation of improved outcomes includes better chronic conditions management, smoking cessation, reduction in hospital admissions, and prevention of injury and disease. There is also evidence of the nursing potential to reduce inequalities in health between the social groups (Hoare, Mills, & Francis, 2011; International Council of Nurses, 2008a; Marshall, Floyd, & Forrest, 2011). The conceptualisation of primary health care is also in harmony with the philosophy of nursing.

Nurses are theoretically grounded in the concepts of wholism, social justice, empowerment, equity, self-determination and collaboration (Newell, 2000). Nurses have experience in forming partnerships with both individuals and communities (Carryer, 2004). The Primary Health Care Strategy document stated though, that primary health care nurses will require further development "with clarification of the appropriate capabilities, responsibilities, areas of practice, educational and career frameworks and suitable employment arrangements" (MoH, 2001, p.23). It was suggested that this would be best addressed at a national level.

It was also supposed that new nursing models would reflect both past and present models of primary health care nursing (MoH, 2005). Historically differing models of nursing practice have evolved in New Zealand (Expert

Advisory Group on Primary Health Care Nursing, 2003; MoH, 2005; Sheridan, 2005). The previous contract culture of the 1990s health system meant numerous primary health care nursing services were designed to meet the market model that drove them (Carryer et al., 1999). This led to fragmentation of services, gaps, duplication, and confusion around the various nursing roles (Expert Advisory Group on Primary Health Care Nursing; Nelson, Wright, Connor, Buckley & Cumming, 2009). Consequently, nursing titles, roles and models of care varied from DHB to DHB, from practice to practice, and from setting to setting.

The variability of models also had a "significant bearing on the cultures that exist within the distinct nursing groups" (Sheridan, 2005, p.71). The artificially imposed divisions ensured that significant levels of nursing expertise remained outside the general practice setting (Carryer, 2004). This subsequently created a deficit in nursing career pathways, clinical leadership, skill recognition and educational support. In order to support primary health care nursing development in line with the principles of the Primary Health Care Strategy, an Expert Advisory Group on Primary Health Care Nursing was established in 2002 at the suggestion of nurse leaders (Expert Advisory Group on Primary Health Care Nursing, 2003).

The Expert Advisory Group on Primary Health Care Nursing group (2003) developed a framework for activating primary health care nursing in New Zealand to implement new models of practice. *Investing in Health* was the resulting document that defined the vision and goals for New Zealand primary health care nursing (Expert Advisory Group on Primary Health Care Nursing, 2003). Its stated vision was to "create the environment that enables nurses to provide integrated comprehensive nursing care to individuals and population groups in New Zealand primary health care settings, and that strengthens the primary health care team towards improving health for all" (p.viii).

The major goals identified in *Investing in Health* included aligning nursing practice with community need by ensuring funding streams, employment arrangements and service delivery patterns, support nurses adopting an

integrated approach to practice (Expert Advisory Group on Primary Health Care Nursing, 2003). Innovative models of nursing practice were to improve access to primary health care services and contribute to improved health outcomes and reduced health inequalities. Primary health care nurses were to be equal partners in the governance of PHOs. At the same time, primary health care nursing leadership was to encourage and promote change while facilitating the development of new roles and models of practice. Postgraduate education was also recommended to support all levels of primary health care practice in order to provide a national standardised career pathway for primary health care nurses (Expert Advisory Group on Primary Health Care Nursing, 2003).

Investing in Health included a number of recommendations to the MoH, DHBs and PHOs to facilitate achievement of these goals (Expert Advisory Group on Primary Health Care Nursing, 2003). The MoH progressed with some key nursing initiatives however, the uptake of these recommendations was variable across DHBs and largely ignored. An update to *Investing in Health* in 2007, identified that primary health care nurses must be both funded and organised in a manner congruent with the full utilisation of the nursing potential in line with the vision and goals of the Primary Health Care Strategy (New Zealand Nurses Organisation (NZNO) & College of Nurses Aotearoa NZ, 2007). It was argued that until this happened, primary health care nurses will not be fully aligned with the principles of the Strategy in order to make the best use of this cost effective workforce.

Similar arguments could be made for the nurse practitioner role. Finlayson et al. (2009) and many other international sources (Alexander, 2004; Cooper, Loeb & Smith, 2010; Flinter, 2012; Harrington, 2011; Poghosyan, Lucero, Rauch, & Berkowitz, 2012), recommend nurse practitioner roles are established in primary health care in order to make services more accessible to people. As yet, very few nurse practitioner roles have been established in primary health care, especially in areas where there are vulnerable communities such as high Māori and Pacifica populations, rural and low

socio-economic communities. These are the very populations that would gain the most from nurse practitioner services.

Nurse practitioners are not new and have had a presence in the United States since the 1960s (Gardner, Hase, Gardner, Dunn, & Carryer, 2006). They were introduced in the United States to improve primary health care to underprivileged communities. Research demonstrates that the performance of a nurse practitioner role improves access to care, is cost efficient (Bauer, 2010) and able to diagnose, manage health issues and prescribe medication with significant consumer satisfaction (Alexander, 2004; Cooper et al., 2010; Dierick-van Daele, Metsemakers, Derckx, Spreeuwenberg & Vrijhoef, 2009; Flinter, 2012; Hughes, 2006; McElhinney, 2010; MoH, 2002; Poghosyan et al., 2012). As a new and smarter way of making the best use of health care resources, nurse practitioners are able to combine "the best of nursing with some skills from medicine" (MoH, Nursing Council of New Zealand, DHBNZ & Nurse Practitioner Association New Zealand (NPAC-NZ), 2009, p.3).

3.4 Context of the Primary Health Care Strategy

When it was first published in 2001 the Primary Health Care Strategy was a high level, high profile document (Love, 2008). Dovey, Tilyard, Cunningham, and Williamson (2011) considered it the most profound departure from previous government "laissez faire" approaches to primary health care policy since the Social Securities Act (1938). Reviews and reforms of the health sector since the 1970s and prior to the Strategy, unsuccessfully endeavoured to curtail rising health sector costs, improve integration and coordination, improve access, reduce inequalities and increase accountability.

The intent of the New Zealand Health Strategy and subsequent Primary Health Care Strategy was to address the core issues as well as consolidate and stabilise the health sector (Gauld, 2001). At the same time it was hoped there would be improved confidence in the New Zealand health system (Gauld, 2005). The Primary Health Care Strategy arguably intended to dispute previous funding structures and to confront general practice business models. It broadened the approach from the individual toward the population and from

treating illness to prevention and promotion of health (Barnett & Barnett, 2001; Workforce Taskforce, 2008). By signalling a shift in focus from the provider to the community, the Strategy required doctors and nurses to work in different ways (McPherson & McGibbon, 2010).

As mentioned in Chapter One, the Health and Disability Act was legislated in 2000. The purpose of this Act was to publically fund and provide personal and public health services, disability support services and the establishment of new publicly-owned health and disability organisations. The Act also provided for a community voice in matters relating to personal health, public health and disability support services. The intent was to improve, promote and protect the health for New Zealanders. DHBs were tasked with working toward improving health outcomes to enhance the health status of the population it served, including the reduction of health disparities of Māori and other population groups.

As crown entities, DHBs were expected to manage their resources effectively and efficiently to improve health status within budget and through financial stability. The rationale for decentralising planning and funding functions at a district level was to facilitate greater understanding of local needs as well as own the decisions that affected their respective communities (Gauld, 2009b). This should have been advantageous as it allowed for local health care planning (Cumming & Mays, 2002; Smith, 2009) and flexibility to best fit district priorities and resources. At the same time each DHB was required to respond to national and regional health policy, goals and targets (Gauld, 2009a; Laugesen & Gauld, 2012).

Elected DHB Boards held responsibility for implementation of the Primary Health Care Strategy and numerous other government strategies. Boards had overall responsibility for assessing the health and disability needs of their geographically based communities, including mental health and primary health care services (Cordery, 2008; MoH, 2007a). The creation of DHBs as new entities was an opportunistic time for new primary health care thinking to be embedded.

Numerous authors have questioned whether each of the DHB Board members has the experience and skill necessary to make the strategic governance decisions which were required (Adam, 2003; Mathias, 2009; Whitfield, 2010). DHB Board members are expected to govern large complex organisations, yet receive limited training (Laugesen & Gauld, 2012). Whitfield (2010) examined the corporate governance of DHBs in New Zealand and recommended that Board members should be selected according to skills, experience and prior knowledge. This expertise was essential for the decision-making required to implement the Primary Health Care Strategy.

The DHB Board electoral process gives credence to the perception that Board members represent their communities and have a duty to act in the best interest of their electorates (Mathias, 2009). They are also accountable to the Minister and the Ministry of Health. Parochial interests have been a source of tension between the Ministry and DHB Boards (Cassie, 2005; Gauld, 2009a). This tenuous situation is evident when the community voice is contradictory to national goals and targets, such as when competing priorities are identified.

3.4.1 Primary Health Organisations (PHOs)

PHOs were considered an integral component to achieving the Primary Health Care Strategy in the long term (Finlayson et al., 2011; MoH, 2007a). There was considerable optimism that these new locally based practitioner and community based networks would reflect an environment for change (Barnett & Barnett, 2001). PHOs were tasked with improving access for high-need enrolled populations through low-cost services. They were asked to improve the health of the communities they serve by organising services around defined populations rather than responding to individuals who actively sought care.

Nationally, PHO formation was achieved successfully early in the implementation of the Primary Health Care Strategy which suggests it was agreeable to the decision-makers and had a high degree of relative advantage. By 2008, a total of 81 PHOs had been established (MoH, 2007b); this increased to over 90 in 2010. Patient enrolment in these PHOs exceeded all

expectations (Ashton & Tenbensel, 2010) with over 95% of New Zealanders notionally enrolled in a PHO by late 2004 (Gauld & Mays, 2006). The MoH provided guidance on the establishment of PHOs but refrained from being prescriptive.

Initially the government side-lined general practice interest groups in the policy formation (Gauld, 2008). Gauld (2008) further stated the early reform process had an unwritten intention to replace the Independent Practitioner Associations (IPA) with PHOs. IPAs were originally established in response to the threats and opportunities of health services restructure in 1990s (Crampton, 2001; Finlayson, 2001; Holdaway, 2002). As such they provided GPs with a powerful coherent voice with which to express their views on local service delivery and health issues.

It was thought that existing IPAs would have less authority and influence in the new PHO environment thus reducing medical self-interest in the decision-making (Gauld, 2008). This was optimistic given that incompatibilities with existing organisational norms and values are a deterrent to the adoption of an innovation (Greenhalgh et al., 2004; Rogers, 2003). Instead, IPAs either became or remained partially independent entities from PHOs (McAvoy & Coster, 2005). In some instances, PHOs were IPAs in another guise. GPs reported some loss of independence but this was balanced by gains in general practice from advancing status and influence of primary health care. Definitely, there was an increase in the power, strength and scope of the GP voice within the health system, particularly with DHBs (Gauld, 2009a; McAvoy & Coster, 2005). At the same time, gains for nursing were not any part of the considerations in either DHBs or PHOs.

The rapid development of PHOs almost exclusively engaged only medical practitioners within primary health care (Carryer, 2005). There was also limited attention to detail and the permissive manner in which PHOs were established has, with hindsight, been suggested as an impediment to PHOs progressing with the Primary Health Care Strategy (Smith, McDonald & Cumming, 2008). As a result there was a wide variety of organisations in

terms of size and structure, all with varying capabilities and complex funding arrangements. Additionally there were different governing processes as well as different legal entities (MoH, 2007a; Smith & Cumming, 2009). The legal entities that were consistent with the Strategy included:

- Non-profit companies: the organisations register as a company under the Companies Act 1993
- Incorporated societies: the organisation registers under the Incorporated Societies Act 1908
- Trusts: the organisation registers under the Charitable Trusts Act 1957.

Prior to the National coalition government elected in 2008, only a few PHOs were established as incorporated societies. The majority were charitable trusts and non-profit companies. Lockett-Kay (2005) states that in "promulgating PHOs the government has taken a more multiprofessional and community-inclusive approach along the lines of the community trust model established in the 1990s" (p.37).

Community trusts were developed following the Health and Disability Services Act 1993. Public hospitals that were not economically viable were offered for sale to local communities and restructured into community/primary care trusts, or sold off to the private sector (Love, 2003; Malcolm, 2000; Quinn, 2009). At that same time, Māori were asking for the opportunity to lead their own health and development (Holdaway, 2002). Subsequently, Māori forged links with local Iwi tribal groups to develop Māori focussed initiatives in 'by Māori, for Māori' health services. Of significance in Tairawhiti was the emergence of two locally owned Iwi based health services: Ngati Porou Hauora (later a PHO in its own right) and Turanga Health (a business partner in Turanganui PHO).

The governance arrangements of PHOs were considered crucial in the robust management of these organisations (Lockett-Kay, 2005; MoH, 2007a). PHOs were directed to include different stakeholder groups and involve communities, consumers, providers and Māori in governance processes. The

Primary Health Care Strategy dictated that all stakeholders should be an integral part of PHO decision-making, and that consultation and collaboration was essential for commitment and accountability to the PHO community (Cordery 2008). By involving the participation of lay people on their PHO governing bodies, the services were to reflect the needs and priorities set by the people, not just by providers (Barnett & Barnett, 2001; MoH, 2001). Essentially, the Strategy provided opportunity for the experts and grass-roots communities to establish a collaborative top-down as well as bottom-up approach to health service planning (Lockett-Kay, 2005).

The extent to which there was full participation of both the providers and the public in PHO governance is dubious (Smith, 2009). It has been questioned whether community representation does have a "voice" in decision-making (Batten, 2008; Laugesen & Gauld, 2012). Further, Batten (2008) states that if community representation is required, then the complexities of representation must be acknowledged and power imbalances managed so that community representation is not tokenism. Tokenism is where meaningful participation is not achievable when individuals or groups do not share a common power base. Greater understanding is required about the working relationships of traditional holders of power with the grassroots communities so that involvement is consistently participatory as opposed to tokenism (Lockett-Kay, 2005).

Governance structures and not for profit status is contradictory as practices remain private enterprises and are profit driven (Mays & Cumming, 2004). Mays and Cumming (2004) argue that this would create an interesting scenario if the PHO Board made a decision that in turn affected the viability of a GP practice. This in itself is unlikely given the strong medical representation on most PHO Boards. It was expected that GPs would dominate PHO Board proceedings initially, however it was thought this would change as community members developed capability and capacity (Lockett-Kay, 2005). There is no evidence that consideration was given to what role nurses, as the largest workforce, might have in governance. Next, changes to service delivery

following the release of the Primary Health Care Strategy are discussed illustrating circumstances that impact, in some way, on the nursing workforce.

3.4.2 Changes to service delivery

The literature is presented utilising the three key principles identified in the Alma Ata Declaration: equity, promoting good health and multisectoral cooperation.

1. **Equity**

Challenging inequity and reducing disparities underpins the New Zealand Health Strategy, and all other strategies released at that time. As mentioned in Chapter One, there is significant evidence to support the premise that people in the lowest socio-economic groups consistently have the poorest health (Carroll, Casswell, Huakau, Howden-Chapman, & Perry, 2011; Daniels, 2004; Graham & Power, 2004; Hefford et al., 2005; Howden-Chapman, 2005). Though there are numerous complexities involved in trying to provide publicly funded health services which are affordable, accessible and address inequalities (Lockett-Kay, 2005).

In health, fairness and equity are difficult concepts to define and carry strong moral overtones (McPake & Normand, 2008). Equity will not happen without support from both the government and the health sector. High on the political agenda, achieving equity is not always backed by resources or political commitment (Matheson & Loring, 2011). These authors suggest that equity is only valued when the economic environment is favourable. With scarce resources and competing goals within health care, trade-offs have become necessary; not everything can be funded (Heshmat, 2001). Services viewed as visible and important tend to continue to be funded and supported. Primary health care outcomes are not always readily visible, are less emotive, and perceived as less important as a result.

With only a finite pool of financial resources, decision-makers seemingly feel compelled to support secondary care priorities at the expense of strengthening primary health care development. Secondary care is more specialised, more

technical and the capacity to cure has far greater marketing and political value than dealing with health promotion or prevention (Radcliff, 2000). As such, acute care demand always takes precedent (Allsop, 2006). Despite emerging evidence to suggest acute hospital based care is not necessarily conducive to better health outcomes, especially for chronically ill elderly patients (Wennberg, 2010). Resources could be better spent in providing increased support for primary health care.

The literature continues to focus on the benefits of providing health care, however good health involves much more than the provision of health services. Starfield (2006) argued that interventions outside of health care have a greater impact on the recurrence or prevalence of an illness. The WHO (2008) concur the health of a population is not determined by clinical activities, but by society and economics, thus requiring nationwide public health action. Other commentators have also suggested that the relationship of medical care with good health is minimal when compared to other determinants, especially in developed countries (Heshmat, 2001; McMurray, 2007a).

The presence of clinicians does not ensure the availability or accessibility of service (Starfield & Shi, 2007). Conversely, access to good quality health care for disadvantaged or marginalised groups could substantially reduce health inequalities (Tobias & Yeh, 2009). Starfield (2006) contends effective health care systems directed at early intervention, prevention and promotion can considerably impact on the reduction of disparities in the severity of illness.

2. Promoting good health

The new direction for primary health care through the Primary Health Care Strategy was for a greater emphasis on population health and the role of the community, health promotion, and preventive care (MoH, 2001). A population based approach is explicit in its organised action to promote and protect the health of identified groups, reduce inequalities between groups and complement high quality care for individual patients (National Health Committee, 2000). The emphasis is on equity, community participation and

the social determinants of health (Neuwelt et al., 2009). Effective health care systems directed at prevention and early intervention can considerably impact on the reduction of health disparities (Holdaway, 2002; Institute of Rural Health, 2004; MoH, 2001; Starfield, 2006; Starfield & Shi, 2007; TDH, 2012; WHO, 2008).

Health improvements and cost savings are achievable if evidence-based cost-effective health promotion and disease prevention programmes are provided to reduce modifiable risk factors and the cause of costly chronic diseases. Health promotion fosters appropriate public policies through education, community development, legislation and regulation. It requires a multistrategic, intersectoral, holistic and equitable approach across all sectors. It is about changing the environment to enable the behaviour of individuals and populations to change (Casey, 2009; Frieden, 2010; Oliver & Peersman, 2001; Whitehead & Irvine, 2010). Therefore, health professionals must work beyond the narrow biomedically defined behavioural frameworks that health education offers, to working within the broader health promotion approach (Robertson, 2006).

There is relatively little in the literature on evaluation of health promotion and population health outcomes since the release of the Primary Health Care Strategy. It has been argued that the system wide shift from individuals to population health outcomes was not delivered (Gauld, 2008; Smith et al., 2008). Instead, the focus remained on the provision of episodic care. A possible reason for this is that a population health approach would represent a considerable change in focus for most doctors and not compatible with existing values, experiences and normal practice. Rogers (2003) confirms that innovations incompatible with the values and norms of a social system are less likely to be adopted.

3. Multisectoral cooperation

In the context of this thesis, multisectoral cooperation refers to actions across sectors including health, education and social agencies, in addition to recognition of the contributions by stakeholders beyond governments. It was

envisaged in the Primary Health Care Strategy that DHBs and PHOs would work with local bodies, education, welfare, housing, and public transport service, to facilitate and lead changes to improve the health of their communities (MoH, 2001).

The broad vision of primary health care in the Strategy meant accepting that no single practitioner or type of practitioner can meet people's needs completely. A range of practitioners with the skills to communicate and collaborate in the patient's interest was required (MoH, 2001). This was considered important as the focus of primary health extended beyond treatment and support toward a more comprehensive disease prevention and management approach.

Evidence demonstrates that successful primary health care is delivery through a collaborative multidisciplinary approach (Bailey, et al., 2006; Buttaro, Trybulski, Bailey, & Sandberg-Cook, 2003; O'Neill & Cowman, 2008; Pullon, McKinlay, Stubbe, Todd & Badenhorst, 2011; Sloand & Groves, 2005; Thrasher, 2002). A multidisciplinary collaborative approach provides the opportunity to recognise and value the roles of all health care professionals (Cumming, 2011; Higgins, 2008).

Collaborative practice means practitioners work together to provide a patient centred approach to health care, aligning the skills of the teams to the profile of the local population (Hansson, Arvemo, Marklund, Gedda, & Mattsson, 2009; Hansson, Friberg, Segesten, Gedda & Mattsson, 2008; O'Neill & Cowman, 2008). Collaborative practice requires the health sector to work differently from how they have worked traditionally (McPherson & McGibbon, 2010). McPherson and McGibbon (2010) also state that this represented a fundamental shift in intention from the doctor as the main provider, to a team approach. Professional role boundaries and identities are not "given" but constructed and reconstructed by practitioners working in historical, social, cultural, economic and political contexts (Thompson, 2006). Medical domination contributes toward an imbalance in power and control that negates collaborative practice.

3.5 External factors (Outer context)

External factors or the outer context as termed by Greenhalgh et al. (2004, 2005), proved to be obstructive to Primary Health Care Strategy implementation. The outer context takes into account the impact of the wider environment beyond organisations involved in the implementation of an innovation (Greenhalgh et al., 2005). The new funding formula dictated organisation priorities and ways of working. At the same time shifting political grounds and biomedical interests also disrupted Strategy implementation as critiqued next.

3.5.1 Funding considerations

New funding models were considered crucial to ensure populations like Tairawhiti had access to affordable primary health care services (Ashton & Tenbensel, 2010; MoH, 2001). The new funding arrangement targeted high need populations by incentivising providers to develop services to meet specific community need (Lockett-Kay, 2005). Certainly, funding streams made available through political direction are known to significantly increase the likelihood of successful implementation of an innovation (Greenhalgh et al., 2005).

Significant additional financial investment was put into primary health care between 2000 and 2009. The New Zealand government committed an additional base funding of $284 million[7] for 2004/05, $338 million for 2005/06 and $425 million for 2006/07 (McAvoy & Coster, 2005). In 2009/10 additional funding equated to 70.0% of public expenditure and 58.2% of the total current health expenditure (MoH, 2012). Most of this additional funding went through the new PHO structures with the intent to reduce patient fees. It was estimated at the time, that this new payment system would cost the New Zealand government at least an additional $600 million per annum (Raymont & Cumming, 2003).

[7] New Zealand Dollars

Substantial changes to the funding formula saw the move from a fee-for-service model to a supposedly fairer population-based formula called capitation funding. This approach was new to the New Zealand health sector, having traditionally provided a fee-for-service primary care model (Abel et al, 2005; Crampton, Sutton & Foley, 2002). Capitation funding was designed to fully or partially meet the cost of servicing each patient during that funding period and was unrelated to the number of patient visits or types of practitioners seen (Cordery, 2008; Crampton et al., 2002; MoH, 2001). To increase the acceptability to GPs, funding was inflation proofed (Mays & Cumming, 2004).

Other PHO based funding included the introduction of Care Plus. Care Plus provided an additional 10% capitation funding targeted toward people with high health needs due to chronic conditions, acute medical, mental health or terminal illness who required more frequent general practice visits (CBG Health Research Ltd, 2005a; McAvoy & Coster, 2005). At a basic level, Care Plus directed funding to improve chronic care management, reduce inequalities, and reduce the cost of services for high-need primary health care users. Care Plus incentivised providers to broaden the flexibility and scope of services within a practice setting (Love, 2008). Unfortunately this funding also suffered from adverse incentives in that the aim of the programme was not always clear to practices and the level of administrative confusion became a constant burden for practice staff (Love, 2008).

The government also provided health promotion funding in the form of an additional $2[8] per enrolled patient per annum, a belated initiative to deliver population based services. This amount meant smaller PHOs were unable to develop effective health promotion programmes. It was "an issue not adequately thought through by the government prior to implementation" (Gauld, 2008, p.104). Likewise, funding for services to improve access (SIA) was introduced. DHBs signed off this additional subsidy to enable PHOs to develop projects to target Māori, Pacifica and low income populations in order to reduce inequalities. In some districts SIA funding was used to increase

[8] New Zealand Dollars

access for Māori and Pacifica patients to cardiovascular screening and mental health assessments (Neuwelt et al., 2009). Potentially, all of these additional funding sources could have been used to develop and implement nurse led services.

Significant unchallenged flaws soon appeared in the new funding formula that restricted innovation and expansion in primary health care (Gauld, 2008, 2009a). Capitation did not drive service change at a practice level (Love, 2008). The new funding model did not deliver on the intent for a system wide shift in focus from the individual to population health outcomes or better coordination between primary and secondary or effective after hour services (Gauld, 2008; Smith et al., 2008).

Funding of primary health care services continues to be a point of contention between the government and GPs creating an 'uneasy relationship' (Barnett & Barnett, 2004a; Gauld, 2008; Gauld & Mays, 2006). GPs consider that capitated funding is theirs rather than designed to provide the right service by the right person. Additional funding allegedly went into raising the income for some GPs (Gauld, 2008). GPs continue the fee-for-service mind-set and episodic care, confirming business incentives are still key drivers for many (Cumming & Gribben, 2007; Finlayson et al., 2011).

GPs have continued to want to set the level of fees they charge to patients over and above the significant increase in the government subsidy (Ashton & Tenbensel, 2010). They have managed to retain this right but this is subject to a review process with each local DHB. Consequently, co-payment rates are variable throughout the country and in some practices are high enough to remain a barrier to access for poorer New Zealanders (Gauld, 2008). In addition, patients not enrolled in a PHO were required to pay a much higher fee per visit to a health practitioner. The higher fee is also charged if the enrolled person visited a general practice outside of their PHO catchment area.

3.5.2 Shifting political grounds

Policy change has not generated the desired behaviour change within existing health structures and systems (Gauld, 2008). Institutional enablers and constraints, including the underlying cultural values of the time, have historically shaped the trajectory of health system reforms in New Zealand (Aston & Tenbensel, 2010). New Zealand's entrenched dependency on tax based financing and subsequent government dominance over funding has meant there are fewer obstacles in the pursuit of major policy alteration. This explains the ease with which significant legislative and structural changes have occurred in this country (Aston & Tenbensel, 2010).

A centre-left Labour-led coalition government launched the Primary Health Care Strategy. Further change was signalled following the 2008 election when an incoming National coalition government[9] was formed. National criticised the previous government for its failure to deliver on some aspects of the Strategy, at the same time expressing bi-partisan support for its goals. The global recession that followed the election forced drastic action to reduce health spending that had increased significantly over the last eight years. There was also an expectation that health finances would be stretched with the escalating cost of technology, new treatments, new services, and the provision of health care for the aging population and people with chronic conditions. What followed was a new direction in health policy: "Better, Sooner, More Convenient" (MoH, 2011).

"Better, Sooner, More Convenient" health care in the community was, according to the political rhetoric, an initiative intended to deliver a more personalised primary health care system to provide services closer to home, and put patients at the centre of health services (MoH, 2011). The major focus of this policy was "keeping people healthier in the community for longer" (MoH, 2011, p. 4). It recognised that while hospitals get most of the publicity, over 90% of health care interactions occur in the primary sector (Minister of Health, 2009). The Minister of Health also acknowledged the potential of

[9] National was the major political party, ACT, United Future, and the Māori Party were the minor partners

primary health care went beyond subsiding doctor fees. The lack of connectivity and collaboration between primary and secondary services was also recognised, along with a lack of shared information.

Under the political rubric of "Better, Sooner, More Convenient" it was envisaged that some hospital services would be devolved to primary health care (PHCS[10] Implementation programme, 2009). The alleged intent of devolution was to support integrated family centres, co-located multidisciplinary health teams that provide primary health care services with a much wider range of services and support for patients (including treatment and diagnostic services). In September 2009, to support the development of integrated family centres, the MoH issued an expression of interest for proposals from eligible primary health care providers to implement 'Better, Sooner, More Convenient'.

More than seventy expressions of interest were received with nine selected to move through to the next stage of development. As mentioned in Chapter One, the strongly IPA led Midland Health Network was successful in responding to the expression of interest. Midland Health Network was formed by amalgamating five PHOs including Turanganui PHO in Tairawhiti. Since then, Midland Health Network has established a number of service level alliance teams to look at opportunities for greater integration, less duplication, with the patient supposedly at the forefront of the proposals. Recommendations have since been put forward to an alliance team for approval. Alliance teams are made up of representatives from the four geographical regions including members of the DHB as well as the PHO. At the time of writing this thesis, implementation plans to move the recommendations forward were under development.

Pressure is also mounting for greater coordination across DHBs to the point of merger. In 2010, 21 DHBs were reduced to 20, with two South Island DHBs joining to form one. The financial viability of smaller DHBs such as Tairawhiti may force further mergers. With mergers comes the risk that the

[10] Primary Health Care Strategy

issues faced in districts with high Māori populations and high health needs may become absorbed amongst the priorities of a much larger population. As yet it is still too early to know if these recent reforms are effective (Gauld, 2012).

3.5.3 Biomedical considerations

The basic constructs of the biomedical paradigm are that good health is expressed as freedom from pain disease or defect (Sheridan & Radmacher, 1992). All illness and disease has a cause and the removal or attenuation of disease will result in a return to health (Sheridan & Radmacher, 1992; Wade, 2004). Psychological factors such as mood, personality, emotions, intelligence, memory or perceptions do not feature in the biomedical model (Holdaway, 2002). This goes back to the 17th century when Cartesian dualism separated the mind from the body (Mohammed, 2012; Sheridan & Radmacher, 1992; Steven, 2011). Emotions belong in the mind and therefore have no influence over the body (Mehta, 2011; Sheridan & Radmacher, 1992; Pohlman, Cibulka, Palmer, Lorenz, SmithBattle, 2013).

Broader social, political, behavioural and psychological influences on health and illness differ from the biomedical paradigm (Sheridan & Radmacher, 1992; WHO 1978). The nature of health care provision has, for at the last century or more, been predominantly focussed through a biomedical lens (Pearson, Vaughan, & Fitzgerald, 1997; Waugh, Szafran, & Crutcher, 2011). This paradigm has its focus primarily on biological factors and is less concerned with social influences.

Biomedical postulations foster a reductionist deterministic disease focus which has meant that physicians tend to treat disease based on what they can hear, see, and count (Arford, 2005). Attending to facts and nothing more (Longino & Murphy, 1995), this model is fundamentality mechanistic. The focus is on laboratory findings and other diagnostic tools as opposed to the subjective feelings of the person concerned. Biomedicine has also fostered the development of a personal health system centred on high cost technologically advanced hospitals, specialisation and medical specialists (Heshmat, 2001).

Biomedicine does not incorporate any of the primary health care principles such as community development, empowerment and recognition of broader socio-economic factors. The strength of biomedical factors in the change process within the diffusion of health innovations requires further investigation.

Medicine's cultivated elitism has been bolstered through the biomedical paradigm. The hegemonic faith in the power and relevance of biomedicine to the health service is beneficial to the self-interest of the medical profession and enforces compliance (Checkland et al., 2008; Pearson et al., 1997). At the same time science, research, specialisation, and advanced education supported continued biomedicine thinking. The historically dominant biomedical focus influence also represents what is or is not valued about nursing (Pearson et al., 1997).

This section has argued that external factors determine the diffusion process. Funding, political influences and biomedicine were somewhat negative influences if not directly contradictory to implementing the Primary Health Care Strategy. These factors in turn, have influenced and largely limited the deployment of primary health care nursing. Failing to recognise and plan for such threats undermined the ability of the Strategy to achieve its vision.

3.6 Summary of the implementation of the Primary Health Care Strategy nationally

In reviewing implementation of the Primary Health Care Strategy it could be said that the goals of Labour's primary health care reforms were laudable and placed New Zealand ahead of most developed countries (Gauld, 2009a). Implementation of the Strategy has led to a number of achievements including:

- A reduction in cost of access to primary health care
- Increased utilisation of primary health care services
- The identification and appreciation of health inequalities
- A stronger focus on the management of chronic disease

- A wider range of health promotion services at primary health level
- An extension of a range of primary health care services (Cumming et al, 2005; Cumming & Gribben, 2007, Gauld, 2008; Smith, 2009).

While there may have been small pockets of change in general practices which have embraced the vision of the Strategy, overall primary health care development has been disappointing and many of the features of health services have remained unchanged (Ashton & Tenbensel, 2010; Gauld, 2009a). In addition, DHBs have performed on a par with previous structures and the historical disconnect between primary and secondary care continues to exist in many settings (Gauld, 2009a).

The Primary Health Care Strategy was a far reaching ambitious set of aspirations for the coordination of health services within and from primary health care (Smith, 2009). It carried a high degree of uncertainty making it less likely to be adopted. It did not take into consideration the effect on existing institutions and structures, the shape of the primary health care sector, or the capacity to deliver the intended goals (Gauld & Mays, 2006). Sufficient attention was not paid to specifying what different models of comprehensive primary health care services might look like.

The proposed change necessitated breaking down traditional barriers, professional boundaries, and employment practices. Existing values, beliefs and norms were counterproductive to Primary Health Care Strategy implementation. Nursing however signalled its absolute desire to change right from the outset. Prior to the release of the Strategy, Carryer et al. (1999) wrote a report for the National Health Committee on locating nursing in primary health care. Further evidence was the work undertaken by the Expert Advisory Group on Primary Health Care Nursing (2003) in developing the framework for activating primary health care nursing in New Zealand. Members of this group were nurses from New Zealand nursing organisations, NGOs and Iwi providers, as well as schools of nursing.

The complexity of the proposed changes meant that the Primary Health Care Strategy was difficult for some to understand and use. Rogers (2003) concurs that a potential adopter's perception of complexity unquestionably affects the rate of adoption. Little consideration was given to the fundamental differences in values, beliefs, and behaviours between the DHBs and their various PHOs. The Crown recognised that the business decisions of contracted parties such as PHOs may also differ from those of the DHB (The Treasury, 2009). However, the attempt to restructure primary health care through PHOs was ambitious given the government neither owned nor fully funded these structures. The ambiguity in relation to the role and functions of PHOs also compromised their ability to assume a strong role in leading change within local health systems (Smith, 2009).

Each DHB was tasked with developing a local strategy which allowed the expression of local variation. Nonetheless, lack of national consistency in the varying interpretations across the country significantly impacted on the configuration of service delivery (Walker & Collins, 2009). For some DHBs primary health care development was taken seriously, in others it was business as usual (Barnett & Barnett, 2004a; Cordery, 2008; Smith et al., 2008). Gauld (2009a) expressed concern that only one third of DHBs understood that an investment in primary health care could make a real difference to the health of a population and reduce the need for secondary care.

The organisational design of DHBs generated numerous tensions (Adam, 2003). Cumming and Mays (2002) question whether DHBs had the right incentives to make the best use of the available resources to meet the needs of their local communities. Funding constraints forced some DHBs to focus on maintaining crucial hospital services curtailing hospital overspend (Gauld 2009a). Gauld (2009a) also stated that tight central government control over decision-making meant DHBs did not have full authority to relocate funds from one area into another. This then reduced DHB capacity to invest in strategies to attend to the broader determinants of health.

The rate at which the reforms took place also resulted in a number of unintended consequences (Gauld, 2008). Much of the implementation effort went into lowering fees and the formation of a large number of PHOs rather than achieving the intent of the Primary Health Care Strategy. Accordingly the complexity and duplications in planning and purchasing were considerable (Ashton & Tenbensel, 2010; Barnett & Barnett, 2004a; Gauld, 2012). Twenty DHBs and over 80 PHOs could be considered excessive for a small country such as New Zealand. Administration costs of PHOs tied up funding that could have been better used to remove patient fees and improve health outcomes.

The labyrinth of funding and organisational systems each with variable capacity supports the notion that there were significant flaws in both design and implementation of the Strategy (Gauld, 2009a). Gauld (2009a) questions whether the development of PHOs was necessary given that the same outcomes may have been achieved through working closely with the existing IPAs, increasing GP subsidies and instigating other primary health care developments such as Care Plus. Instead, a significant number of PHOs simply passed on their capitation payments to general practices without requiring the change expected (Ashton & Tenbensel, 2010; Barnett & Barnett, 2004a; Cordery, 2008; Finlayson et al., 2011; Gauld, 2009a). The funding approach necessitated the incentivising of desirable outcomes (Primary Health Care Advisory Council (PHCAC), 2009).

Reviewing the situation in 2008, Smith et al. argued that greater lucidity was still required around the role of the PHO in shaping services that can deliver and improve population health (Smith et al., 2008). Cordery (2008) identified that PHOs still faced three main challenges:

1. The change from an illness to a wellness focus
2. The management of a short-term funding regime and government demands
3. The balancing of stakeholders and community foci.

The Primary Health Care Advisory Council (PHCAC) (2009) identified "the importance of primary health care planning taking place within the wider context of health system planning" (p.3). Recommendations from the working group included service models based on a person/whanau centred approach and multidisciplinary/interdisciplinary working together in the best interest of the patient. There was acknowledgment that teamwork and leadership must be developed and nurtured. This required awareness of the wide range of health practitioners who contributed to primary health care. Consumer and community voices must be heard in the development of service models, especially in meeting the needs of Māori. The importance of integrated information technology systems was recognised as needing to be progressed alongside the development of technical tools to accommodate the wide scale service change expected. A review of the current funding models was considered necessary in order to bring about the desired change.

The Minister of Health disestablished the PHCAC late in 2009. The PHCAC was originally set up in 2008 to replace the previous PHO Task Force; its function was to provide timely and quality high-level advice to the MoH and DHBs. The mandated membership represented a wide cross section of the primary health sector. It appears illogical that this voice was considered unnecessary given the issues identified through various evaluations of the Primary Health Care Strategy **(**Barnett & Barnett, 2004b; Cumming & Gribben, 2007; Cumming et al., 2005; Raymont & Cumming, 2003).

3.7 Concluding statement

What this chapter demonstrates is that a number of conventional enablers and constraints heavily predisposed the trajectory of changes that took place in New Zealand following the release of the Primary Health Care Strategy. Resistance and numerous impediments in the health sector meant the Strategy was rich in vision but, as detailed throughout this chapter, the operational decisions were in some measure at odds with this vision. This in turn negatively impacted on the effective deployment of primary health care nurses. Understanding such complexities is the epitome of case study research that seeks to explain, describe, illustrate and explore the implementation of a

programme (Yin, 2003). Next, Chapter Four presents the philosophical and methodological location that underpins this research.

Chapter Four: Philosophical and methodological location of the study

4.1 Introduction

The purpose of this chapter is to present the philosophical location and methodology underpinning this study. My epistemological and ontological position is presented before an interpretive qualitative approach as the methodology used. I reiterate that the intention of this research was to evaluate the impact of the implementation of the Primary Health Care Strategy on the primary health care nursing workforce in Tairawhiti from 2001-2010. As such, it generates new knowledge for primary health care nursing service delivery by making visible the multitude of factors that supported or impeded the nursing workforce in Tairawhiti from being full partners and participants in the Strategy.

To begin, I developed a research perspective that informed my overarching research framework as illustrated in Figure 8. This contains constructionism as explanation of the epistemological position. An interpretive qualitative approach also contributed to understanding. A single qualitative instrumental case study was the most appropriate methodology for the information sought. To complete the framework, data collection methods are explained in Chapter Five.

Figure 8. **Overarching research framework** (modified from Crotty, 1998, p.4)

4.2 Epistemology

Providing a description of epistemology is inherent in the theoretical perspective of every research project and therefore in its methodology (Crotty, 1998). Crotty (1998) defined epistemology as a "way of understanding and explaining how we know what we know" (p.3). Consistent with my worldview, a constructionist epistemological position allowed the views and experiences of participants to be heard and shared. This position fits nicely with my beliefs that there are multiple realities. That is, different people have different life experiences and different views of the world. As there are different views of the world there are therefore different ways of researching the world (Crotty, 1998).

Constructionism sits well with the diffusion of innovation theory. As mentioned in Chapter Two, the diffusion of innovation theory helps identify the complexities involved when an organisation adopts a particular innovation including the political, social, cultural, technological and economic characteristics (Greenhalgh et al., 2005). It was these complexities that I

sought to understand by listening to the views and experiences of participants and by gaining an understanding of the multiple realities.

There is a range of epistemologies including objectivism, subjectivism and constructionism. Objectivism encapsulates the notion that meaning exists outside consciousness including the positivist and post-positivist paradigms inherent within quantitative inquiry. Burr (2005) is critical of objectivity as being impossible since we all encounter the world from some perspective or other. Crotty (1998) stated that in subjectivism, the object makes no contribution to meaning and therefore meaning is created out of nothing. However, Crotty (1998) also argued that even in subjectivism we all make meaning out of something. Creating meaning out of nothing is impossible since meaning is created from our own collective unconscious based on previous experience, values, and beliefs. Larsen (2013) provided further clarification by noting that subjectivists believe that norms and values are special constructions that have little meaning outside of a specific context.

Constructionists contend meaning (or truth) cannot be described as either subjective or objective (Crotty, 1998; Tom, 2012). The world we experience and the people we find ourselves to be are first and foremost the product of social processes and people construct ways of understanding between them (Burr, 2005; Lock & Strong, 2010). Crotty (1998) defined constructionism as the view that "....all knowledge, and therefore all meaningful reality as such, is contingent upon human practices, being constructed in and out of interaction between human beings and their world, and developed and transmitted within an essentially social context" (p.42). Constructionists expect to see different things, examine them through different lenses and come to different conclusions. In this sense, "multiple and even conflicting versions of the same event or object can be true at the same time" (Rubin & Rubin, 2005, p.27).

It is through the daily interaction between people in the course of social life that our version of knowledge becomes fabricated. There can be no final description of the world and reality may be inaccessible or inseparable from

our discourse about it (Burr, 2005). Nor is it possible to make comment about the nature of reality if we cannot be in direct contact with it (Harper, 2012). Therefore, all knowledge is provisional and contestable. I sought to understand these different world views in order to determine the impact of the Primary Health Care Strategy on primary health care nurses in Tairawhiti.

4.3 Ontology

Ontology sits alongside epistemology to inform the theoretical perspective. It is "concerned with 'what is' with the nature of existence" (Crotty, 1998, p.10). Subjectively experienced contextual factors influence interpretations of the world. As such, there are diverse ways of knowing, distinguishable sets of meaning and separate realities. One cannot speak of truth but must accept the existence of many alternative constructions of events in that the way things are is really the sense we make of them (Berg & Lune, 2012; Burr, 2005; Crotty, 1998; Rubin & Rubin, 2005). Realism and relativism are both ontological notions (Crotty, 1998).

Burr (2005) stated that realism "asserts that an external world exists independently of our representation of it" (p.22). Representations might include perceptions, language, and thoughts. Conversely relativism argues if such a reality exists it is inaccessible to us, the only thing we have available are representations of the world and therefore they cannot be judged against reality for truthfulness (Burr, 2005). Within this position, social science cannot uncover the truth about people or society.

Crotty (1998) argued that constructionism in epistemology is compatible with both realism and relativism in ontology. A researcher might be epistemologically and methodologically relativist but it does not necessarily make them ontologically relativist (Harper, 2012; Lock & Strong, 2010). What this means is that "they are relativist about what we can know about the world but they are not relativists about whether there is a world at all" (Harper, 2012, p.91).

Truth is defined as the best informed and most sophisticated construction on which there is consensus. Therefore, the findings of this study will exist because of the interaction between the researcher and participants in creating a constructed reality that is as informed as it can be at this particular time in this particular setting. Consequently, researchers must acknowledge their intrinsic involvement in the research process and view their piece of research as a co-production between themselves and the people they are researching (Burr, 2005).

4.4 Interpretive and qualitative underpinnings

There are two main but competing paradigms or ways of thinking about the world: positivist and interpretive (naturalist) traditions (Davidson & Tolich, 2001; Lincoln & Guba, 1985). The positivist inquiry asserts that inquiry is value free (Davidson & Tolich, 2001; Hays & Sing, 2012). This means it is supposedly free from assumptions, perspectives and social, cultural or personal influences. Hays and Sing (2012) contend that positivist inquiry has "dominated and characterised scientific pursuit for several centuries" (p.39). However, Denzin and Lincoln (2005) argued that all research is interpretive. It is guided through a researcher's own set of beliefs and feelings about the world and how it should be understood and studied.

This research required the "how", "when" and "why" questions to be answered. The need to understand the nature of the social world as experienced through participant interaction is central to the enquiry. An interpretivist approach provided the theoretical basis for capturing the array of situations within which people constructed and gave meaning to these "how", "when" and "why" questions. The approach lay in the acceptance of the importance of understanding and the appreciation of the influence of interpretations and perceptions. The individual and society are inseparable units and one is not possible without the complete understanding of the other (O'Donoghue, 2007). The configuration of meaning and institutional life informs and shapes reality, constituting behaviour (Holstein & Gubrium, 2008; Jun, 2006; O'Donoghue, 2007). The intent is to understand the deeper meaning inherent in the phenomenon under study (Crotty, 1998). Change is

not the basis for interpretive research but greater understanding will in itself effect change.

It is important to understand that interpretive research is not a synonym for qualitative research (Rowlands, 2003). Although qualitative methods dominate the interpretive paradigm, qualitative "researchers study meaning" (Ezzy, 2002, p.81). The data is a source of rich descriptions and explanations occurring in local contexts that have a concrete, vivid, and meaningful flavour (Ezzy, 2002; Ryan & Bernard, 2003). Interpretations and meanings relate to a particular piece of research and might not fit with another (Ezzy, 2002). It is the people and their experiences that are important in the qualitative research process (Roberts & Taylor, 2002).

4.5 Case Study methodology

4.5.1 Introduction

There appears to be confusion over whether case study is a method or a methodology. Methods are the procedures used to gather and analyse the data (Crotty, 1998), while methodology is the strategic plan that shapes the choice of methods and links them to the desired outcome. Both Yin (2009) and Stake (2005) referred to case study as a method, as does Crotty (1998). Other authors such as Creswell (2007) put forward case study investigation as a methodology. In this research I am presenting instrumental case study as a methodology.

There are multiple definitions and understandings of case studies (Zucker, 2001). In the past three decades there have been more than 25 different definitions each with their own particular emphasis and direction for research (Van Wynsberghe & Khan, 2007). However, there are common properties of case study research that include an intensive and in-depth focus on a specific unit of analysis, a highly detailed contextual analysis of the case, specific time and spatial boundaries and the use of multiple data sources.

Baxter and Jack (2008) state there are two key approaches that guide case study methodology: one proposed by Stake (1995) and the second explored by Yin (2003). Both seek to ensure the topic of interest is well explored and the phenomena revealed, but the methods of data collection and analysis they employ are quite different. Stake (1995) classified case studies into three different types: intrinsic, instrumental and collective. In an intrinsic case study a researcher wants to know more about a unique phenomenon of a particular case. An instrumental case study is one that seeks to better understand a theoretical question or problem to enhance understanding of a particular issue. The case is of secondary interest, the focus is on a single concern that the case serves to illustrate. However, Stake (1995) also suggested that sometimes there is no solid line drawn between an intrinsic and an instrumental case study because researchers tend to have multiple interests.

On the other hand, Yin (2003) identified three main types of case study: exploratory, descriptive and explanatory. Exploratory case studies seek to define research questions of a subsequent study or to determine the feasibility of research procedures. This type of case study is often used in pilot programmes. Descriptive case studies present a complete description of a phenomenon within its context. Explanatory case studies pursue cause and effect relationships to determine how events occur and which ones may influence particular outcomes.

Case studies can also be either single or multiple (Stake, 1995; Yin, 2003). A single case looks for the detail of interaction within its context, investigating the particularity and complexity of that case and often because the researcher has a special interest in that case (Stake, 1995). The information gained generates a picture of the case for others to see that then informs other situations.

Case studies can be either qualitative or quantitative, or both. There are certain advantages for the qualitative inquirer in that the researcher seeks greater understanding of the case in order to appreciate the uniqueness and complexity of “its embeddedness and interaction within its contexts” (Stake, 1995, p.16).

What Stake is suggesting is that the difference for qualitative inquiry is the need to understand the complex interrelationships that exist. The uniqueness of the individual case and context of that case is important to understanding and knowing the particularity of the case. The case study is a virtual reality in that the reader will enter the reality, explore it inside and out, and gain in-depth understanding of the issue (Flyvbjerg, 2004).

The selection of a specific type of case study is guided by the study purpose (Baxter & Jack, 2008). I elected to use a single instrumental case study as I was interested in the impact of the implementation of the Primary Health Care Strategy on primary health care nursing; the case was of secondary purpose. A great deal has already been written about the implementation of the Primary Health Care Strategy, as outlined in Chapter Two. In this research I wanted to understand the factors of the Strategy as an innovation that should have influenced the effective deployment of primary health care nurses in a DHB with a high needs population and a particular need for primary health care reform. Tairawhiti was chosen as the case most suitable to understand this issue. The methodology and methods employed also influenced my decision to use Stakes' (1995) instrumental case study.

Through this instrumental case study I sought a highly detailed contextual analysis of the impact of the implementation of the Primary Health Care Strategy on primary health care nurses in Tairawhiti. I wanted to understand how the Strategy had influenced the role of the primary health care nursing workforce from the participant's perception. To achieve this I sought answers to the following two questions:

1. What change has occurred within the primary health care nursing workforce in Tairawhiti since the implementation of the Primary Health Care Strategy, how and why did this come about?
2. What factors influenced the deployment of primary health care nurses in Tairawhiti?

In case study research, the questions guiding the study ask about the description and experience of the phenomenon in question (Zucker, 2001). The two questions were formulated in response to my local knowledge of primary health care nursing and current literature and they are critical to the case in question. The questions relate to how the implementation of the Primary Health Care Strategy in Tairawhiti contributed to any change to the primary health care nursing environment and why this occurred. Boundaries and a timescale define the case under investigation to determine the impact of the Strategy implementation on the primary health care nursing workforce in the Tairawhiti district from 2001-2010.

Yin (2009) contends that a good case study researcher must have a firm grasp of the issues being studied as analytic decisions are made throughout the data collection phase. The author stated that the research is not a case of merely recording the data but interpreting that information as it is being collected. Without prior knowledge, essential information may be missed. As a primary health care nurse in Tairawhiti for over 20 years and with sound knowledge of the Primary Health Care Strategy, I believe I was able to sufficiently capture and analyse the data obtained to provide in-depth understanding of the issue under investigation.

Richly descriptive, case study research is grounded in deep and varied sources of information (Hancock & Algozzine, 2006). As discussed in more detail in Chapter Five, qualitative data was obtained from the document audit, literature review, primary health care nurse focus groups as well as individual interviews with nurse leaders and other managers. This approach enabled a more detailed probing rather than mere surface descriptions in identifying the challenges that influenced the advancement of primary health care nursing in Tairawhiti. At the same time I sought to preserve the meaningful characteristics of real life events. The holistic approach of a case study was appropriate for finding out how and/or why a programme has worked or not worked in order to improve action and make better decisions (Scholz & Tietje, 2002; Stake, 1995).

4.5.2 Strengths and weaknesses of using case study

A sound case study provides abundant information for decision-making with a clear teasing out of the intricacies that can be found in naturalistic settings. Case studies are particularly useful for exploring and understanding the dynamics of change to determine factors critical to the implementation of a programme (Simons, 2009). As a research strategy, case study enables an investigation of a contemporary phenomenon within its real life context especially when the boundaries between phenomenon and context are not clearly evident (Scholz & Tietje, 2002; Yin, 2003).

Generally more exploratory than confirmatory, case studies seek to identify themes, categories or behaviour and events rather than prove a hypothesis (Hancock & Algozzine, 2006). They are a comprehensive examination of the given phenomenon and include a myriad of dimensions, factors and categories woven together into an ideographic framework (Stake, 2006; Stufflebeam & Shinkfield, 2007). Case studies also offer a sense of reality, increased flexibility, and can be used to stimulate action (Griffiths, 2004). They facilitate the examination of the goals, aspirations, plans, resources, unique features, actions, achievements and disappointments of the case (Stufflebeam & Shinkfield, 2007). Thus case studies make the case understandable (Flyvbjerg, 2004; Stake, 1995).

Case studies have been viewed as a less desirable form of inquiry (Flyvbjerg, 2004; Griffiths, 2004; Yin, 2003). A formal plan is followed in case study design though the specific information obtained is not readily predictable (Yin, 2003). Another critique is in the level of subjectivity involved (Flyvbjerg, 2004). If it leans more toward qualitative research it can be impossible to know the extent to which the researcher has selected the data while other potentially significant data have been ignored (Griffiths, 2004). Despite this criticism, I believe case study methodology helped inform how participants in this research made sense of their world. I was able to uncover the intricacies involved in implementing the Primary Health Care Strategy in Tairawhiti. As the researcher I was able to capture multiple realities and

provided important evidence that is transferable to other locations for primary health care nursing.

4.6 Concluding statement

This chapter identified the tools within my research framework. My epistemological constructionist worldview was presented demonstrating a correspondence with my belief that different people have different life experiences and therefore different views of the world. My ontological position was declared within which the constructs of reality and knowledge were consistent with my epistemological position. Sustaining my constructionist beliefs, the interpretative qualitative paradigm was explored before case study as the methodology for this research was examined. An essential feature of case study is that multiple sources of evidence and sufficient data are collected for researchers to be able to explore significant features of the case and to put forward interpretations (Yin, 2003, 2009). The more the case study relies on different types of evidence, the stronger it will be. The next chapter presents the investigative processes employed.

Chapter Five: The process of data collection and analysis

5.1 Introduction

The previous chapter provided the philosophical location of the research. The intent of this chapter is to describe the specific details of the practical and procedural processes used. To reiterate, the purpose was to evaluate the impact of the implementation of the Primary Health Care Strategy on the primary health care nursing workforce in Tairawhiti from 2001-2010. I sought to make visible the factors that supported or impeded full participation and partnership with the nursing workforce.

To begin, I present the insider-outsider location of the research. I acknowledge that my background knowledge of primary health care, nursing experience and my personality, influenced each stage of the research process. This is followed by the steps taken to ensure robust ethical and cultural considerations. Data collection methods are then described and include recruitment processes, individual interviews, focus groups, sample size and document audit. The analytic procedures are explained before trustworthiness of the data is explored. Reflexivity and triangulation strengthen trustworthiness. The chapter is completed with mention of the transformative use of the information.

5.2 Insider-outsider location

The insider-outsider dichotomy is a catalyst for much debate (Dwyer & Buckle, 2009; Costley, Elliott, & Gibbs, 2010; Kerstetter, 2012; Unluer, 2012; West, Stewart, Foster, & Usher, 2013). The unique perspective of the researcher inevitably makes a difference to the research (Costley et al., 2010). Research has attempted to move beyond the strict insider-outsider dichotomy to emphasise the relative nature of researcher's identity and social position (Kerstetter, 2012). The opportunity to research my own area of knowledge presented a number of opportunities, as well as complexities which required in-depth consideration. This was further complicated by being a staff member

of the organisation directed by the MoH to lead the implementation of the Primary Health Care Strategy in a small DHB.

An insider is a researcher who studies the group to which they belong (Dwyer & Buckle, 2009; Unluer, 2012). According to Moore (2012), it is common in qualitative research for the "researcher to be part of the social group they are investigating" (p.11). The notion of being an insider and outsider is a continuum that the researcher traverses at different times throughout the study (West et al., 2013). West et al. (2013) also stated that the researcher can take on a role that allows them to distance themselves when appropriate, even when they have intimate knowledge of the phenomenon under study.

Undertaking case study research as an insider is valuable in determining the case as well as entering the research site (Unluer, 2012; West et al., 2013). Researchers are uniquely positioned to "understand the experiences of groups of which they are members" (Kerstetter, 2012, p.100). Without some insider knowledge, researchers will never come to realise the richness of the phenomenon they are studying (West et al., 2013). As a primary health care nurse I had easy access to nurses who were able to answer any questions. I was accepted as a member of the nursing profession, who spoke the same language and appreciated the implicit meaning of being a primary health care nurse.

As a member of the planning and funding team I was able to speak to people to clarify some of the events that occurred. These are recorded as personal communication in this thesis. After the data collection process I was employed as a part-time portfolio manager for older persons. Through this position, I gained insight into the decision-making processes of the DHB. This enabled an increased understanding of the intricacies and complexities of decision-making in a tight fiscal environment. I experienced the realities of balancing the financial resources to meet the demands of secondary care against the development of primary health care.

Incorrect assumptions by readers of research can be made about research processes. Furthermore, asking questions of a politically or administratively sensitive nature can often engender opposition from certain individuals or groups (Christianson, Laegreid, Roness & Rovik, 2007). I was determined not to play down aspects of the findings that may cause conflict for me. Researchers must address disadvantages in order to ensure credible insider research (Costley et al., 2010; Unluer, 2012). I believe I collected data without prejudice and from the start I was reflexive by examining my own assumptions. I was also aware of my involvement as both an insider and outsider in the research process. This is discussed further in the section on reflexivity. I also used multiple sources of evidence to support my findings. As identified in the following ethics section, I did not hide my experience or employment status with any of the participants and it was declared on the information sheets provided. I had the support of the chief executive and that support was endorsed by the clinical board. I also discussed potential issues with my supervisors.

5.3 Ethical considerations

Ethical considerations were considered paramount in this research and ethical approval was obtained after submitting a detailed ethical application to the Massey University, Northern Campus Human Ethics Committee (MUHEC) (Appendix One). I sought the advice of the National Coordinator, Health & Disability Ethics Committee who informed me it was not necessary to submit an application to a Regional Ethics Committee as this piece of research did not involve patients. Health and Disability Ethics Committees are Ministerial committees (established under section 11 of the New Zealand Public Health and Disability Act), whose function is to secure the benefits of health and disability research by checking that it meets or exceeds established ethical standards.

There are unique ethical issues relating to issues of coercion and the anonymity of organisations and individual participants (West et al., 2013; Unluer, 2012). It was therefore important that I declared my role as an insider. My employment status was clearly identified on my ethics application to

MUHEC. As an insider and an employee of the DHB tasked with leading the implementation of the Primary Health Care Strategy, I sought prior approval from the chief executive and clinical board. As an outsider I sought permission from the chief executives of other organisations involved and was required to formally apply to one PHO through their research application process.

At the time of data collection my role as nurse leader-primary and community was clearly stated on the participant information sheet as well as on all promotional material. The title of the project identified Tairawhiti DHB as the focus of the study. After reading the finished thesis, written permission was granted by the chief executive of Tairawhiti DHB to retain Tairawhiti in the title (Appendix Two). Participants were informed that my nursing leadership position had no direct line management responsibilities. Potential participants were also informed that non-participation in this project would not affect future working relationships. I discussed the risks with all participants, an information sheet was provided (Appendices Three & Four) and written informed consent was obtained prior to the interview/focus group (Appendices Five & Six). All participants were advised that the interview/focus group would be audio-taped and were made aware of their rights in relation to this. All participants were given the opportunity to ask questions about the study at any time prior to, and throughout the interview.

5.3.1 Risk of harm

The risk of harm to participants was minimal although there was potential for an increased awareness of their role in implementing the principles of the Primary Health Care Strategy. If frustration had resulted from self-awareness during the interview and focus group process I would have managed this by encouraging participants to look at possible solutions to the issues raised. I am an experienced registered nurse trained in facilitation, and with the ability to detect discomfort had it surfaced. I felt confident I was able to deal with any potential issues and fortunately all participants were relaxed and spoke with ease.

5.3.2 Confidentiality

As an insider I had to consider ethical issues such as honesty, privacy and responsibility. I was very careful that the information collected and collated was not discussed outside of the interviews or focus groups. Confidentiality cannot be entirely guaranteed in a small place like Tairawhiti but it was the overarching aim of all processes. Pseudonyms were used in the transcripts. In written reports related to this study, no participant was identified. All tapes and transcripts were carefully scrutinised to ensure participant names and any other identifying references were removed.

In focus groups it is more difficult to achieve confidentiality than in individual interviews (Berg & Lune, 2012). What the participants say to the researcher, they share with the other group participants. Ground rules were set at the beginning of each focus group, reinforced at the end and the consent form included a non-disclosure agreement (Appendix Six). Participants were asked to respect the privacy of fellow participants and not repeat to others what was said in the focus group. Confidentiality considerations included storing and access to collected data.

A password protected all computer files. The only other people who had access to the transcripts were my two supervisors. Transcribers signed a confidentiality agreement prior to receiving the transcripts and had explained to them the importance of ensuring confidentiality (Appendix Seven). All participants were advised that the interviews and focus groups were audio-taped and were made aware of their rights in relation to this. All documents including consent forms, taped interviews and transcriptions will be held by a representative of Massey University for safe keeping for a minimum period of five years after completion of the research. Attention to cultural concerns was of equal importance to ethical considerations as discussed next.

5.4 Cultural considerations

Culture includes a wide array of ideas and customs. This research acknowledged the diversity of different groups as part of the investigation.

Consultation and communication were considered a necessary part of being responsive to Māori. Māori input was actively sought in each step of the research process. Protection of Māori includes respect of individual and collective rights, cultural data, cultural concepts, values, norms, practices and language.

I have an appreciation of the attitudes and values which constitute the cultural property of ethnic groups other than my own. As such, cultural advice was sought from the TDH Māori health manager. I also engaged the support of a Māori cultural advisor. Every attempt was made to ensure the culture of Māori and others was respected and all protocols adhered to. When making the interview and focus group appointments, I asked each participant if they had any specific cultural needs. Consistent with Māori consultation, an update on the progress of the research and a full copy of the report will be provided to each participating organisation and all individual participants on request.

5.5 Data collection

An essential feature of case study is the use of multiple sources of evidence as data in order to be able to explore significant features of the case (Stake, 2005; Yin, 2003). The more the case study relies on different types of evidence, the stronger it will be. Information sought from the data collection included:

- A critique of the evolving literature surrounding the development and implementation of the Primary Health Care Strategy in Tairawhiti such as TDH, Ngati Porou Hauora and Turanganui PHO policy documents and strategic plans as available on their respective websites
- All public Board and statutory advisory committee minutes (2002-2010) and district annual plans, as available from Tairawhiti DHB archive
- An account of how nurses in Tairawhiti have been deployed since the implementation of the Primary Health Care Strategy
- An analysis of the current primary health care nursing infrastructure in place in Tairawhiti, and how and why this came about

- An investigation into Tairawhiti primary health care nurse perceptions of the Primary Health Care Strategy
- An appraisal of Tairawhiti middle and senior manager's perceptions of where primary health care nursing fits within the Primary Health Care Strategy locally
- A critique of the strengths, weaknesses, and barriers to effective implementation of the Primary Health Care Strategy as it relates to nursing and why these exist.

From my constructionist perspective I wanted to understand the world from the participant's perspective of the events they had experienced or observed. At the heart of this is an interest in understanding the experiences of the participants, and the meaning they make of that experience. In order to obtain this information, data were collected using a number of appropriate qualitative methods including in-depth individual interviews with managers at middle and senior levels at TDH and the two PHOs. Focus groups were also held with primary health care nurses and analysis of documents relevant to the case under investigation.

5.6 Interviews/focus groups

The interview/focus group process is detailed to enable an understanding of the procedures employed. A total of 42 people participated in this study: 10 individual interviewees and 32 nurses in the five focus groups that took place over a 20 week time period. Semi-structured questions were used for both the interviews and focus groups; these were well suited to case study research. Using a semi-structured approach allowed predetermined questions to be asked while allowing the flexibility to probe more deeply into issues of interest when the researcher has a list of topics or broad questions that need to be addressed (Polit & Tatano Beck, 2006). At the same time, participants are able to express themselves openly and freely and define the world from their own perspectives (Hancock & Algozzine, 2006).

The case study researcher should be able to ask 'good' questions, be a "good" listener and not be trapped by their own ideologies or preconceptions (Yin,

2003). Being a “good” listener means assimilating large amounts of new information that captures the mood of the participants and enables an understanding of the context from which the interviewees perceive their world. Questions in this study prompted discussion on the Primary Health Care Strategy specifically around participant perceptions of the Strategy, the changes that had taken place, and how and why those changes occurred. Individual interview and focus group prompts are included in Appendices Eight and Nine.

With the exception of the focus groups held at existing primary health care nursing forums, participants themselves selected the venues where the interviews and focus groups took place. This encouraged a feeling of ease and stimulated the conversation. Participants were seated around a table to facilitate discussion. The table also provided an object on which the audio-taping equipment was placed, and while suitable for the participants, the venues were not always appropriate for audio-taping. Two audio-tapes recorded each interview/focus group to ensure all information was captured clearly. The scheduled time for each interview/focus group was 60 minutes with an extra 30 minutes allowed for introductions and conclusions. Refreshments were offered at the end of each interview/focus group and allowed participants the opportunity to debrief.

5.6.1 Individual interviews

Individual interviews were conducted with key stakeholders and decision-makers at middle and senior management levels of TDH and two PHOs. I used purposive sampling to select participants for the individual interviews. In purposeful sampling there is no random selection process (Ezzy, 2002; McGivern, 2006; Silverman, 2005, 2009). Individual participants were selected on the basis of their perceived knowledge of and ability to influence implementation of the Strategy in Tairawhiti and subsequent nursing contribution. They were considered key players in the implementation of the Primary Health Care Strategy in Tairawhiti. Chief executives, representatives from planning and funding, as well as senior nurses and a doctor were included.

I chose individual interviews for these participants as they had different levels of responsibility and I wanted them to speak freely without concern. I was also aware of the commercial sensitivity of the given information as the managers were employed by different organisations. Individual interviews also allowed increased flexibility in setting the date and times for the interviews to occur. From the managers, I sought information on the implementation of the Primary Health Care Strategy in Tairawhiti at a more strategic level. I also wanted middle and senior management perspectives on where primary health care nursing sits within the Strategy.

5.6.2 Focus groups

Focus groups were chosen as the preferred technique for the primary health care nurses as they offered a way to listen to the multiple voices of others while significantly reducing the risk of any threats of intimidation from my nurse leader position. Focus groups provide a powerful means to explore the variation, diversity and consensus of both ideas and beliefs on a given topic within a social context (Hennink, 2007; Liamputtong, 2011). This was considered especially important for making audible the voices of people who are rarely heard (Liamputtong, 2011).

Some diversity in the composition of the group aids discussion, but too much can inhibit it. Participants tend to feel safer and prefer being with others who share similar characteristics (Finch & Lewis 2003). A very heterogeneous group can feel threatened and can inhibit disclosure. The focus groups in this study were relatively homogenous and this facilitated disclosure. Conversely, the conversation can become too easy and the researcher might need to work hard to tease out the differences in views.

Focus groups produce a concentrated amount of data on precisely the topic of interest and in a shorter time frame than if the individual interviews were held with the same number of participants (Hennink, 2007; Liamputtong, 2011). The hallmark is the explicit use of group interaction to produce data and insights which would be less accessible without the interaction found in a group situation. Interaction is actively encouraged to maximise the spontaneity

that arises from the stronger social context (Barbour, 2007; Finch & Lewis 2003; Hennink, 2007).

The comments made are dependent upon the context and group member's responses to contributions from others as well as the dynamics of the group (Hennink, 2007). The language they use, the emphasis they give, and their general framework of understanding, all emerge from the discussion. The group context in this research allowed participants to ask questions of each other, and comment on what they had heard while prompting others to reveal more. The discussion was less influenced by interaction with the researcher than it might otherwise be in an individual interview, although researchers do take an active role in creating the discussion.

Focus groups have the advantage of being stimulating to respondents and aid recall and elaboration. Focus groups facilitate participant recognition and awareness of their own subjugation which may lead to participant involvement as change agents for their cause (Madriz, 2003). The person conducting the focus group must be objective, empathic and persuasive while encouraging all respondents to participate to ensure the fullest possible coverage of the topic (Finch & Lewis 2003; Liamputtong, 2011).

The disadvantage of this form of data collection is that less information is obtained from each respondent at the individual level (Hennink, 2007). There is also the potential for psychological factors and group dynamics to affect the group. The greatest threat is "groupthink" wherein stronger participants influence responses from other group members (Boateng, 2012). This can severely limit the self-expression of members and limit the conversation. Had this occurred it would have been managed by allowing each participant to challenge ideas and present objections as well reining in participants that attempted to "steamroll" their opponents.

The study population identified for the focus groups included all primary health care nurses in Tairawhiti; this numbered approximately 100 potential participants. I sought representation from most primary health care nursing

groups including practice nurses, public health nurses, occupational health nurses, district nurses, plunket nurses, tamariki ora nurses, rural nurses, sexual health nurses, Iwi based nurses and community mental health nurses.

The majority of focus group nurse participants were between 40-55 years of age. The high number of Māori nurses (just over half) is noteworthy and reflective of strong Iwi organisation participation in this study. European, two Pacifica nurses and one other made up the remaining ethnicities. A significant proportion of participants were tertiary educated and overall represented many years of nursing experience and practice between them. Less than a third had commenced or completed post graduate qualifications. It is acknowledged there was no representation from district nurses, occupational health nurses or nurses employed in the smaller NGOs and therefore the sample is not representative of all primary health care nursing groups in Tairawhiti.

5.7 Sample size

Ten decision-makers at the middle and senior level of the local health services were invited to attend the individual interviews. The number of primary health care nurse participants and therefore the number of focus groups was determined by the level of saturation. Rather than sampling a specific number of people I was looking for repetition and confirmation from a variety of primary health care nursing cohorts as supported by Streubert-Speziale and Carpenter (2007). Five focus groups were held with the primary health care nurse participants. Between five and nine participants attended each focus group. Both Finch and Lewis (2003, and Liamputtong (2011), recommend no more than ten people per focus group; any more seldom provide meaningful insight.

5.8 Recruitment process

As an insider, the selection of participants for my research was influenced by my local knowledge of primary health care, primary health care nursing and health service providers in Tairawhiti. I was known to most of the participants. My local knowledge and professional networks meant relationships were

already established. I gave careful consideration to potential power imbalances and the exploitation of relationships when recruiting participants. As previously mentioned, I was employed as a public health nurse for 18 years in Tairawhiti. During the course of this research I was promoted to a position as nurse leader-primary and community for TDH.

Participant selection was also governed by pragmatism. Because of established relationships, participants were sought through existing contacts. The dilemma was finding a balance between encouragement and harassment, or being seen as using my nurse leader position to coerce potential nurse participants. This was achieved by not approaching each individual nurse face to face, to request participation.

I promoted my research at relevant meetings and made use of primary health care nurse forums and existing opportunities. I advertised the impending focus groups through established local communication mediums, such as GP newsletter, primary health care nurse newsletter, and TDH and Turanganui PHO newsletters. This exercise created local discussion, but the response rate from primary health care nurses was poor. With management permission, I then offered to hold focus groups at existing primary health care nursing forums and three focus groups were held as a result. Nurses had the opportunity to opt out of the focus group part of these forums. A flyer was distributed offering evening focus groups to allow more primary health care nurses the opportunity to attend. After the first evening focus group I determined that practice nurses were not well represented. I then sent further invitations to all practice nurses and five participated in the fifth focus group. After five focus groups I had good representation by Iwi based nurses, public health nurses, rural health nurses, tamariki ora nurses and nurses working with long-term conditions.

In regards to the individual participants I had limited previous contact with the non-nursing individuals, although we knew of each other. I approached each individually and invited participation in the study. All those approached agreed to be interviewed. Participants in both the individual interview and

focus groups were provided with information sheets (Appendices Three & Four) and consent form prior to agreeing to participate (Appendices Five & Six).

5.9 Documentary analysis

The advantage of using documents as a source of evidence in research is in its unobtrusiveness, the possibility of repeat reviews and access is usually easy (Hodder, 1994). However, disadvantages are that documents can reflect author bias (Jacobs, 2006) and the records may be incomplete. To build a systematic understanding of the manner in which the Primary Health Care Strategy had been implemented in Tairawhiti I examined documentary data gathered from a range of sources:

- All Board and statutory advisory committee minutes (2002-2010) with a focus on primary health care decisions as available from Tairawhiti DHB archive
- District annual plans
- MoH, TDH, Ngati Porou Hauora, Turanganui PHO and Midland Health Network public documents, media reports and publications.

Information was sought on MoH policies and current literature that depicted the political, economic, social and historical contexts of primary health care and the introduction of the Primary Health Care Strategy locally and nationally. I sought evidence on the Strategy's implementation and potential impacts on the primary health care nursing workforce. Gathering the documents served a number of purposes:

- To provide an understanding of Board and advisory Committee decision making priorities
- To provide current and historical insight into organisational environments
- To determine the specific Primary Health Care Strategy implementation actions

- To provide contextual information that could corroborate and augment the evidence gathered from interviews and focus groups.

All documents were examined for authenticity, as well as dates and events. A summary of this information is provided in Appendix Ten and all were documents of public record. Under the New Zealand Public Health and Disability Act 2000[11], any member of the public may inspect and take notes from any DHB minutes of Board or advisory group meeting or any part of it, unless it was a meeting or part of a meeting from which the public was excluded. The next section outlines the data analysis procedures undertaken.

5.10 Data analysis

Data analysis involves creative insight and careful attention to the purposes of the research. It makes the invisible obvious, recognising the significance from the seemingly insignificant while linking unrelated facts logically (Stake, 2010). Data collection, data analysis, and report writing are not distinct steps in the qualitative process; they are interrelated and often occur simultaneously (Creswell, 2007; Zucker, 2001). As a recursive process, the researcher interacts with the information throughout the investigative process in seeking the deeper, hidden, socio-cultural meanings and assumptions contained in the data (Stake, 1995). This requires a number of systemic procedures and techniques to engage with the complexity of analysing human action in terms of meanings (Braun & Clarke, 2006; Denzin & Lincoln, 2003; Ezzy, 2002). The analysis is based upon participant descriptions; however the interpretations are those of the researcher.

Every researcher is subject to the influences of their own life experiences and how they have come to view and understand the world (Grbich, 2007; Rubin & Rubin, 2005). As an insider I was mindful I already had a significant amount of knowledge of primary health care, primary health care nursing and primary health care organisations locally. Despite this prior knowledge, I still had significant knowledge gaps. I did not fully understand Iwi providers or the

[11] http://www.legislation.govt.nz/act/public/2000/0091/latest/

general practice environment. As an insider, I had to have an explicit awareness of the possible effects of bias on data collection and analysis. Analysis of the data is threatened by greater familiarity which can lead to loss of objectivity (Costley et al., 2010; Unluer, 2012). This is more of an issue where there is impartiality or vested interest in certain results being achieved (Costley et al., 2010). Maintaining objectivity with my data was therefore something of which I had to be very aware.

My constructionist worldview and qualitative interpretive approach also guided my interpretation of the data. The diffusion of innovation theory provided the overarching framework that allowed for the social dimensions of change and therefore meaning to be illuminated. The framework was utilised to determine the perceived attributes of the Primary Health Care Strategy. It served as a tool to tease out the intricacies and interactions that influenced the diffusion process within complex organisations, and ascertain the interaction between the innovation and intended adopters.

Thematic analysis was used as the process for analysing the data obtained from the individual interviews and focus groups. It is a method for identifying, analysing and describing themes or patterns within the data and is compatible with constructionist paradigms (Braun & Clarke, 2006). This enabled the communication of findings and interpretation of meaning providing crucial insight into what is known. The stages in thematic analysis include:

1. Familiarisation of the data (sensing themes and recognising a codable moment)
2. Generation of initial codes
3. Identification of themes
4. Review of themes
5. Defining and naming of themes
6. Producing the report (Braun & Clarke, 2006).

5.10.1 Preparation of the raw data

To begin, all tapes from the interview recordings were transcribed verbatim as soon as possible after the interview. A transcriber was employed. After receiving the first two transcripts there was a considerable delay and another transcriber was required to fulfil the task. As mentioned earlier, the importance of confidentiality was stressed with both transcribers and a written agreement for confidentiality was obtained from each.

I decided against using a qualitative research analysis programme although in hindsight it would have been useful in improved auditability. Instead I chose to manually process and analyse the data. Initially I printed hard copies and used highlighter pens to identify common codes and text interpretation. At the same time a computer generated interview and focus group transcript file was opened and an index system implemented. All transcripts were labelled and dated along with a brief overview of study participant's roles. This made it possible to revisit the electronic transcripts multiple times to examine the broader context in which that data occurred as well as write on and annotate texts. Both processes enabled clarification and confirmation of some of the snippets of data and allowed the data to be re-contextualised.

I listened to the recordings at the same time as reading through the transcripts to check for accuracy. I listened to the audiotapes several times and re-read the transcripts until I was familiar with the content. Being "close" with the data is essential (Braun & Clarke, 2006; Hennink, 2007). This allowed me to make decisions about what was more important or less important in relation to the data.

For the documentary analysis I visually skimmed all Tairawhiti Board and advisory committee minutes (2002-2010) as well as district annual plans for information specifically relating to the implementation of the Primary Health Care Strategy and primary health care. MoH, Ngati Porou Hauora, Turanganui PHO and Midland Health Network public documents, media reports and publications were scanned for significance. The relevant documentary data were recorded in chronological order on a computer spread sheet (Microsoft

Excel) by date, source, and document type and with a brief description of key points.

5.10.2 Coding procedures and development of themes

As mentioned previously, I did not use a Computer Assisted Qualitative Data Analysis Software tool to assist with data management and analysis. Instead I manually reduced the extensive data to a more manageable format. Data reduction refers to a process of selecting, focusing, simplifying, abstracting and transforming the data that appear in written transcripts (Hancock & Algozzine, 2006; Myles & Huberman, 2004; O'Dwyer, 2004). This information management system, although seemingly simplistic, was laborious but essential. I disassembled and reassembled the data, breaking them into sections which I then grouped and placed in a table with headings added to clarify the contents of each column. This forced me to make judgments about the meanings of the text for a system of coding to be applied. Being able to revisit the electronic and hard copy transcripts multiple times meant no relevant data was missed.

Creswell (2009) advises to look for codes that are not anticipated, unusual, and that address larger theoretical perspectives. Sometimes there is a significant meaning in a single occurrence, but usually the important meanings are those that are repetitive. It is not uncommon in qualitative analysis that a single text segment may fit into more than one code (Braun & Clarke, 2006). Where this occurred in this study I placed them under all of the codes to which they related. I repeated this process with each interview and focus group. Likewise, some of the text was not assigned to any code and was placed in a one off code box if relevant. Only a very small amount of text did not "fit" into the codes that emerged from the raw data. Each data item was given equal attention in the coding process.

I tested the robustness of the codes, continually revising and refining the coding system. I looked for relationships between codes, an overlap of codes, contradictory points of view and new insights. There was no overt sequence to the coding although they were closely linked and comparative with each other.

The revision and refinement processes continued until I was comfortable with the results. An example of the coding is provided in Table 3. The key to understanding the excerpts is as follows:

- The capital letter in brackets identifies that the quotation was provided either by a middle or senior manager (I) or from a nurse in one of the five focus groups (FG)
- The number that follows the capital letter signifies the order in which that interview or focus group took place.
- For auditability the p. represents the page number that this quotation can be found on the typed transcripts.

Table 3. Coding of data

Code Label	Description of code	Text associated with code
The Primary Health Care Strategy	Participant knowledge and understanding of the Primary Health Care Strategy	It's interesting because I don't believe that the primary health care sector, I think they accepted the Strategy as opposed to believe the Strategy. (I.5, p.1) May I ask what is the Primary Health Care Strategy, can we get that right in my head. (FG.1, p.1)
Nursing leadership	Primary health care nursing leadership in Tairawhiti	In our organisation we have some really great leaders. But they don't step up to the leadership role because they have already got enough bricks on their head. (FG.1, p.8) I do think it will be through leadership and having that voice, things may change in the future. (I.3, p.5)

Once the data has been initially coded and collated the next process is to refocus the analysis (Braun & Clarke, 2006). Braun and Clarke (2006) state this phase re-focuses the analysis at the broader level of themes rather than codes. It involves sorting the different codes into potential themes, and collating all the relevant coded data extracts within the identified themes. The

authors state the theme should cohere around a central idea or concept. I concentrated on identifying patterns within the data and the different ways these patterns related to each other. As a result of this process a synthesis of the data emerged and produced a new understanding that allowed me to search for nuances in the way each concept was used. From this, I developed a thematic map as illustrated in Figure 9.

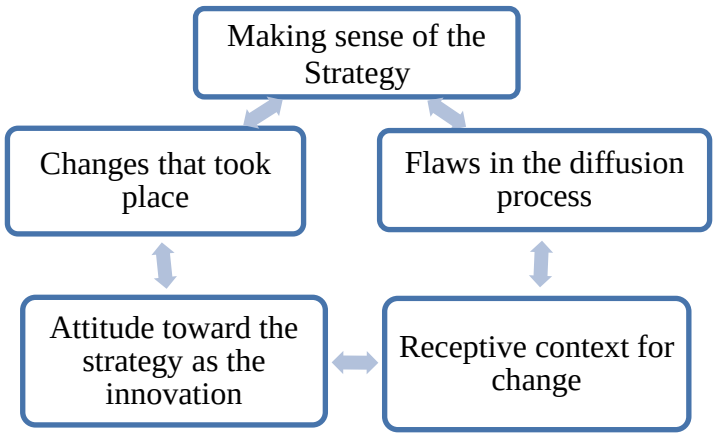

***Figure* 9. Thematic map showing original themes**

These themes were reviewed until three key themes were defined and named and formed the basis of the data presentation chapters: making sense of the Strategy, multiple layers of resistance and primary health care nursing investment. Making sense of the strategy was influenced by the diffusion process, the flaws contributed to the negative receptive context for change. This then influenced the attitude toward the strategy resulting in significant resistance. The changes that took place related to primary health care nursing investment. All relevant extracts for each theme were collated. Themes were also checked against each other and back to the original data set.

The analysis should show how all the evidence has been accommodated and address all major rival interpretations and most significant aspects of the case (Yin, 2003). Attention to detail increases the clarity of the reasoning (Zucker, 2001). The strong preference is to demonstrate an awareness of current

thinking and discourse about the case study topic. Trustworthiness of the study is discussed next.

5.11 Trustworthiness of the data

All knowledge is provisional and contestable and all accounts are local, and historically and culturally specific (Burr, 2005). The conventional criteria for judging trustworthiness are internal validity, external validity, reliability and objectivity. The naturalistic paradigm questions such criteria to demonstrate robustness of qualitative research (Liamputtong & Ezzy, 2006; Tobin & Begley, 2004). Tobin and Begley (2004) use criteria like goodness and trustworthiness to evaluate the robustness of naturalistic inquiry.

As a single case study, the emphasis is on uniqueness or particularisation, not generalisation (Stake, 1995; Van Wynsbergh & Khan, 2007; Zucker, 2001). The case is tied to a specific situation and location making it less generalisable than other qualitative research (Flyvbjerg, 2004). Therefore, the suggestion that the findings may be applied more widely is contradictory and therefore invalid. The results are not generalisable to other locations and populations however, this is an instrumental case study and I sought to understand the impact of the Primary Health Care Strategy on primary health care nurses. The results will invite connections to similar situations. The case is of secondary interest and therefore the results will help inform other DHBs facing similar issues. In order to achieve this, the results need to accurately reflect the opinions of the people in the study (Zucker, 2001). The emphasis is on the description of things to which the reader of the research ordinarily pays attention, particularly places, events and people.

Qualitative research demonstrates trustworthiness when the researcher has shown that they have worked to understand the nature of the participant's interpretations and meanings (Ezzy, 2002). Being explicit about the purpose and operationalising definitions and procedures establishes the trustworthiness of the data (Griffiths, 2004). In this research trustworthiness was established using the terms: credibility, auditability, fittingness, transferability and confirmability.

i. Credibility

One of the major criteria qualitative researchers use is credibility (Hays & Singh, 2012). Credibility refers to the truth and believability of the findings and is achieved when participants recognise and acknowledge the researchers understanding and account of their viewpoints (Cooney, 2011; Roberts & Taylor, 2002). Claims to credibility were strengthened in this research through forwarding data collected from the individual interviews and focus groups to my supervisors to recheck themes and confirm interpretation, and through individual interview participant checks and audio taping of the interviews and focus groups.

The trusting relationship between me as researcher and the participants encouraged the disclosure of genuine information at that moment in time. Sharing the results with participants enabled them to feedback on their perceptions of the plausibility of the findings. I returned the transcripts back to each individual participant for editing and verification, and because of the sensitive nature of the information they had provided. Known as member checking this can be time consuming and problematic for a number of reasons (Holloway & Wheeler, 2010). I chose not to return the transcripts to focus group participants due to the complexity of focus group interactions and the potential inability to identify individual responses.

ii. Auditability

Auditability is established when the adequacy of the information leads the reader from the research question and raw data, through the steps of analysis, to the interpretation of the findings (Cooney, 2011). Maintaining and reporting an audit trail of methodological and analytical decisions enables an external observer to trace the steps in either direction, from conclusions back to the initial research questions or from questions to conclusions (Tobin & Begley, 2012; Yin, 2003). This was achieved in the study by describing the processes in full and providing a rationale for the methodology and methods chosen.

iii. Fittingness

Fittingness is a logical consequence of supplying a substantial amount of information about the entity studied and the setting in which that entity was found (Schofield, 2000). It includes describing the phenomena in enough detail so others in the discipline can evaluate the importance of their own practice, research, and theory development. Fittingness is also about being faithful to the everyday reality of the participants. Guided by Creswell (2009), I used rich, thick descriptions to convey my findings. Verbatim data outlining participant dialogue is included in Chapters Six, Seven, and Eight, in combination with both local and national literature about the implementation of the Primary Health Care Strategy.

All research reflects the interests of the researcher (Hays & Singh, 2012). Therefore, researchers should make known their personal stance in relation to the subject under investigation as well as their relationships with the participants (Fade, 2003). Whilst I made every effort to remain impartial, I acknowledge my knowledge, interest, and experience influenced the research. I concede my position as nurse leader-primary and community position at TDH may have influenced some of the participants and their responses. What could be seen as coercion in obtaining the desired feedback was a potential threat and is discussed in more detail in the section on reflexivity.

iv. Transferability

Lincoln and Guba (1985) use the term transferability in qualitative research as opposed to generalisability. Generalisability is a term used in quantitative research and addresses the ability to replicate the research, including findings and conclusions, from one study and apply them to another setting (Fendler, 2006). Alternatively, the knowledge gained from qualitative research can be transferred to a similar situation. Transferability does not imply broad claims but invites connections. It depends on the congruence between the context in which the research is conducted and the context where the research findings can be applied (Carcary, 2009; Koch, 2006). The rich description and detailed findings from this instrumental case study will inform on similar issues primary health care nurses face in other DHBs.

v. Confirmability

Confirmability takes the place of objectivity and the researcher must declare their background and feelings for the research and maintain an audit trail (Holloway & Wheeler, 2010). My research decisions and influences are declared throughout the study as were my beliefs and assumptions. Reflexivity support confirmability as presented next.

5.12 Reflexivity

Reflexivity in qualitative research requires maintaining a sense of awareness and openness to the study and requires a self-critical attitude on the part of the researcher about how one's own preconceptions affect the research (Thomas & Magilvy, 2011). Derived from a Latin word reflexus, reflexivity means "bent backwards" (Oren, 2006) or being able to step back and separate oneself from one's ability to be unbiased while also recognising and considering the effect of one's existing biases on the research.

The task of the researcher is to critically engage and acknowledge their own intrinsic involvement in the research process and the part this plays in shaping a study and its results (Appignanesi, Garratt, Sardar, & Curry, 2004; Burr, 2005; Hayes, 2007; Rubin & Rubin, 2005; Thompson & Harper, 2012). No human can step outside of their humanness and view the world from no position at all (Guba & Lincoln, 1989). Therefore it is about being cognisant of one's views and social position, of the effects that these may have on the research process, as well as on those being researched (McCabe & Holmes, 2009; Rabinow & Rose, 2003). Not without its critics, reflexivity has now become an expected characteristic of interpretive research (Adkins, 2002).

Reflexivity provided me with the opportunity to unmask hidden agendas that influenced my research process. I critically reflected and examined my own assumptions and looked at the power relations between me and the study participants. I repeatedly questioned myself on the method I had chosen to gather the data, how I analysed the data, and what I was looking for when asking the questions I did. For example, focus groups were chosen for the

primary health care nurses as the discussion was less likely to be influenced by my interaction than it might otherwise have been in an individual interview.

As my research reflects my own interests and experiences, I made known my personal stance in relation to the subject under investigation and articulated my personal bias. This approach is corroborated by Fade (2003) who states that researchers must also identify how to mitigate the potential effect of biases and assumptions. As mentioned earlier, at the time of data collection I was employed as the nurse leader-primary and community at Tairawhiti DHB. In my senior nursing role I had a professional relationship with both the nurses and the managers being interviewed. Being honest and upfront about the information sought and the rationale prior to each interview and focus group mitigated this risk.

I acknowledge my passion for nursing, particularly within primary health care and admit my frustration to a perceived lack of progress of the Primary Health Care Strategy. I believe this has reduced the ability for primary health care nurses in Tairawhiti to best serve a most vulnerable population. I declare and value my prior knowledge of the subject area, including an understanding of the internal workings of the planning and funding arm of the DHB. I treat as valid the effect that my existing beliefs and values bought to this piece of research. My interest lay in determining potential opportunities for the effective deployment of the primary health care nursing workforce and I was truthful to the research as was humanly possible.

There was, however, no direct line management with any of the participants. All participants were made aware of my senior nursing role prior to agreeing to participate, and it was indicated on the information sheet. The information was discussed prior to the commencement of each interview and focus group. All participants had the opportunity to withdraw from the study at this time and were reassured that non-participation would not affect future professional relationships. All data gathered from the interviews were recorded on tape. To further support a robust research processes I made use of triangulation as discussed next.

5.13 Triangulation

Triangulation has been used to demonstrate trustworthiness in this case study. Triangulation brings the different kinds of data together so that it can be compared, contrasted, and verified. Comparing different accounts facilitates the emergence of understanding. Patton (2002) identifies four types of triangulation:

- Methodological triangulation: checking out the consistency of findings generated from different data collection methods. If different sources of information are saying similar things then the researcher can have greater confidence in the findings
- Triangulation of sources: checking out the consistency of different data sources within the same method
- Analyst triangulation: using multiple analysts to review findings
- Theory/perspective triangulation: using multiple perspectives or theories to interpret the data.

I used multiple methods of data collection which is considered one of the strengths in case study design. Findings or conclusions in a case study are more likely to be convincing and accurate if based on several different sources of information (Hancock & Algozzine, 2006; Stake, 1995; Yin, 2003). Triangulation of sources occurred when audited documents confirmed participant responses. Recruiting participants from different roles at different levels served to strengthen the accuracy of the data.

5.14 Transformative use of the information

The information obtained as part of this research was used for the purpose of writing and submitting a thesis for a Doctor of Philosophy. Findings from the research will be distributed to the chief executive of TDH, group manager of planning and funding, the two managers of the respective PHO, and primary health care nurses in Tairawhiti.

At least two articles will be written based on this research and publication sought in a New Zealand and an international journal. Feedback to nursing organisations within New Zealand will be provided through a conference paper. A copy of this thesis will be available for loan through Massey University Library. Copies will be available through TDH, NZNO libraries and two participating PHOs in Tairawhiti.

The findings will be distributed and discussed with stakeholders and decision-makers in Tairawhiti and beyond to those who have the ability to enable change to occur. It is hoped this report will facilitate more effective deployment of the primary health care nursing workforce and contribute to recognition of nursing as a valuable professional resource. I will present the findings at nursing forums, seminars and conferences to create post-research discussion and raise awareness which may lead to positive change in the nursing working environment.

5.15 Concluding statement

This chapter presented an overview of the methodology and methods employed to undertake this research. To begin, I discussed insider-outsider considerations before presenting case studies as the methodology used to explore the significant features of this research, and put forward interpretations. The investigative processes followed and began with the ethical considerations. Cultural matters were presented before an outline of participant data collection processes including recruitment and sample size. The documentation review was discussed before the data analysis section that explained the preparation of raw data, coding procedures and theme development. Trustworthiness of the data was declared using credibility, auditability, fittingness, transferability and confirmability, supported by reflexivity and triangulation. The chapter concludes with the transformative use of the information. This chapter completes the background information and paves the way to present the findings.

Chapter Six: Making sense of the Primary Health Care Strategy

6.1 Introduction

Previous chapters presented the rationale and context for the case as well as the research schema. The next three chapters present the findings that emerged from the combined data gathered during the individual interviews, focus groups and publically available documents. Verbatim participant dialogue supports the findings in combination with official documents, national and international literature. The data analysis was guided by the diffusion of innovation theory as the theoretical lens. Informed by constructionism and underpinned by a qualitative interpretive design, a single instrumental case study enabled the in-depth evaluation within the wider context of the local environment.

The focal point of Chapters Six and Seven are the attributes influencing system readiness in Tairawhiti. System readiness describes the notion that organisations can make to assess, prepare and anticipate the impact of an innovation (Greenhalgh et al., 2005). This chapter explores the attributes of the Primary Health Care Strategy that influenced making sense of the Strategy at both organisational and individual level. In this context, making sense of the Strategy does not imply and is different to, sense-making methodology. Chapter Seven explains the multiple layers of resistance toward the Strategy, while Chapter Eight examines the changes that did or did not take place for primary health care nursing in Tairawhiti. The framework identified in *Investing in Health* put forward by the Expert Advisory Group on Primary Health Care Nursing (2003) is used for this purpose.

This chapter begins by examining the propensity to act in the Tairawhiti region and is followed by data on local strategic planning. The Primary Health Care Strategy as an innovation is then explored before analysis of the local diffusion processes.

6.2 Propensity to act

As mentioned in Chapter Two, the diffusion of innovation theory argues that the adoption of a new idea follows a predictable pattern. At first, only a few individuals adopt the innovation in each time period. The propensity to act is high initially, but decreases as the majority adopt an innovation (Robinson, 2009). However, it is the understanding and belief about an innovation that predisposes the reaction and subsequently directs actions in response. In order for both individuals and organisations to adopt an innovation such as the Primary Health Care Strategy, they must first ascribe meaning to it. This occurs by making sense of it in a way that relates to previous understanding and experience (Greenhalgh et al., 2005).

The release of the Primary Health Care Strategy signified a government commitment to improving the health of all New Zealanders. Health policy in New Zealand is centrally controlled by the MoH but the operational decision-making for implementation of the Strategy rested locally with newly formed DHBs. The Tairawhiti DHB 2002/2003 District Annual Plan clearly identified it was understood by the Board and by planners and funders, that there was a Ministry requirement to implement the new strategies:

> Tairawhiti District Health is required to implement the objectives of the New Zealand Health Strategy, and Primary Care Strategy (TDH, District Annual Plan, 2002/03, p.49).

The 2002/2003 District Annual Plan also suggested the DHB was waiting for supporting documentation from the MoH regarding implementation:

> The Ministry of Health has been working on a series of policies, practices and processes for the implementation of Primary Care Strategy objectives (TDH, District Annual Plan, 2002/03, p.49).

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. Conversely, Greenhalgh et al. (2005) state mandated change does not necessarily increase capacity for adoption. In

addition, Harvey and Broyles (2010) contend legislatively mandated change does not work and only serves to create resistance.

Collective decision making can also slow down adoption rates (Rhodes, 2004). This is confirmed by the variability in each DHB response to the Primary Health Care Strategy across New Zealand (Cumming et al., 2005; Finlayson et al., 2011; Gauld, 2008; PHCAC, 2009). Some DHBs did not change much in their functional relationships, while others adopted local primary health care strategies (PHCAC, 2009).

In Tairawhiti it appears that the DHB was committed to embracing the principles of the Primary Health Care Strategy. Primary health care was identified in the 2002/2003 District Annual Plan as a priority service area. Based on work done in other DHBs, TDH reported the following:

1. A Primary Care Steering Group has been established
   The group is composed of funder arm staff, Board members, advisory committee members, Māori caucus member and primary care provider representation.

2. A Terms of Reference has been established for the group
   Primarily the group would be used to provide governance of the implementation of the primary care strategy. Both the steering group and terms of reference have been approved by Board.

3. A Primary Health Care Plan to be developed
   This will be completed after the finalisation of the strategic plan. To ensure that the process is effective, TDH needs to have a view on primary care pathway that ties to the goals and objectives of the district services plan (DSP), and has had feedback from the primary health care sector.

4. Registrations of Interest are called for
   TDH will provide the opportunity for all providers to show their position in regard to PHOs. The process will involve providers registering their interest in becoming a PHO. This process provides the framework around which we implement changes in primary care in this district in an open and transparent manner. It allows the Board, advisory committee and steering group the opportunity to discuss and debate if necessary the logistical pathway for implementation (TDH, District Annual Plan, 2002/03, p.50).

It is noted that the District Annual Plan cites a primary health care plan as opposed to a strategy. PHO development was also the focal point of the preliminary direction from the MoH to each DHB as confirmed in this same District Annual Plan:

> A majority of that work has been around the establishment of Primary Health Organisations (PHOs) - the infrastructure that will be used for implementation of the objectives (TDH, District Annual Plan, 2002/03, p.49).

What this suggests is that PHOs would work with TDH to implement the objectives of the proposed primary health care plan. PHOs were funded by DHBs for the "provision of a set of essential primary health care services to those people who are enrolled" (MoH, 2001, viii). The early establishment of two PHOs in this district was consistent with widespread establishment across the country and at the time was a positive sign that the DHB had embraced the move toward primary health care development. The establishment of both PHOs was achieved one year ahead of the timeline identified in the 2002/2003 District Annual Plan. This followed a formal process requesting registrations of interest for PHO development. Tairawhiti DHB received three applications. After an in-depth decision-making process two PHOs were formed in 2002: Ngati Porou Hauora and Turanganui PHO (TDH, Community and Public Health Advisory Committee (CPHAC) minutes, 24 May, 2002). Enrolment in these two PHOs exceeded all expectations, consistent with what occurred across the rest of the country.

The rapid formation of PHOs may well be related to the high relative advantage to GPs and Independent Practice Associations (IPAs). In Chapter Two, relative advantage was defined as the degree to which an innovation is perceived as better than the idea it superseded. The greater the perceived relative advantage of an innovation, the more rapid the adoption rate will be (Rogers, 2003). Indeed, the new PHO structure provided IPAs with an ideal opportunity to remobilise and reassert as pre-existing institutional arrangements that represent medical practice. Nationally, all of this was achieved without general practice making change to the way they practiced at

a service level (Ashton & Tenbensel, 2010; Finlayson et al., 2011; Love, 2008).

Alternatively, PHOs might not have had high relative advantage but rather were a way to access needed MoH funding under another guise. Gauld (2008) states the policy device that propelled PHO formation was in fact the significant additional funding from government. Prior to the Primary Health Care Strategy, primary health care in New Zealand had traditionally been understood as synonymous with general practice (National Health Committee, 2000). The Strategy intended a broader vision than general practice, but this particular perception still existed across the health sector as confirmed by the following manager:

> I think again that this is my problem with the Primary Health Care Strategy, as it stands and its true interpretation. Which is about GP practices and the way thing are going because ethically and morally whether people want to accept it or not with that model. (I.3, p.7)

Early PHO formation could be taken as a positive sign that Tairawhiti had embraced the Primary Health Care Strategy. However, as will be discussed later in the chapter and as was reflected nationally, the reality was PHOs were another form of business as usual. Certainly there were improvements in primary care such as lower cost access to primary health services, improved consultation rates for most patient groups and improvements in performance for a broader range of health indicators both in Tairawhiti and across the country (Barnett & Barnett, 2004b; Carryer, 2005; Cumming et al., 2005; Cumming & Gribben, 2007; Gauld, 2008; Smith, 2009). But the face to face model of primary care appointments with a medical practitioner remained generally unchanged.

Much of the national literature on implementation of the Primary Health Care Strategy to date has focussed on the early formation of PHOs, the number of patients enrolled in PHOs, the level of fees and the primary health care funding subsidies and initiatives (Controller and Auditor General New

Zealand, 2008). The accuracy of this for Tairawhiti was confirmed by one of the primary health care based managers:

> A lot of the time within primary care at a political perspective, the component of the Primary Health Care Strategy that was emphasised the most was reduction of fees. So it was like for some people the only thing about the Primary Health Care Strategy was fee reduction. (I.5, p.1)

This, in effect, distracted attention away from the focus on better health for the population. As mentioned in Chapter One, the broader goals of population health, collaboration and coordination were expected. Workforce development was a priority (especially in the area of cultural competence) and inequalities were to be addressed (MoH, 2001). These objectives required a change to traditional practice that proved more difficult to achieve.

Putting a national strategy into practice can be difficult, especially if it involves changing the way people think about and deliver services (Controller and Auditor General New Zealand, 2008). Rogers (2003) acknowledged that the adoption of an innovation is not an instantaneous act but a process occurring over time and consisting of a series of different actions. Implementing the Primary Health Care Strategy was said to be evolutionary (Finlayson et al., 2011). As the three data chapters will demonstrate, 10 years since the release of the Strategy, progress in Tairawhiti has been slow. In saying that, one manager intimated that Tairawhiti DHB had moved more toward primary health care thinking in recent years:

> So I've seen over the last one to two years more engagement and awareness on those issues with the DHB getting more involved with primary health care. (I.2, p.2)

The complexity of organisations, especially those with fragmented internal and external structures, constrains innovativeness (Greenhalgh et al., 2005). Making it happen requires an orderly, planned and regulated approach, with all systems "properly managed" in order to mainstream the innovation within the organisation (Greenhalgh et al., 2004). The Primary Health Care Strategy required a planned approach in Tairawhiti to drive the expected changes

forward. Next, the development of local strategic planning as a blueprint for change is presented.

6.3 Local strategic planning

The MoH directed each DHB to develop a local strategic plan to provide direction in working toward the Primary Health Care Strategy objectives. This plan was to have local meaning, local buy in and local support. A primary health care discussion document was developed in Tairawhiti and identified the why, who, and the what, of the primary health care plan. The goals were centred on primary care to improve access and to bolster, a skilled workforce and quality improvement. It included a proposal for the two PHOs to organise their services around primary health care teams including GPs, primary health care nurses, community health workers and administration staff. As a discussion document, it did not include timeframes or explicit steps on how the goals were going to be achieved.

In November 2002, the draft primary health care discussion document was presented to the CPHAC as one of the TDH Board's advisory committees for endorsement (CPHAC minutes, 28 November, 2002). This particular advisory committee was given the mandate to:

- Review and monitor actions to address the health needs assessment
- Ensure TDH has a population health focus
- Oversee the development of local and regional mental health advisory group, emphasising regional collaboration and workforce development
- Guide the developments in primary health care arising out of the localisation of the Primary Health Care Strategy (TDH District Annual Plan, 2002/03, p.13).

The TDH CPHAC minutes (28 November, 2002) 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 discussion document was also distributed to a recently established primary health care development steering group. The purpose of this steering group as identified in the 2002/03 District Annual Plan, was to:

> ….implement the demand-driven project, and to ensure primary care issues are reflected in all relevant processes (TDH District Annual Plan, 2002/03, p.37).

It was expected that this group would comprise representatives from the DHB funder arm, DHB Board, DHB Board advisory committee (CHPAC), Māori caucus and primary care providers. Despite the wide distribution, the volume of feedback was disappointingly poor. The discussion document was never finalised into a local primary health care strategy. This notable absence of a local strategy was confirmed by one manager:

> We should have had a local primary health care strategy. I understood that there was going to be a primary health care strategy..... and seven years on there still hasn't been a strategy. (I.5, p.5)

As a PHO based manager this quote suggests disappointment and an inability to effect change. Without a local primary health care strategy to set the direction, pace and evaluation, the Primary Health Care Strategy was destined to remain a high level framework for primary health care development. This same manager also stated that the DHB District Annual Plan did not provide confidence of any formal commitment or direction toward Strategy implementation by Tairawhiti DHB:

> Even the District Annual Plan hasn't provided a kind of stake in the ground about what we should be doing. (I.5, p.5)

However the 2002/2003 District Annual Plan did indicate that the DHB intended to manage the rate of implementation:

> It is up to Tairawhiti District Health Board to determine what timeframe is practicable for the implementation within this district. However, given the poor health statistics of this district, and the intent of the goals outlined in the District Strategic Plan, the implementation timeframe should start sooner rather than later (TDH District Annual Plan, 2002/03, p.49).

This District Annual Plan stated 'sooner' rather than 'later'. And implementation implied a keenness on behalf of the DHB to progress with the

Primary Health Care Strategy. However, lack of a local strategy was concerning and raised doubts about the level of commitment to primary health care. Limited activity implementing the intent of the Strategy suggests a lack of understanding or trust in its ability to address broader population health issues.

Greenhalgh et al. (2005) argued in their interpretation of the diffusion of innovation theory that it is the interaction with the intended adopters within the context of their environment that determines the adoption rate. This requires relevant stakeholders to have sufficient information about the innovation and be clear on how to use it as well as able to determine the consequences and how it may affect them personally. Rogers (2003) confirms the innovation decision-making is more of a process than an event and consists of a series of choices and actions through which both individuals and organisations proceed. However, I found no national research that has investigated this phenomenon. The next section of the chapter analyses individual and focus group participant understands of the core principles of the Primary Health Care Strategy.

6.4 The Primary Health Care Strategy - the innovation

This section of the chapter examines the variable participant perceptions of the Primary Health Care Strategy as a significant precursor to health sector readiness in Tairawhiti and uses the diffusion of innovation theory as the framework for the analysis. It provides some understanding of what is known nationally: ongoing issues with equity in health, especially for Māori and Pacifica people, a failure to implement a population health approach, a lack of a multidisciplinary approach, and limited community input in the decision-making (Ashton & Tenbensel, 2010; Gauld, 2008). The core principles are the essence of a robust primary health care system. Consequently, one manager thought the release of the Strategy was timely:

> Yes, well I think it was very timely when it came out. It was inactive on primary health care when the emphasis hasn't been there for a long time. (I.8, p.1)

At the time of the interview, this DHB based primary health care nurse manager demonstrated a deep understanding of comprehensive primary health care, the Strategy and the potential of the nursing role. To say the "emphasis hasn't been there for a long time" indicates disappointment at the limited protracted change that had taken place. After all, it had been more than 30 years since the Alma Ata Declaration (1978) outlined the need for a strong primary health care focus.

Overall, most participants were theoretically supportive of the Primary Health Care Strategy as a framework for health, as the following managers confirm:

> The Primary Health Care Strategy, I believe is a very good framework and a very good template for actually looking at what it is that we're looking to gain in trying to move forward. There is sufficient evidence behind the fact that if we invest in primary care we will get primary care functioning well. Then we can actually reduce the overall health burden and the health costs which in the current moment absolutely is something that has to be done. (I.6, p.1)

> I think the Strategy as a whole is a good strategy document and I believe the intention of it is very good particularly from a patient's point of view. (I.3, p.1)

These comments suggest the Primary Health Care Strategy was recognised as outlining needed changes to health service delivery. Given then that implementation did not progress as anticipated, this raises the question as to why this did not occur. Discussing this inactivity on the Strategy's 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 Primary Health Care Strategy, and many of the strategies that we've seen enlighten the life of the health sector, have become really live working documents. It has become another "nice to have" that I go and find in the library and refer to if I'm doing academic papers and I need something to actually try and peg what it is. (I.6, p.2)

> I feel the Strategy is a document that sits on the shelf which some people know about and use when it suits. It is not a live

> document unless it suits and it is thrown in as a reference to support the bits it supports. (I.3, p.6)

These comments suggest that these participants in senior positions seemed to think that implementation of the Primary Health Care Strategy would come from somewhere else. The perception that the Strategy as an innovation was considered an academic document suggests flaws in the diffusion process and this is discussed later in the chapter. Overall, there was general agreement amongst the managers that there were issues with doing nothing. Participant perceptions of the principles of the Strategy are now explored using the three key principles that underpin an effective primary health care system: equity, promoting good health and multisectoral cooperation.

6.4.1 Equity

The Primary Health Care Strategy was explicit in stating that one of the six key directions for primary health care was to identify and remove inequalities. This was to be achieved once the cost barriers for people accessing services were removed (Ashton & Tenbensel, 2010; MoH, 2001). Prior to the Strategy, the cost of visiting a GP was not affordable for a significant number of low income people in Tairawhiti. Capitation and additional funding significantly reduced patient fees and consultation rates increased, with improved access to first contact appointments. This was confirmed by the following manager:

> You know two of the most obvious changes, there was the advent of primary health organisations and the lowering cost of access to primary health care services on a Monday to Friday aspect; maybe not in the weekend and after hours, but on a Monday to Friday. (I.4, p.2)

Across New Zealand there was an increase in consultation rates for most ages, socio-economic and ethnic groups (CBG Health Research Ltd, 2005b; Controller and Auditor General of New Zealand, 2008; Cumming & Gribben, 2007; Gauld, 2009a). This was considered an improvement in Tairawhiti which was identified as one of four DHBs with “high needs”. Overall, it appeared that the equity component of the Primary Health Care Strategy was

well supported, at least in principle, and understood by all participants as there was strong support from the managers:

> There's certainly a greater knowledge of the inequities and looking at those of the person who needs it - that's been a shift as well. (I.8, p.1)

The majority of primary health care nurse participants were also fervent about equity issues but recognised the cost of visiting general practice remained a barrier as the following comments illustrate:

> One of the difficulties was affordability. You see a lot of patients out there in the community that can't afford to go and see GP. Or, even if they really have a problem they don't go because of the bills piling up there. (FG.2, p.8)

> I think that's part of the problem to why health care is so poor because people don't have the money to pay for medication or to access the health care and so they have these chronic diseases and have all the complications with them. (FG.3, p.9)

Additional "reducing inequalities" funding was provided by the MoH to support primary health care initiatives to further reduce inequalities in Tairawhiti. There were two successive funding rounds over a two year period. Allocation was signed off by both DHB and MoH (V. Brind, personal communication, 1 August, 2013). This funding was used to purchase x-ray equipment for Ngati Porou Hauora and a local review of children admitted to hospital with cellulitis was undertaken. In addition, a population health analyst was employed by Tairawhiti DHB as was a GP Liaison and a primary health care nurse leader (I. Diamond, personal communication, 6 November, 2013).

The drive to reduce inequalities and improve health and wellbeing in society was considered necessary to improve Māori and Pacifica health (Abel et al., 2005; Ashton & Tenbensel, 2010; Hefford et al., 2005; Holdaway, 2002; MoH, 2001; TDH, 2011). A primary health care based manager believed the Primary Health Care Strategy was a new starting point for Iwi providers:

> I think the, Primary Health Care Strategy is, I think it is the new frontier... it consolidates a lot of things around primary health, community health and Māori health. (I.9, p.1)

This was reflective of the call by Māori for opportunities to lead their own health and development with the emergence of Iwi owned health services. The Strategy was ideologically congruent with the existing values and needs of Māori providers and was intended to be participatory, self-reliant, whanau orientated and self-determining, bringing care as close as possible to where people live and work. The Strategy signalled a move away from a biomedical world view to broader definitions of health in a way that was entirely acceptable to both Māori led services and indeed to nursing (Holdaway, 2002).

The Māori provider movement was well under way prior to the release of the Primary Health Care Strategy. Across New Zealand a number of Māori providers already had the structures, philosophies and approaches to primary care provision in place and sat comfortably with the Strategy's direction (Abel et al., 2005). As one manager stated, there were advantages for an Iwi provider over a mainstream service in meeting the health needs of Māori. One advantage included most of the nurses they employed sharing whakapapa (genealogical heritage) back to the people:

> That's our kaupapa (strategy policy or cause). I guess that is the reducing inequalities part of it. I mean looking after a population that is dominantly Māori, rural. Low socio-economic and also in our area it's unique and that our nurses whakapapa back to a lot of those people. It's quite personal so I think in a way that reduces inequalities. (I.1, p.11)

Both the Māori Health Strategy and the Primary Health Care Strategy purportedly assured development of Māori providers and those receiving devolved services. DHBs were tasked with continuing to contract with Māori providers to support Māori communities having control over their health and wellbeing (MoH, 2001; Holdaway, 2002). Improving the delivery of mainstream services to Māori and Pacifica people was also considered essential. The DHB commitment to Māori provider development was demonstrated in the very first District Annual Plan:

> In order to recognise and respect the principles of the Treaty of Waitangi (partnership, protection and participation) within the framework of the New Zealand Public Health and Disability Act 2002, and with a view to improving health and disability outcomes for Māori, TDH has established mechanisms to enable Māori to contribute to decision-making on, and to participate in the delivery of, health and disability services. In particular, TDH aims to:
>
> - reduce disparities by improving health and disability outcomes for Māori, and other population groups
> - establish and maintain processes to enable Māori to participate in, and contribute to, strategies for Māori health improvement
> - continue to foster the development of Māori capacity for participating in the health and disability sector and for providing for the needs of Māori
> - provide relevant information to Māori for the purposes set out above (TDH District Annual Plan, 2002/03, p.5).

DHBs were required to have relationships with Iwi and other Māori groups that facilitated stronger relationships between Māori and health agencies (National Health Committee, 2002). This was considered important as the following manager confirms:

> You know being Māori and with a Māori Health Provider you feel a bit more trust sticking with Māori because in the past going with mainstream has not been good for us. (I.1, p.13)

Analysis of this statement suggests that mainstream services have not always met the health needs of Māori or Māori providers. However, Iwi provider development was fraught with difficulty and further growth in Tairawhiti was limited. The contractual framework between DHB purchaser and Māori provider does not necessarily recognise Māori health service delivery (MoH, 2001; Boulton, 2005). For example, from a Māori health provider perspective, the framework does not account for other dimensions of health care that are important to Māori. Whanau and spiritual wellbeing, culturally appropriate service delivery and a prioritised commitment to Māori workforce development were imperative (Abel et al., 2005).

In addition, Iwi providers tended to be less dominated and influenced by the medical profession. Their worldview is less biomedically driven and more holistic. Māori specific models of health are more encompassing of the physical, spiritual, family/whanau realms and the link with the broader community (Durie, 1998). Conversely a significant number of mainstream providers tend to view health in biomedical terms where the focus is on the individual as opposed to the community in which they live (Holdaway, 2002).

Holdaway (2002) states the philosophies of primary health care nursing are consistent with the broader Māori health objectives. However, current clinical nursing practice is underpinned by dominant western health ideologies and structural barriers which may adversely affect service provision and clinical nursing practice within Māori paradigms of health (Finlayson et al., 2009). Day (2011) also argues the concepts that underpin Māori health provider development and subsequent nursing practice to meet the differing priorities of the Māori community, are negatively influenced by funding and contractual requirements. Certainly, PHO viability impacts on the utilisation and development of Iwi based nursing services. McAvoy and Coster (2005) suggest that populations of around 150,000 are required for PHO viability; this is greater than the entire population of Tairawhiti.

Contracts held with DHBs focus on clinically narrow and inflexible models of care which do not account for the environment in which the service is delivered (Boulton, 2005). Traditional performance measures do not reflect how services are delivered by Māori providers. The greatest difficulty was in data collection and applying it meaningfully within the context of funding restraints and the clinical demands of a PHO population with high levels of morbidity and co-morbidity (Abel et al., 2005). Inconsistencies in monitoring impacted negatively on the ability of Māori providers to deliver positive outcomes for Māori health (National Health Committee, 2002). The relationship between cultural interventions and clinical interventions was often ill defined and in some areas, Māori providers were encouraged to take up cultural support contracts quite independently of associated clinical contracts

(Durie, 2005). This has resulted in misguided perceptions around the capacity and capability of Māori providers as the following manager alludes:

> I mean, the biggest thing is perception around understanding capacity and capability and the preparedness for that to occur. (I.9, p.6)

This excerpt suggests a mistrust of Māori providers who feel they continually have to justify their existence with increased reporting:

> You know you have got to double the level of compliance to validate what it is you do so people say well stuff it why bother. They are not going to give you more money, if anything they are going to increase your reporting levels. (I.9, p.6)

In summary, this section demonstrates that, despite reduced fees, it is uncertain whether the concern for equity translated into any concerted action to positively address the needs of Māori and Pacifica people, or in truth all underserved groups in Tairawhiti. While the focus remained entirely on reducing fees, there was no attention paid to models of care or different utilisation of the workforce. The opportunity to embed real primary healthcare services was lost in the rush to make existing primary care cheaper.

6.4.2 Promoting good health

Promoting good health is a key attribute of the Primary Health Care Strategy that must be considered when examining making sense of the Strategy at an organisational and individual level. As mentioned in Chapter Three, the Strategy emphasised population health, health promotion and community involvement (MoH, 2001; Sheridan, 2005). In the 2002/03 Tairawhiti District Annual Plan population health was acknowledged:

> ..advancing the health and independence of the people of Tairawhiti will occur best through population health measures (District Annual Plan, 2002/03, p.6).

The District Annual Plan declared the intent toward a population health approach. As mentioned in Chapter One, the population of Tairawhiti had high

health needs and the DHB district annual plans reported on the poor health statistics experienced by the people of this district. However, it is apparent that the powerful focus on general practitioner needs and aspirations acted as a distraction and maintained the energy and focus on personal health services. This is described by one of the primary health care nurses:

> The GPs focus is their business models. It doesn't seem to mean that their focus is on the health issues that exist in the community. (FG.3, p.15)

The shift to population health was a fundamental change required for successful implementation of the Primary Health Care Strategy. In many ways, this shift was a far bigger challenge to the model of general practice than was ever overtly acknowledged at DHB level. In reviewing the comment from the District Annual Plan presented earlier, it is not possible to be certain how much this was related to the rhetoric of the time, or a real understanding of the changes being requested. The poor appreciation of population health is captured in the words of one manager describing a nursing role as below:

> I see her role as being a mixture of education, promotion as well, assessing a patient and looking after their clinical needs. (I.1, p.1)

This manager is clearly still focussing on personal health and one-on-one encounters which, whilst important, is not the essence of population health. Winnard et al. (2008) identified a need for shared understanding of the terms "population health" and a "population health approach" to support ongoing implementation of the Primary Health Care Strategy. The authors defined population health as the consideration of the health outcomes or status of defined populations groups, families and communities and the distribution of such outcomes within populations. A population health approach means taking account of all the influences on health and how they can be tackled to reduce inequalities and improve the overall health of the population.

A number of the nurses in the focus groups similarly misunderstood population health as the following excerpts illustrate:

> It's handing people education and awareness and hopefully encouraging people to take care of their own health. (FG.5, p.1)

> For me I think it is preventative medicine. (FG.2, p.3)

Primary health care nursing is said to encompass population health (Expert Advisory Group on Primary Health Care Nursing, 2003; Holdaway, 2002). But in practice, with employment and contractual constraints, nurses tended to work under a personal health model and provide education to patients. Health education and personal health are closely linked, one following the other quite naturally (Buckley, et al., 2009; Hain & Sandy, 2013; Kelo, Martikainen & Eriksson, 2013). This connection was clearly understood by a number of the primary health care nurses:

> ..you know like working in the clinics, education, immunisations, doing our cervical smears. Now there are things like Care Plus (FG.1, p.2)

> So we will do health promotion, health education in order to prevent a patient getting diabetes and getting admitted and then getting into chronic diabetes where the complications comes in. (FG.2, p.4)

> We're doing eating healthy, walking healthy. We're doing all that stuff but the people from days gone by that are set in their ways and they're not going to change that pattern and that's ok, but we can only empower them with the knowledge and they make the knowledge and they'll make those changes. (FG.1, p.6)

Despite the obvious importance of health education in personal consultations, population health requires a wider group response to community embedded processes to support the health of various populations within a defined community. Population health outcomes were not fully understood and were thus difficult to implement and measure.

The PHO performance management programme did not begin until 2006, four years after the establishment of PHOs. Three categories of indicators were initially introduced:

1. Clinical indicators including immunisation, cervical and breast screening rates for which practice nurses are generally responsible. Additional clinical indicators including prescription and investigation ratios and doses of inhaled corticosteroids.
2. Process/capacity indicators on the uptake on PHO enrolment with more than 96% of PHO registers showing a valid National Health Index (otherwise known as NHI). Other capacity indicators include progress against a performance plan.
3. Financial indicators demonstrating evidence expenditure against pharmaceutical and laboratory considerations (DHBNZ, 2005).

One of the nurses was aware that targets existed and that she had a role to play in achieving them:

> We have got targets and they cover obesity, smoking, diabetes, all these target areas that the government sees as being our high health needs so they are putting funding into primary health care to look into these things and try and capture those people in primary health care services. (FG.5, p.1)

As funders of PHOs, DHBs monitored these indicators that notionally provided some index of PHO performance in their catchment area (DHBNZ, 2005). The increased effort put into monitoring and improving quality should have been an additional driver for change (Love, 2008), instead it created a dichotomy. The Primary Health Care Strategy emphasised population health, health promotion and community involvement, yet performance measures were recorded in terms of volumes or outputs. As Sheridan (2005) noted, the perpetual reliance on goals, targets and measurable outcomes as a means of monitoring "strongly suggest a continued medical and behavioural focus" (p.24). Starfield and Mangin (2010) recommend that efforts to achieve quality in primary health care should shift toward understanding which types of intervention are more efficient and equitable. The authors state the challenge is to "develop an innovative system which promotes and supports care that is informed by medical science, yet provides informed options for primary care physicians and patients to choose from" (p.400). Next, multisectoral

cooperation as the third component of a robust primary health care system is examined to gain understanding of participant perceptions.

6.4.3 Multisectoral cooperation

The Primary Health Care Strategy signalled the intention to increase work across the multidisciplinary team within health. This move was supported by substantial international evidence (Bailey, et al., 2006; Buttaro, et al., 2003; O'Neill & Cowman, 2008; Pullon et al., 2011; Sloand & Groves, 2005). A multidisciplinary team approach provided the opportunity to break down some of the existing silos between primary and secondary care, between doctors, nurses and allied health, and between individuals. Supporting and developing a team ethos would clarify and consolidate the nursing contribution and create independence (O'Neill & Cowman, 2008). Most participants agreed with the basic principle of working together. Nine years later at the time of data collection, the continued existence of a siloed mentality was confirmed by the following manager:

> I'm here and they are there in the silos. Some of us work in different positions and we see ourselves completely differently. The silo mentality is still there. (I.6, p.9)

Another manger was quite excited about the potential that this principle of the Primary Health Care Strategy offered:

> Yeah I mean it is an exciting time [now], it will be, with an exciting time comes all the challenges of course, breaking down some of the silos that have been created in primary health with general practice is definitely one. (I.9, p.1)

The multidisciplinary momentum was further endorsed with the change in government in 2008 and the National Coalition's push for the development of integrated family health centres which supported greater multidisciplinary opportunities:

> That we're now moving to integrated family health centres where we've got you know, many GPs and many practice nurses, many

> other disciplines, midwives you know physios, occupational therapists, pharmacists, everything all in one centre. (I.4, p.11)

This could be seen as a positive sign that progress was being made. The initial intent of PHO development was to see the wider multidisciplinary team housed under the one roof and actively participating in both governance and clinical service delivery. Nine years after the release of the Primary Health Care Strategy this movement was finally underway confirming that the diffusion of innovation is a process that takes time. However, there was limited opportunity for health professionals to work together across traditional disciplinary boundaries and improve the patient journey.

> As I recall when PHOs first came out they were meant to be multidisciplinary and all those things and that really hasn't happened. (I.8, p.2)

> It was strong in the Primary Health Care Strategy that there were going to be multidisciplinary teams to work to improve the health of the patients and that to me had also not happened because we haven't again addressed the traditional and long standing hierarchical process. (I.5, p.2)

The vision of a multidisciplinary collaborative approach was not supported by the complex and fragmented funding models and organisational structures within primary health care, secondary care and ACC (Finlayson et al., 2009; Gauld, 2008, 2009a; PHCAC, 2009). Capitation paid a fixed sum of money to a PHO for each person formally enrolled with a GP (Gauld, 2009a). Patients no longer had to see a GP in order for the practice to qualify for the general medical service funding (Hefford et al., 2010). This was alleged to encourage greater use of other members of the primary health care team (Ashton & Tenbensel, 2010). The requirement to enrol with a named GP contradicts the notion that other primary health care providers, including nurse practitioners, would join a PHO on an equal footing (Gauld, 2008). Therefore, the business ownership of service delivery organisation did not incentivise teamwork or collaboration (Finlayson et al., 2009; Gauld, 2009a).

Gauld (2009a) suggests removing co-payments to GPs, changing the way midwives and pharmacists are reimbursed and replacing this with a range of

funding paths paid directly to PHOs themselves to fund practitioners and services. Notably, Gauld did not mention nurse practitioners in this proposal and linked practice nurses in with GPs under PHOs as primary medical care providers. This suggests that he, along with most policy makers, did not view nurses as independent health professionals entitled to or requiring any funding other than a salary.

The lack of formal recognition of providers other than medical practitioners is at odds with the ethos of the Strategy. Theoretically health services are moving away from a perspective of physician centred care to patient centred holistic multidisciplinary care (Berryman, Palmer, Kohl, & Parham, 2013; Reed, Conrad, Hernandez, Watts, & Marcus-Smith. 2012). Patient-centred care includes but is not limited to, active engagement of patients in shared decision-making, ready access, continuity of care and having the right person provide the right service at the right time to the patient. The shift from a provider focus to the community requires the whole of health sector to work differently from how they had traditionally worked (Berryman et al., 2013; Hansson et al., 2008; McPherson & McGibbon, 2010; Snelgrove & Hughes, 2000). This was outlined by one of the mangers:

> You can see the difference in the collegial relationship of how things can work in tandem really, really well. The person can get the best out of the nursing service and the best out of the GP service and the best out of whatever. Or potentially the best out of a combination of care and have the right person with the right skills see them verses this is a GP practice and this is how it's done here. (I.7, p.10)

Regardless, traditional hierarchical processes and structures were cited as preventing a multidisciplinary approach from occurring according to the following manager:

> And yet from my perspective they've never quite cracked the multidisciplinary team perspective when a medical practitioner has been involved because people default, for one reason or another, to a hierarchical system. (I.5, p.2)

Success is reliant on the full autonomy and clinical freedom of all team members (Casey, 2007; Cumming, 2011; Finlayson et al., 2009; Hansson et al., 2008; Hansson et al., 2009; McPherson & McGibbon, 2010). Nationally, multidisciplinary collaboration proved especially difficult given that historically medicine has dominated the nursing workforce (Carryer, 2004; Furedi, 2006; Finlayson et al., 2009; Mays & Cumming, 2004; O'Connor, 2012; Piji-Zieber, 2013; Willis, 2006).

The critical and core components that underpin an effective primary health care system are undeniable. That, on its own, was not enough to bring about the changes required. Understanding these core components of the Primary Health Care Strategy was absolutely essential for successful implementation. But, if the perception does not match the intent, then implementation is unlikely. Rogers (2003) argues that an individual's perception of an innovation drives the diffusion process.

6.5 Local diffusion processes

The readiness of the health sector to adopt the Primary Health Care Strategy was dependent on the diffusion process, or its communication. Diffusion refers to a specific type of communication in which the facts are distributed, or the way in which the message content is exchanged and spread to the members of a social system (Rogers, 2003). As data has already shown, there was a significant deficit in the understanding of the Strategy and consequential flaws in the knowledge construction process.

Knowledge construction begins when the decision-making unit is exposed to the innovation's existence and gains an understanding of its purpose (Rogers, 2003). Interpretation is an essential step in adopting a new programme into the workplace (Dearing, 2009). Greenhalgh et al. (2005) argue successful dissemination and assimilation of an innovation depends on the ability of an organisation to have knowledge manipulation structures and activities in place, as well as the ability of the stakeholders to understand the new conceptualisation that accompanies the diffusion process.

If the diffusion process is not effective then the chance for successful adoption of an innovation is unlikely. The importance of the communication channel for the diffusion of the information was not accounted for in Tairawhiti. 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 Primary Health Care Strategy. This is supported by the following comment by one of the managers who was a key player in primary health care at the time the Strategy was released:

> They have relied on the structures to circulate that information. If that happens then they have their slant on how that is interpreted, and then interpretations you know mixed messages so when you are filing through from the outset the messages aren't congruent. Without having the one message deliverer you have got multiple deliverers all having a take on health and unfortunately we have got multiple deliverers.... I mean the policy documents they all come out and they espouse, but then again they are probably not followed through with some good robust dialogue, some debate you know. (I.9, p.3)

This manager is suggesting that the information about the Primary Health Care Strategy was passed through existing hierarchical structures. This allowed for multiple interpretations of the Strategy 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)

Greenhalgh, et al. (2005) state the message contains information that to some extent needs to be encoded; communication is about persuading, as well as informing. There also did not appear to be an opinion leader, a key person or cluster of people who stood out as driving the Strategy forward in Tairawhiti. Opinion leaders are the people who can foment positive attitudes toward an innovation and the diffusion process (Rogers, 2003). They serve as role models for the followers (Grimshaw et al., 2006).

Implementing the Primary Health Care Strategy required deliberate stakeholder communication and engagement processes. Different people knew

different things at different times; the diffusion process was imperfect. Locally and nationally, this created tensions between the professions, management and DHBs (Mathias, 2009). I found no evidence of a planned communication approach. No district annual plans articulated how information of the Strategy was to be communicated, or how all the stakeholders were to be engaged.

I made an Official Information Act request to the MoH in May 2013 for information on the communication plan(s) for the release of the Primary Health Care Strategy. The purpose of this Act is to make available official information to the people of New Zealand to enable their more effective participation in the making and administration of laws and policies, as well as promote the accountability of Ministers of the Crown and officials[12]. This was not part of the original research strategy but became important in understanding the data as it related to the communication process from the MoH as the original source.

The objectives of the communication plan included the purpose of the Primary Health Care Strategy, process for implementation, emphasis on its importance, as well as key messages (Draft MoH Communication Filing, 18 December, 2000, Archive 1995-2006). From this there were a number of publications produced, a series of road shows conducted, and briefings with individual DHBs as required/requested, and working sessions with communication managers around the country. There was a MoH Primary Health Care Strategy project plan that identified key assumptions and risks including an objective to:

> Ensure DHBs understand and incorporate the Strategy into their planning processes, are engaged with the Ministry's development of toolkits on PHOs, and are encouraged and supported to move the Strategy forward in their Districts" (MoH Primary Health Care Strategy implementation project, 27 February, 2001, p.2).

Given the limited implementation in Tairawhiti, the effectiveness of the MoH communication plan is debatable. There were a number of "updates" that

[12] http://www.legislation.govt.nz/act/public/1982/0156/latest/DLM65364.html

followed the initial release, most of the information related to PHO formation. As an example, one update to chief executives (14 November, 2003) included information on the release of a stock take related to the first year of PHOs, the monitoring framework and management fees increase. Another (20 August, 2004) included key findings from a report on GP fees, public awareness of PHOs, Care Plus and a primary care conference. In order to reach a point of effectiveness there firstly needed to be shared understanding of the terminology. Both the MoH and Tairawhiti DHB continually struggled with this as outlined in the next section.

6.5.1 Understanding and implications of the terminology

The term primary care was frequently used interchangeably with primary health care in the Tairawhiti district annual plans and other strategic documents. Primary care is defined as the first point of entry into a health system, usually within general practice, whereas primary health care has a broader more comprehensive remit. The Primary Health Care Strategy was frequently referred to as the primary care strategy (TDH District Annual Plan, 2002/03, p.7, p.7 & 52). Then again in the 2007/08 it stated:

> Continue the primary care rollout strategy, with the development of new models of services, the involvement of a broader range of professionals and an improved primary/secondary interface (TDH District Annual Plan, 2007/08, p.8).

For as long as primary health care is considered primary care, movement toward a population health approach will be marginalised. The interchange of terminology also served to create confusion which aggravated the perceived complexity of the Primary Health Care Strategy implementation (Adamson et al., 2005; Docherty, 2004; Holdaway, 2002; Keleher, 2001). Carryer (2004) stated that if the terminology is not well understood then invariably barriers are created that impede the implementation of the Strategy's intent. For example, the MoH website directs you to their primary health care publications[13] which are predominantly primary care related documents.

[13] http://www.health.govt.nz/our-work/primary-health-care/primary-health-care-publications

Similarly, the definition of primary health care nursing was not well understood across the sector. This was confirmed by the significant number of participants who struggled to articulate the fundamental ideology of primary health care nursing. The limited appreciation of the role and the difficulty in articulating the depth was illustrated by managers and nurses alike. A number of participants identified primary health care nurses by what they did not do rather than by what they did do:

> A nurse that doesn't work in the hospital that works out in the community I guess. (FG.4, p.1)

> What I think primary care nursing is in this community is all of those nurses that are not available in hospital based settings would be my description of primary care nurses. (I.5, p.2)

In the excerpts above, primary health care nursing was defined by where the nurse did not work. Whereas another manager identified a primary health care nurse through their place of employment:

> ..... primary health care nursing posts would be any nursing post whatsoever outside of that, to me, could be in a factory, it could be in a school, it could be in a GP surgery, again it could be in a private organisation that works in the community it could be for the DHB that works in the community. (I.3, p.3)

One other manager understood that primary health care nurses worked across the life continuum and that the focus was not necessarily on ill health:

> A primary health care nurse is somebody who is having that contact through that health continuum, through that life continuum that is a constant, that is regularly looking at all of the components rather than I'm sick today and therefore only responding to the sickness. (I.6, p.1)

As mentioned in Chapter One, primary health care nurses are registered nurses with knowledge and expertise in primary health care practice; a role that includes population health, health promotion, disease prevention, disease state management, wellness and first point of contact care (Expert Advisory Group on Primary Health Care Nursing, 2003). Nonetheless, the public health

nursing participants felt there was a general misconception in the sector that primary health care nurses were only employed in a general practice setting:

> It's like we are primary health care nurses and we work for the DHB, but they don't see us as primary care nurses, but we are out there. (FG.2, p.3)

This thinking was corroborated by two managers, who whilst not necessarily agreeing with it, signalled that this misconception did exist:

> I think traditionally, primary health care nursing has, within the primary health care sector, been all of those nurses that worked within general practice. (I.5, p.1)

> The Ministry clearly don't understand the Primary Health Care Strategy and they clearly don't understand primary health care nursing because even programs now that are coming out through the Ministry, their understanding of the way to offer a primary care nursing service, they only see one way of doing that and that's through PHO through general practices .... If the Ministry can't see past that and doesn't understand the true definition and the true options… (I.3.p.4)

It could be argued that there was a shared degree of ignorance about the place, role and contribution of primary health care nurses. If the information available on the MoH website under primary health care is an indicator, primary health care does not go beyond general practice. It is highly likely that this continued to influence decision-making and communication processes at all levels of the health system in Tairawhiti. Primary health care development did provide the opportunity to expand the practice nurse role (Cumming et al., 2005; Cumming & Gribben, 2007), but could equally have applied to other primary health care nursing groups employed in the primary health care setting in Tairawhiti.

Nationally practice nurses do make up the largest group of primary health care nurses (Sheridan, 2005), yet the term primary health care nursing covers a wide variety of nurses providing care in the community (Expert Advisory Group on Primary Health Care Nursing, 2003). It is the setting that determines the model of practice (Expert Advisory Group on Primary Health Care

Nursing), as was confirmed by one manager who stated it was where the nurses were based that distinguished their role:

> … people start using the term community based nurses and hospital based nurses as a way to distinguish, a way of distinguishing where they are based, not necessarily the silo they have been funded out of. (I.5, p.2)

Despite the numerous roles and titles within the primary health care context, there is a core body of knowledge from which nurses practice in order to promote, improve, maintain and restore health; there are more commonalities than differences.

Nurses in this study alleged they were the poor relative of nursing and that hospital based nurses were awarded a much higher status. One DHB based primary health care nurse stated she had been informed by very senior staff in the DHB that they were not "real" nurses because they did not work in the hospital and were not "saving" lives:

> They don't see some of the nurses in primary health as real nurses....they think we are sort of like pretend nurses. (FG.2, p.21)

Two nurse participants suggested the inferior perception of primary health care nursing stemmed from management not understanding what primary health care nurses actually do:

> I don't think they have any idea of what we do. (FG.1, p.9)

> I am not sure whether they understand what we do in the community..... So there is kind of like a bit of a gap. (FG.3, p.1)

This reflects naivety concerning the true value of a robust primary health care system and is further explained from statements made by a number of primary health care nurses. It was suggested the lower value assigned to primary health care nursing stemmed from the inability to measure what they did:

> What we represent is quite hard to measure a lot of the time so we don't get the recognition or value placed on our roles that perhaps should be. (FG.3, p.3)

> Primary health care nursing isn't measured, it isn't measured the same way the task orientated nurses on the ward do, you know, you discharged your six patients today so you have produced the outcomes in secondary. You know secondary is much easier to measure I guess, so there is more value placed around that because it is more visible. (FG.3, p.12)

> It is not just numbers, it is like the high depth and you know, like why can we achieve that and nobody else can. It is being able to demonstrate that. (FG.2, p.13)

The productivity that nursing contributes cannot easily be measured given the complex nature of the work of nurses (O'Connor, 2010). As a result, financial assumptions constrain the nursing contribution in health care; nursing often being perceived as a cost rather than an asset (Aiken, 2011). Although Aiken (2011) was referring to nursing in the acute setting, this may well apply in the primary health care nursing situation where nursing services are rarely priced or fiscally valued.

One of the nurse participants proposed this was exacerbated by the public silence around their role. She noted:

> ...they don't write letters to the paper about the impact of the care that they receive. You get letters to the paper about people that have been in hospital, you know, had a wonderful time like accident and emergency You know had their hip done and I don't disagree with them those things probably did happen but I'm saying the profile is in the way that is communicated. (FG.2, p.19)

Media images shape how the public perceives nurses influencing their expectations of their providers. Typically, nurses are depicted primarily as hands-on and hospital based rather than in other settings (Norwood 2001). One of the nurses believed there was a need for a media campaign to change this image:

> I think that it's about changing attitude and I'd like to see more publicity, more marketing on primary health nurses and what they do. Because, when I'm out there, or I'm telling somebody about what I do when they ask they say oh OK. (FG.2, p.21)

The nursing participants suggested that their perceived lack of value was reflected in the different salary structures and resources available to primary health care nurses when compared to that of hospital based nurses. This was aggravated by the limited ability of nurses to coherently express the significance of their role in terminology understood by decision-makers. It has been argued that nursing's professional challenges are related to the difficulty in articulating the nuances of nursing services (Radcliff, 2000). The value of nursing as adjunct to medical endeavour in high technology environments (like hospital) is recognised. Conversely, community based nursing roles are seen as ambiguous, difficult to explain, low-tech and lack the immediacy of a curative role; they are undervalued (St John & Shabon, 2011). The low value placed upon primary health care nurses was a precursor to the low level of engagement about the Strategy and impeded the knowledge construction process.

6.5.2 Knowledge construction

In Tairawhiti there were notable failings in the communication channel about the purpose, function and impact of the Primary Health Care Strategy's intent. A communication channel is the means for which the message of a new idea gets from one person to another (Rogers, 2003). Communication involves a sender, a message and a recipient. Early signs of misunderstanding were evident regarding the purpose of PHOs:

> There are also some perception issues about PHOs that they will be set up only for Māori or for Māori at the expense of other people in this district with poor health statistics (TDH, District Annual Plan, 2002/03, p.49).

Finlayson et al. (2009) agree that nationally, a significant number of people including nurses were unaware of the role of PHOs let alone the broader remit of the Primary Health Care Strategy. The differences in meaning and

understanding of primary health care/primary care implications of the Strategy between those who participated in the study confirmed this locally. Knowledge of the Strategy by the managers ranged from basic understanding through to in-depth comprehension:

> I read through one of the documents some time ago but in some ways for me it's more the concept of trying to have a greater focus around primary health care as opposed to me being familiar with some dot points contained within the Strategy. (I.2, p.1)

> I like its focus in terms of population health. That wasn't there before the Primary Health Care Strategy it was very much focussed on the individual. I like its attempt to try and integrate services and health professionals in a way that it hasn't before. I mean there is still a long way to go. I like its emerging focus in self-management and self-responsibility and its emerging attempt to share ownership of the information and probably clinical decision-making not only amongst the health professionals but also with the person as well. (I.10, p.1)

Conversely, only four of the 32 primary health care nurse participants demonstrated any awareness of the Primary Health Care Strategy 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)

This finding was similar to previous research undertaken in Tairawhiti which demonstrated that primary health care nurses did not understand the implications of the Primary Health Care Strategy (Adamson et al., 2005). This is concerning given that the Strategy as previously noted, explicitly recognised the significance of nursing's contribution to primary health care (Expert Advisory Group on Primary Health Care Nursing, 2003). I found this mismatch perplexing 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 to have had your eyes shut if you were around at that time. (I.8, p.2)

Despite the certainty of this manager, I found no evidence of the information on the Strategy being provided to the broad range of primary health care nurses in Tairawhiti around the time of its release. Condensed information was provided seven years after the Strategy's release in a local primary health care nurse newsletter emailed and sent to primary health care nurses.

Communication is always challenging in complex organisations, across communities and between different practitioner groups. Even when the information is disseminated, it may not be actively received. One of the nurses cites that high clinical workloads and time pressures interfered with the uptake of any information sent electronically:

> I don't even have time sometimes, to be on my emails because you know like my clinical work is so high. (FG.1, p.4)

The time factor also suggests a reason why hard copy information might not be read. It does however highlight the importance of active engagement with stakeholders following the roll out of the Primary Health Care Strategy. Face to face discussion may have been more effective in persuading individuals to accept a new idea. In saying that, there was evidence in the TDH Board minutes that a primary nursing meeting was facilitated for groups of nurses that:

> ...brainstormed solutions to health scenarios. This was particularly useful in demonstrating the variety of expertise, the potential for overlap of services and the necessity for a coordinated approach (TDH Board minutes, 28 November, 2003, p.7).

Nelson Connor et al., (2009) state key people who are responsible for communicating from within and to the nursing sector must be identified. There was evidence that one cohort of nurses had greater appreciation of the Primary Health Care Strategy than others. From the focus groups it became apparent that the public health nurses employed at TDH had opportunity to discuss the Strategy, 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 to show that we were meeting the some of the topics talk about but like the outreach immunisations and those sorts of things. (FG.4, p.1)

Public health nurses are employed by TDH's provider arm rather than being in general practice or private community based settings. As one of the public health nurses at the time of the release of the Primary Health Care Strategy, I can confirm public health nurses were not only provided with information, but actively discussed the Strategy to look at opportunities to contribute to achieving its goals. This is somewhat ironic given that public health nursing was largely excluded by the singular focus on the general practice environment.

Despite this focus, nurses in a general practice in the newly formed PHOs, or NGO sector, showed minimal awareness of the Strategy. One primary health care nurse, acutely aware of her limited knowledge, used her initiative and read the Strategy in preparation for a focus group. For this nurse, reading the Strategy clarified her understanding of the changes that had taken place in her working environment and the impetus behind those changes.

> So the more that I read and I had never seen the document before, which was a bit sad ....and so when I was reading it I was thinking it was like all lights were switched on all over the place thinking well that is because that's when that happened and that's why that is and yeah, so it all made sense but I hadn't read the document. (FG.4, p.1)

What this suggests is that understanding of the Primary Health Care Strategy was dependent on the nurse's place of employment and was generally limited. Rogers (200) and Greenhalgh et al. (2005) both confirm that intra-organisational networks and inter-professional team work facilitate the development of shared meanings and values in relation to the innovation. But if such networks are not operating effectively then dissemination is limited through widespread lack of awareness.

The diffusion process is comparative to societal norms, value systems and accepted behaviour within organisations (Greenhalgh et al., 2005). Further, the capacity to influence others is associated with an individual's social standing, personal characteristics, self-esteem and intelligence. Rogers (2003) argues most people depend upon the subjective evaluation of information conveyed from individuals like themselves, especially when there is a high degree of professional resemblance between the person/people attempting to introduce the innovation. In analysing the data against the importance of professional relationships one of the managers confirmed its significance:

> ….and yeah there is something to be said that doctors talk to doctors and nurses talk to nurses. We have completely different language sets and that makes sense. (I.6, p.8)

People with similar education, social standing and beliefs share homophilous communication. Homophilous innovation communication is more effective than heterophilous or that between people with different attributes. Individuals also tend to expose themselves more readily to ideas that comply with their existing values (Rogers, 2003). There is a close association between knowledge of innovations and an area of interest. Peers with similar dispositions in life are more inclined to accept one another's messages than if the same peers were receiving the information from individuals outside the group (Diaz, 2007). The author extends this acceptance to individuals with more education or more money.

6.6 Concluding statement

The success of implementing any innovation depends on the knowledge of the nature of that innovation, as well as the adopters within their socio-organisational context (Greenhalgh et al., 2004, 2005; Rogers, 2003). This chapter provided evidence of the numerous contributing factors that prohibited the effective diffusion of the Primary Health Care Strategy in Tairawhiti. This was made worse by the lack of a local strategic plan for primary health care development. Overall, there was little evidence in Tairawhiti of steps taken in moving toward a state of readiness, in adopting the broader intent of the Strategy and towards having all the key players supported and on board.

Initially the propensity to act was high as evidenced by activity around PHO development, the mainstay of the changes that took place. However, limited participant understanding of the Strategy negatively influenced the implementation processes.

As a direct consequence of the poor diffusion process, shared understanding was not reached in Tairawhiti and not all parts of the health system were disposed to adopting the Primary Health Care Strategy. The chance of successful implementation diminished further with limited and ineffective engagement following the Strategy's release. Incomplete understanding then reduced the chance of effective deployment of the primary health care nursing workforce to contribute toward achievement of the Strategy's intent. In the next chapter multiple layers of resistance in Tairawhiti are examined.

Chapter Seven: Multiple layers of resistance

7.1 Introduction

In this chapter I examine the multiple layers of resistance that were evident following the release of the Primary Health Care Strategy in Tairawhiti. Resistance considerably influenced system readiness in Tairawhiti and negatively impacted on the deployment of the primary health care nursing workforce. In order to fulfil the intent of achieving equity, strengthening community involvement, adopting a population health approach and working in multidisciplinary teams, the entire health sector had to be willing to adopt the proposed changes. The principles were incongruent with existing structures and processes and this reduced the receptive context for change.

The chapter begins with a brief and general overview of resistance. Subtle organisational resistance is demonstrated by inactivity in implementing the complete system-wide change. Medical practitioners overtly expressed their resistance by challenging any proposed change that did not fit with their business model, hegemonic interests and biomedical beliefs. The nursing workforce remained largely oblivious to the changes occurring around them; their lack of engagement was a significant barrier to the effective deployment of this workforce. The chapter concludes with detectable levels of reform weariness across the district.

7.2 Resistance to change

The release of the Primary Health Care Strategy in 2001 was consistent with the priorities of the Alma Ata Declaration (1978) and signalled the Labour-led coalition's intention to redesign the financing and delivery of primary health care (Hefford et al., 2005). It was ambitious to expect marked change to take place given that previous New Zealand health reforms had been unsuccessful in bringing about the desired change. Resistance and scepticism are recognised as real threats to progress of organisational change within health care systems

(Gollop, Whitby, Buchanan & Ketley, 2004). This is made worse when the choosers of an innovation are not always the users, and if they do not feel any connection with it (Dearing, 2009). Hence, one of the PHO based managers was not surprised at the limited progress since the Strategy's release:

> Yes well, if you think about the length of time it took to build up the hierarchy, then the length of time to dismantle it ...you could assume that it will take just as long, or even if it was half as long that is still a long time. (I.5, p.7)

The contribution of historical structures to change resistance cannot be underestimated. This is worsened when the party with the most power in the context is not supportive of the innovation (Makinen, 2010). Disconnection between primary and secondary care, differences in communication structures and funding systems all exacerbated challenges to embedded traditions. In justifying the "Better, Sooner, More Convenient" policy, the Minister of Health (2009) acknowledged a lack of connectivity and collaboration between primary and secondary services along with a lack of shared information.

It was not surprising perhaps that implementing all of the principles of the Primary Health Care Strategy met with significant resistance across the health sector. Regardless, resistance to reform is debilitating to a health system and to the health of a community. Despite such resistance, it was repeatedly noted that there was a need for change as confirmed in a much later District Annual Plan:

> National figures suggest Tairawhiti has the highest rate of population preventable hospitalisations for all age groups. For Tairawhiti, more than 35% of admissions are potentially avoidable if people receive timely, high quality primary care services. Therefore a strong primary health care system is central to improving our health and, in particular, removing inequalities in health (TDH District Annual Plan, 2007/08, p.36).

This statement recognised value in a robust primary health care system. The district annual plans applied the language and sentiments expected by the MoH in strategic documents. Despite this, subsequent actions did not support

the intention. One PHO based manager likened the lack of progress to being in a time warp:

> You know if the earth stood still we would be in the same time warp we were in the 50s, 60s and 70s. Things are changing and we need to evolve. Primary health care I suppose is at the forefront of that type of change. (I.9, p.1)

Using the diffusion of innovation to analyse this comment, some theorists have suggested that the adoption of new ideas follows a predictable pattern. At first only a few individuals adopt the innovation and if the diffusion process is successful, that number is expected to increase accelerating to a maximum until half of the individuals have adopted (Rogers, 2003). As confirmed in the previous chapter, in this particular DHB, initially only a few individuals understood all the principles of the Primary Health Care Strategy. At the time of data collection, it never reached the point where half the individuals had adopted the innovation.

One of the few focus group nurse participants who understood and was excited about the potential the Primary Health Care Strategy offered, expressed an eagerness to move forward but was also disappointed with the trajectory of change:

> I think from when I went away and didn't nurse for so many years in paid employment and I thought PHOs came in it was all going to be, you know, there's going to be big changes. Well excuse me, but I didn't see many changes when I came back. I was peeved off and I thought 'what', what has happened? We were driving all this and it's just a waste really. (FG.2, p.7)

The frustration expressed represents the historical disempowerment of a constrained nursing workforce juxtaposed with an absence of any control over the working environment. Such constraint is well articulated (Chiarella & McInnes, 2010; Fagin & Garelick, 2004; Lawler, 1994; Piji-Zieber, 2013; Radcliff, 2000). This is discussed further in this chapter when considering the nursing workforce. Feelings of constraint were not limited to nurses in direct patient care. One of the nursing managers verified a higher level of

disempowerment when she confirmed the Primary Health Care Strategy had not progressed as rapidly as anticipated:

> It is not happening quickly enough for me, but change is a slow process and you do have to accept that. (I.7, p.20)

Despite being a nurse leader, her views indicate she felt frustrated by the pace of change, but at the same time she seemingly felt she had little ability or power to affect or lead the necessary change. Nor was disempowerment exclusive to nursing, the following non-nurse manager likened the rate of transformation to throwing darts at a dart board:

> It is more of the same you know unless you try and throw darts at a dart board that don't stick in, they just keep bouncing off. Nothing happens and so if you don't get change you can wait for the change or you start doing things as normal. (I.9, p.6)

Individuals respond to the threat of change in different ways, some are more comfortable with the certainty in their roles while others relish the challenge the future brings (Gough & Richards, 1998). There were people, who were prepared for change and tried to make it happen. Once defeated, acceptance ensued, individuals and organisations continued as normal until another chance presented. The process of influencing attitudes and change takes a considerable amount of time and requires persistence (Gollop et al., 2004). Managers confirmed that limited change or alteration in awareness had taken place since the release of the Primary Health Care Strategy in 2001.

> I feel that in very many ways care is still very traditional. (I.3, p.1)

> Yet reducing inequalities, more community involvement, a broader population health perspective and multidisciplinary teams were all components of the Primary Health Care Strategy but it was if they didn't exist to everybody. (I.5, p.1)

The Primary Health Care Strategy as a document for primary health care development was not taken seriously according to this manager:

> I think the sadness of the Primary Health Care Strategy is that it doesn't order any change or anything. (I.3, p.1)
>
> The principles are sound and good, but it is poorly used, interpreted when it wants to be. (I.3, p.6)

As the above excerpts demonstrate, there were participants who believed in what the Primary Health Care Strategy had to offer as an innovation. For these participants the Strategy had a high degree of relative advantage but as noted previously, relative advantage on its own does not guarantee adoption (Greenhalgh et al., 2005; Rogers, 2003). The obvious gains to the people of Tairawhiti were unquestionable. However, if the perception of an innovation is not compatible with existing beliefs, then any advantages that an innovation presents will be immaterial. Because the expected changes did not take place as anticipated, it seems likely that there was significant resistance to what was proposed. This may have arisen from misunderstanding of the intent of the Strategy and/or fear of the intended and unintended consequences. Nor did there appear to be any person or group to drive the Strategy forward and thwart resistance. In such a context resistance flourished.

Specific opponents can provide resistance to an innovation as tensions arise from different ideological values. These opponents not only do not adopt an innovation, but may negatively influence the diffusion process and restrict movement for others. However, the existing literature is relatively silent about the role opponents play on the diffusion process (Cavusoglu, Hu, Li & Ma, 2010). What is reported is that incompatibilities act as deterrents for adoption, even when evidence suggests the properties of that innovation are beneficial.

Williams and Sibbald (1999) confirm that changing roles and professional responsibilities create a culture of uncertainty. This together with a lack of predictability threatens innovativeness. The majority of people have no prior desire to change (Ram, 1987), making change only when it becomes essential. Most people tend to feel safe with what they know, taking a wait and see approach. Without a doubt, the potential consequences of the change suggested by the Primary Health Care Strategy were immense in terms of how

existing staff within primary health care and the hospital were used. This was substantiated by the following PHO based manager:

> I think there are a couple of challenges for me. In the current structures people are safe within those structures. You know people don't want to unbundle the structures to allow some fresh views to come though. There is I suppose strong resistance to change, you are dealing with a particular cohort that have been there for years, and years, and years, and when change starts to come then everything comes out. (I.9, p.5)

As this manager suggests, change is especially hard for those who have been in the system for a number of years. Despite an abundance of evidence to support the proposed change, Gollop et al. (2004) state embedded cultures within health organisations prevent this change from occurring. Maintaining the status quo is easier and more comfortable as any change suggested by an innovation creates insecurity, fear of the unknown and fear of losing benefits (Gollop et al., 2004; Hayes, 2007). Resistance to change is a normal human response to anything perceived as new. Doubt, dissent or disagreement, while not necessarily equating with disobedience or disloyalty, preserves the comfortable conditions that currently exist (Szabo, 2002).

The diffusion of innovation theory does not explore resistance to change as such. Rather the focus is on system antecedents or the receptive climate, and the fit with the adopter's needs and values (Greenhalgh at el., 2005). What is known is that when understanding of an innovation is not compatible with the existing values of potential adopters as determined by the individual themselves, it is less likelihood to be adopted (Rogers, 2003). In order for adoption to occur, organisations will need to be receptive to the evidence, as well as be prepared for change. It can be assumed that the innovation-system fit of the Primary Health Care Strategy in Tairawhiti was variable across the organisations and with each individual within that organisation, as the following comments suggest:

> I don't think anyone in primary health care beyond these walls was interested in what was going. (I.5, p.8)

> I think our funders…I don't think that they understand or have a full commitment to what primary health care does. (I.1, p.11)
>
> The barriers to change are entrenched attitudes. You have a clash of public health systems and private enterprise. (1.10, p.9)

Strong leadership, clear strategic vision, visionary staff in pivotal positions and a climate conducive to experimentation and risk taking increases the receptive context for change (Greenhalgh et al., 2005). Without this, the amenability for change is negligible. At the same time, coercion or manipulation by those in authority wanting to implement an innovation strengthens levels of resistance. As previously mentioned Greenhalgh et al. (2005) argue that neither authoritative approaches nor dictating the adoption of an innovation is conducive to success. Instead, both Gollop et al. (2004) and Smollan (2011) advocate for the need to assess the potential impacts of change on the various stakeholders and "engage their views". If resistance was viewed differently, or planned for, then it could be managed**.** The authors suggest that opposition may then turn into collaboration or compromise.

In summarising this section of the chapter, the roll out of the Primary Health Care Strategy by government was not well thought through given previous attempts at change. The more compatible an innovation is with organisational or professional norms, values, beliefs, and ways of working then the more likely it is that the innovation will be adopted (Greenhalgh et al., 2005).

7.3 Organisational resistance

Knowledge underpinning the implementation of an innovation is not necessarily objective but socially constructed within an organisation or system (Greenhalgh et al., 2004). As mentioned in Chapter One, underlying cultural values have historically shaped the trajectory of health system reforms in New Zealand (Aston & Tenbensel, 2010). Organisations are cultural identities, how the social construction process influences change requires greater understanding (Davies, Nutley & Mannion, 2000). It is this culture within a social system that determines system readiness. Harvey and Broyles (2010) agree that the strength of organisational culture should not be underestimated

and that challenging traditional cultures can be difficult. The more the balance between the risks and benefits of an organisation reflect an organisation's established power base, the greater is the likelihood that the innovation will be implemented (Greenhalgh et al., 2005). This section of the chapter explores the possible causes of organisation resistance across Tairawhiti.

Devlin, Maynard, and Mays (2001) state that while structural changes and changing laws may create a new ethos; they serve to distract attention from making change at a service level, especially if the issues are not structural. People may get embroiled in the process of change, hoping that all deep seated issues will be resolved by the changes taking place. As the following manager suggests, the foundations of a system must be robust for primary health care change to occur:

> We still haven't got the foundations strong and we are going to keep changing things at a higher level than thinking about the patients, getting it right for them and then building on it. I think the reality is far from equitable, and I think because the foundations of what is quite shaky still, I do have trouble with the next steps. I believe you should sort out the first steps and then build on changes and new initiatives.... I don't believe the basics have ever been fixed. (I.3, p.1)

This excerpt suggests that the funding and employment model across the health system in Tairawhiti was not conducive to a primary health care approach. Making minor changes did not supersede traditional approaches to health service delivery. Greenhalgh et al. (2005) confirm organisations provide different contexts for innovation and it is the structural as well as cultural features which influence the likelihood of success. Organisations with a better receptive context for change are better able to assimilate innovation (Greenhalgh et al., 2004). The social dimensions of change and the characteristics of the people who make up that social system cannot be underestimated (Rogers, 2003). Tradition for example, has a significant part to play in the way health care systems of a country are shaped (McMurray & Cheater, 2003). The Primary Health Care Strategy challenged the traditional health care system in New Zealand. Institutionalisation can also be seen as the

enemy of change as it is said to bring stability and thus raise resistance (Burns & Scapens, 2000).

For the decision-makers, the Primary Health Care Strategy confronted DHB priorities. Secondary care dominated both the agenda and expenditure in all Tairawhiti DHB Board minutes. The Chief Executive, quality and employment, technical, financial, funder and governance reports which feed into these meetings, were predominantly hospital focussed. This is despite the fact that the provision of secondary care services does not equate to the largest health care gain for communities, although it does consume the largest portion of the health spending.

Lack of visible primary health care activity supported the generalised perception that the DHB looked after its secondary concerns first, as the following manager's comments suggest:

> I think a lot of that funding is held onto by the DHBs. (I.1, p.2)
>
> I think our funders, I don't think that they understand or have a full commitment to what primary health care does. I think they are actually more focused with secondary care services. (I.1, p.11)
>
> I think the challenge will be around the mind-set, around evolving primary health as a core function of health like you know all you get is hospital, hospital, and hospital. (I.9, p.1)

There was some misunderstanding in the meaning of the title District Health Board. Rather than understanding a DHB as the entity charged with keeping a district or regional population well, community based participants saw the DHB as synonymous with the hospital provider arm. In fact, the combined purchaser-provider function did encourage the use of hospital services first (Mathias, 2009). Gauld (2009a) states that secondary care remains under DHB control, but it becomes problematic when increasing funding constraints force the financial focus on maintaining crucial hospital services. Still, DHBs are responsible for meeting the health and disability needs of their entire geographically based communities (Cordery, 2008; MoH, 2007a).

The MoH did show tolerance of short-term teething problems and allowed flexibility during the transition period (MoH, 2001). This was to enable each DHB to develop initiatives to suit the unique needs of their district. At the same time, this flexibility legitimised minimal change. Flexibility allows for reinvention, refinement or modification to suit the needs of the adopters (Greenhalgh et al., 2004). Instead of focusing on the individuals changing, the diffusion of innovation theory explains change as being the evolution of products or behaviours so they become a better fit for an individual or group (Robinson, 2009). Limited primary health care activity supported the notion that the DHB instigated actions based on what met their own needs:

> I think they (the DHB) only used the bits of the Strategy that fitted in with what they like. Because it is broad enough that you could have had any number of focuses and it would have still have the Strategy intent. (I.5, p.5)

When the government gave a directive to the DHB they responded, but only to the extent required to report on that activity. For example, each DHB was required to look at devolving services to primary health care. Devolution was mentioned in a number of the DHB district annual plans:

> TDH has indicated in its District Services Plan that areas of secondary care that could be provided in primary care will be assessed and, if appropriate, will be shifted to PHOs. A report on the process to identify those areas will be prepared by the end of 2003/04. Therefore 2004/05 will be a year for acting on these changes (TDH District Annual Plan, 2004/05, p.32).

This was updated in the 2005/2006 District Annual Plan where it states under a heading 'Ensuring Primary Care Services are in the Best Place for People':

> TDH has developed a draft tool for assessing and evaluating the best place for primary care services. The tool will assess and evaluate TDH Provider Arm primary care services that may be better placed in the PHO environment. A working group will be formed to identify services that may be shifted. The group will evaluate the risk to TDH Provider Arm and ensure capacity in the PHOs to take on the management of any transferred services (TDH District Annual Plan, 2005/06, p.54).

Devolution was again reinforced in 2009 when DHBs were asked to provide plans for shifting some secondary services to more convenient primary care settings as part of the district annual planning process for 2009/10 (PHCS Implementation Programme, 2009). This was confirmed by the following manager:

> One of the Minister's desires is to see more services that he would perceive to be hospital based services to be delivered in primary care closer to patients. (I.4, p.15)

In a subsequent summary report, only two items were identified for devolution in Tairawhiti: minor surgery which was later discontinued and post-acute pulmonary and cardiac rehabilitation which was already occurring in the community setting (PHCS Implementation Programme, 2009). A claim from one of the TDH managers suggested that devolution of services was not a simple process, especially for smaller DHBs such as Tairawhiti:

> You know one of the other things that we've got to do and it's going to be more tricky for us here than it will be in Auckland or you know in bigger centres is the whole integration of things like district nursing into, not into but with primary care. I think that is something that needs to be thought through. What is the model that will work for Tairawhiti? Because I just cannot see the district nursing services being broken up between the two PHOs. (I.4, p.15)

Consequently, compared with other DHBs, the proposal for devolution in Tairawhiti was meagre. The DHB was accused of being selective in its commitment to devolution by other non-DHB managers:

> I think a lot more services could be devolved. I think the movement has really only happened you know, with the devolvement of services put there in the last couple of years. (I.1, p.2)

> I would personally like to see district nursing and public health come right out of the hospital because I think they actually belong more in primary care. I think the long-term conditions centre shouldn't be up at the hospital because most of that stuff is primary health care based. (I.7, p.13)

To conclude this section of the chapter, the Strategy required a change in traditional thinking. This resulted in organisational resistance demonstrated by inactivity in implementing system-wide change. At the same time, the DHB was charged with providing essential hospital services and thus accused of looking after their secondary interests first. There were multiple layers of opposition and the resistance exhibited by GPs is discussed next.

7.4 Resistance by GPs

In New Zealand as is the case elsewhere, the medical profession was established very early on as a powerful interest group (Gauld, 2009a). Disparities of power and control in health are well articulated (Carryer, 2004; Finlayson et al., 2009; Mays & Cumming, 2004). The conceptualisation of this power contributes to the construction and reproduction of knowledge. The hegemonic interests of medicine are supported at various levels in western society (Furedi, 2006; Mays & Cumming, 2004; Piji-Zieber, 2013; Willis, 2006). Anything connected with health defaults to the supervision of the medical profession (Sheridan & Radmacher, 1992). Medicine has more authority than a non-medical voice (Long, Forsyth, Ledema & Carroll, 2006) and is secured through gate keeping (Furedi, 2006; Mays & Cumming, 2004; Willis, 2006). The notion that the environment was not equitable was commented on by one of the managers:

> The environment hasn't been created equitably and sustainably and people come back to two things; they come back to money and they come back to hierarchy or tradition. (I.5, p.3)

As theoretical agents of the DHB, GPs were neither ready nor agreeable to adopt the requirements expected within the Primary Health Care Strategy. Initially there was a willingness to work alongside the DHB in implementing the Strategy. A primary health care steering group was set up and consisted of GP and DHB representatives. However, ongoing disagreements arising from a mismatch between the values and beliefs of GPs and the DHB resulted in no action and subsequently shortened the life of the local steering group (B. Duncan, personal communication, 21 September, 2012). This was confirmed in Board minutes:

> After a discussion with the primary health care steering group and CPHAC, a decision was made to disband this steering group (TDH Board minutes, 27 February, 2004).

Rather than working through the issues raised by the GPs, disbanding the group appeared to be the easier option. This proved to be a stumbling block in the ongoing relationships between the DHB and GPs. Later, a working group replaced the steering group; this was made up of chief executive officers from the two PHOs (Turanganui PHO & Ngati Porou Hauora) and the group manager of planning and funding at TDH. The GP voice from the primary health care steering group was gone, as was any nursing contribution.

The funding model especially, was steeped in controversy as it had strong political overtones and aroused fervent emotions. GPs believed that proposed funding changes threatened the traditional benefits they had come to expect since the 1930s when the government lost the battle to prevent GPs charging co-payments and general practice became a private industry (Ashton & Tenbensel, 2010). Since then, altering the behaviour of GPs has been unsuccessfully attempted on numerous occasions in New Zealand's history. Both politicians and health care decision-makers, ably supported by the media, appear to regard the medical profession as worthy of persistent reverence. This has had significant influence over the decision-making, pace, and extent of change in health care (Mays & Cumming, 2004).

GPs strongly resisted any incorporation into a public health system (Gauld, 2008) and were unwilling to be dependent on the government for their livelihood (Mays & Cumming, 2004). Yet they were enthusiastic to accept incentives and the high level of public funding into their private businesses. They successfully managed to articulate the vulnerability of their personal investment in their businesses (Kent et al., 2005), firmly retaining their power and control through the business model in which they work. This business model was seen as holding back change as suggested by the following managers:

> ...the model that they work in, the business model, the small business unit, whereas that in fact the sole life of a GP is to run a small business and be a successful small business. I think some of that business model is what is creating some of the barriers to going forward. (I.6, p.2)

> I think again that this is again my problem with the Primary Health Care Strategy as it stands, and its true interpretation which is about GP practices and the way things are going. Because ethically and morally, whether people want to accept it or not, with that model it is a funding model. It is not about the care, it is not about the person getting to the nearest GP; it is about where the funding goes. (I.3, p.7)

> I definitely think the business structure of primary care is a barrier because GPs are the owners. Unless they can see the clear clinical and financial benefits of a change and they tend to be immersed in their businesses, businesses rather than day in and day out, and status quo tend to just prevails. So it's difficult to break that mould. (I.4, p.10)

A nurse participant also commented on this:

> There is so much more potential out there and until it's not business orientated and doctors don't own the businesses. I think we've got a long, long, way to go. (FG.2, p.7)

Participants frequently expressed a commonly held perception about the inevitability of the private business barriers which raises a bigger contextual question. Why did the MoH not directly address this when it was widely understood that GP ownership was a strong operational impediment to the vision of the Primary Health Care Strategy?

The notion that capitation would bring about the desired change was acknowledged as simplistic according to the following manager:

> The process of capitation was supposed to pay a block amount of money to general practice so that any person in general practice could deliver a service and it not matter whether that person was a general practitioner or a practice nurse... and it didn't change one iota. (I.5, p.2)

> Like thinking that capitation is going to change. The solution is too simplistic for the complexity of what needs to change. (I.5, p.13)

Changing the funding formulae did not emerge as the expected driver of change (Finlayson et al., 2011; Love, 2008). The government allowed practices to charge an additional co-payment which encouraged continuation of the fee-for-service mind-set. In addition, GPs believed that capitation funding belonged to them personally and this again prevented a shift in the focus of care from fee-for-service toward a population health approach.

One of the nurses believed the business model should be replaced, and that GPs should be salaried:

> ...and get rid of the business model with the GPs. Salary them and make them want them deliver a better quality of service. Make it around a better quality of service as opposed to profit. Profit driven isn't right when it comes to health and we are not profit driven because we are all salaried and it should be outcome driven really. (FG.3, p.8)

Making a profit out of government funding for the delivery of health services was unacceptable to this particular nurse. These comments were echoed by another nurse participant who believed the additional financial incentives given to general practice to achieve certain targets should be removed:

> Incentive shouldn't be for providers to do the job that they've been paid their wage to do. Their incentive is the fact that they get a pay packet so that doesn't matter whether you're a nurse or a GP. The actual incentive should be for the person who is receiving the service. To actually give someone who is taking a pay packet more incentives to do something which is already recognised as a national good and is something we would actually want. For the money to go that way I just can't see anything right in that and again the funding only goes that way if you're a doctor. (FG.5, p.13)

Analysis of this excerpt suggests this nurse understood the additional revenue that went toward reducing patient fees and the availability of new funding streams had not equated to improved outcomes for patients. Profit making over care infuriated another of the nurse participants:

> In the whole business model I mean it is just infuriating. Particularly with the GPs because that is their focus and their

> business model. It doesn't seem to mean that their focus is on the health issues that exist in the community. (FG.3, p.15)

Yet, one of the PHO based managers was hopeful that the evidence of the emerging service burden might instigate change:

> I do know what is going to happen we are going to create an environment where general practice is not just based on instinct and perception. They will understand what their service burden is and their population is in a far more evidence based way than they have in the past. I think that for a number of them that's going to freak them out and probably be a vast difference between who is being seen and who should be seen. In order to move closer to who should be seen they are going to have to do a different model than the way they are doing now. Yet for those who are keen to you know grasp hold off that and get into that it will reap huge benefits for them professionally and their population. (I.5, p.19)

This data directly criticises the model of general practice in which an undifferentiated patient group are seen acutely while those who do not attend are largely ignored. General practice has traditionally focused on individual episodic care supplemented with some health education and health maintenance activities such as individual screening (Gough & Richards, 1998). Altering the fee-for-service mind-set toward population based activity was not achieved to any significant degree across the district. In short, general practice provides a biomedically underpinned service to meet illness care rather than health needs (Gough & Richards, 1998).

Biomedicine has previously provided doctors with a framework for understanding and treating disease. This has served as the foundation of many advances in medicine over the last century (Waugh et al., 2011). However, the Primary Health Care Strategy did signal a strong intent to move away from a deeply entrenched biomedical paradigm toward recognition of the social, behavioural and psychological influences on health and illness as confirmed by the following manager:

> Where the Strategy comes in that it is in fact supposed to be focusing on that overall wellness model for the population. (I.6, p.1)

Primary health care necessitates working in partnership with the patient; the patient possesses the knowledge and skills required to improve their health, as the following manger supports:

> The patient is the one who is empowered and so a lot of that is trying to bring education and options to the patient. Giving them the ability to make decisions and being involved in their own decision-making rather than being seen as a passive object, drives things to be done to them rather than with them. (I.2, p.4)

The prevalence of long-term conditions has escalated the necessity to further challenge the assumptions of the biomedical paradigm. The management of these chronic conditions requires the psychological and social impacts on health to be recognised just as important as treating the signs of disease. Developing effective relationships with patients to support healthier lifestyles takes into account how an individual experiences disease and requires a multidisciplinary approach to care.

As already noted and supported by evidence (Bailey, et al., 2006; Buttaro et al., 2003; Hansson et al., 2010; O'Neill & Cowman, 2008; Pullon, et al., 2011; Sloand & Groves, 2005; Thrasher, 2002), the Primary Health Care Strategy explicitly stated that there was to be a collaborative, multidisciplinary approach to service delivery in primary health care (MoH, 2001). This was another example of the proposed change which was incongruent with existing values and beliefs, creating a source of resistance. The Strategy encouraged a multidisciplinary approach to ensure coordination of care across service areas, the roles of the primary health care team members were not made clear as confirmed by this manager:

> And so part of the debate needs to be about what the different roles of each team player are so that we're clear as to what our different brief is in any given situation. (I.2, p.8)

Collaboration is a fundamental requirement of the relationship between the nursing and medical professions (Hansson et al., 2010; Zwarenstein & Bryant, 2009). There are considerable differences in attitude towards collaboration between doctors and nurses; nurses are much more positive (Hansson et al., 2010). Most doctors struggle with the concept of collaboration having traditionally been in charge (Snelgrove & Hughes, 2000; Youngwerth & Twaddle, 2011). This was a cause of further resistance. The concern that nursing would encroach on the field of medicine has been especially marked at the interface between nursing and GP contexts (Thompson, 2006). Collaboration, based on provider equality, requires the full autonomy and clinical freedom of all team members (Youngwerth & Twaddle, 2011; Zwarenstein & Bryant, 2009). This was acknowledged by the following two managers:

> One problem is that often doctors like being in that team but they also like being in charge of that team. Part of that problem is that some doctors see themselves as, subconsciously with a doctor centred approached as opposed to a patient centred approach. (I.2, p.8)

> I think in the past doctors would be quite negative because they would see it as probably nurses having a bit too much power and knowledge which is never a good thing and I think lots of doctors think this, even though they [nurses] would still remain the cheaper option and flexible and everything. (I.3, p.9)

Having a duty of care was raised by another manager as contributing to the doctor wanting or feeling the necessity to be in charge:

> The issue with that, those general practitioners still feel very strongly that they still hold the duty of care in that nurses within their general practice and nurses outside general practice who are providing service in the community are fitting around duty of care. (I.5, p.3)

Duty of care is an interesting but misguided concept. Doctors believe they are ultimately responsible for the decisions and interventions made for patients by non-medical health professionals. It clearly states in the Health Practitioner Assurance Act (2003) that each professional is legally responsible for their

own practice. The foremost purpose of this Act is to protect the health and safety of members of the public by providing mechanisms to ensure that health practitioners are competent and fit to practice within their professions. It seems the misunderstanding about another professional's responsibility has contributed to this erroneous belief.

Medical resistance to loss of control or change of services models has taken many forms. Most arise from a seemingly deeply held belief in the rightfulness of the status quo:

> ...every practice has got its own little way of being, own personalities and own ways of functioning and you can't influence that. You can have all the resources, you can have all the training, but if people have got an attitude that is not willing to look at change or attitude that they may not have every answer under the sun or have thought of every solution and you can't tell us anything. If they have that attitude, nothing is ever going to change. (I.7, p.20)

Modelling partnership, strengthening networks and shared learning were offered by three managers as their personal (even if not evidence based) solutions to overcoming the barriers to a multidisciplinary approach:

> I just like the idea of multidisciplinary training so that there are doctors and nurses who are training together. So they can appreciate each other's role more fully and the strengths that everyone brings to the table. (I.2, p.9)

> Then if we don't even share the same education and that all the opportunity to talk about that then every one's going to be going round still in their little boxes, not joining up. (I.3, p.8)

> So we have to be modelling strong partnerships at all levels. If the long-term gain is that we actually get some partnerships going and clinical networks going and a joint activity going and some joint learning and joint interaction between the disciplines then sometimes you just have to bite the bullet. (I.6, p.8)

The comments appear to suggest that behaviour change might be sufficient to alter deeply entrenched practices and approaches to service delivery. However, attitude change does take time, and the culture within a given social

system determines the system's readiness to adopt (Sanson-Fisher, 2004). For innovations to be successfully diffused, the majority of people will have to make fundamental change to the way they conduct their activities (Szabo, 2002).

The Primary Health Care Strategy may have intended clear benefits for the patients, but threatened traditional medical practice and their associated social system. The relative advantage of the Strategy for the GPs was minimal, it was not perceived as better than the idea it superseded. It was essential that the professional interest groups and stakeholders were allies in the Strategy's implementation (Finlayson et al., 2011; Mays & Cumming, 2004). This is confirmed by Martin, Weaver, Currie, Finn and McDonald (2012) who state that networks of clinical champions and sponsors from different clinical and managerial backgrounds are crucial.

Overall, there was a definite belief expressed by nearly all participants that partnerships were essential in moving primary health care forward in Tairawhiti:

> We need to be working on those partnerships all the way, on those networks to make sure that that's happening. (I.6, p.8)

Only by letting go of tradition can multidisciplinary teams work together to improve services for patients. Instead of boundary disputes, effort must be directed towards capitalising on the variety of skills that professionals offer with the patient at the centre of service delivery.

Continuing this theme I now move to exploring the nursing workforce, a professional group that should have been included as one of the major stakeholders. Their omission resulted in their inability to actively participate in the implementation of the Primary Health Care Strategy process that could be viewed as covert resistance.

7.5 Nursing workforce

Nursing leadership in New Zealand warmly embraced the Strategy seeing it as an affirmation of a nursing response to primary health care (Carryer, 2004). But as discussed in the previous chapter, the majority of nurses in Tairawhiti were unaware of the Primary Health Care Strategy. Those few who were aware felt powerless to control their environment. Inadequate communication, professional oppression and lack of collaboration have disempowered nurses and hindered the development of this valuable resource. Gender has also played a significant part in reproducing disadvantage among nurses, irrespective of speciality and position (Smith & Mackintosh, 2007; Ulrich, 2010). Nurses work within oppressive political systems and are not sanctioned to make change happen (International Council of Nurses, 2008a).

Nationally, many primary health care nurses attempted to contribute meaningfully to primary health care. Nurses themselves identify a lack of confidence, a lack of willingness to embrace change and contentment with the status quo (Docherty, Sheridan & Kenealy, 2008; Finlayson et al., 2009). These authors assert that some nurses believe their existing roles are appropriate and their unwillingness to take on new roles was self-limiting. One of the managers believed that practice nurses made a conscious decision to go into such roles for the personal benefits associated with them:

> I think many people working in practice nursing roles have made a conscious decision to go onto those roles because they're seen as relatively quieter lifestyle, it's safer, quieter, its Monday to Friday, you're working directly with doctors. We might bitch and moan round the fact that we're glorified receptionist but in fact actually you know where we are in our stage and time of life it just suits us to, you know. (I.4, p.10)

In the general practice setting, the perception was that significant change was less likely. Personal reasons have been acknowledged as a contributing factor in why people might resist change (Gollop et al., 2004). As discussed in Chapter Two, Rogers (2003) defines the level of innovativeness as the degree to which an individual adopts a new idea compared with other members within a system or organisation. He identified distinct characteristics based on

socio-economic status, personality, communication, behaviour and so forth. Rogers classified people into adopter categories on the basis of when they first began using the new idea. Using this categorisation, a nurse would fit into the laggard category and be well behind with awareness of an innovation. I challenge this and agree with Greenhalgh et al. (2005) who offered more realistic aspects of adopters and the adoption process. The general psychological and context specific antecedents' better relate to the levels of disempowerment faced by nurses. After all, the health system is designed to keep nurses disempowered as a nursing based manager suggests:

> The system is specifically designed to the results it gets and it is specifically designed to not empower nurses (I.6, p.6).

Without redesign, the same systems and processes which have created the current reality for nurses will work together to repeat it. The responsibility is clearly placed, but the infrastructure is often inadequate to accomplish the task (O'Conner 1997). One of the Iwi provider nurses identified that their service did not have doctors and that this had a positive impact on each nurse's ability to contribute to decision-making in their organisation:

> Probably because we don't have doctors, we are the health professionals of the organisation so when we want to have a voice around things we definitely have our say. (FG.3, p.7)

Nurses continue to blame doctors for the oppressive relationships which exist in many settings (Carryer, 2011). They view themselves as victims remaining powerless to have any control over their work environment. However disempowerment is something for which nursing as a profession must also accept some responsibility, according to the following nurse based manager:

> I can't totally blame the system. I think the nursing profession has a lot to answer for as well. (I.6, p.3)

> They are their own worst enemy and actually putting themselves forward and saying well hang on and becoming clever about saying what about us without sounding like we're whinging, because we do have a tendency to sound like a bunch of victims. (I.6, p.6)

This nursing manager suggests nurses have become so disempowered that they are now their own worst enemy, choosing to see themselves as victims. Allowing a state of disempowerment to continue will negate the nursing workforce's ability to meet the increasing need of populations experiencing the burden of illness and disability associated with chronic conditions. One manager identified that the new integrated family centres might provide opportunity for a collective voice for nursing:

> I am thinking that a sort of a step wise change in that area is going to free up some of the relations, some of the issues. I think that the fact in primary care has been one or two GPs with one or two practice nurses in one small practice with a quite small defined bunch of patients.....It will change the dynamics there because now you've got ten GPs and you might have ten practice nurses. You have actually got a body of nurses that can band together and force change. (I.4, p.11)

This participant suggests that because integrated family centres are large multidisciplinary practices with a greater number of nurses, together they might become more powerful and influence change. The participant notes that traditionally practice nurses have worked in isolation alongside a solo GP or in a small group of GPs with a small number of nurses. This is logical reasoning however, the reality for nurses is not as simple as suggested. If primary health care nurses are not part of the information and knowledge process or part of the decision-making, then a learned helplessness reduces their ability to lobby for the expansion and augmentation of their role. It also reduces their ability to clearly articulate their needs. Indeed, the primary health care nurse focus group participants tended not to speak on behalf of their profession.

When attempting to discuss primary health care nursing a significant number of nurses continuously turned toward meeting the needs of their client group. The issues they discussed were related to service user, while the positive aspects of their role were positives for their community, the solutions offered were around improving health and reducing inequalities. For example when asked what has changed for nursing in the last few years in primary health care the answers included:

> We are still sending quite a lot of patients into hospital but they are sicker and I am not quite sure why that is whether they're getting older or getting sicker or whether it is the community that we work in. (FG.5, p.8)

> There's been a huge change you know and the way people are looking after themselves, they're really taking responsibility for their own health, because they can understand it. Because previously the doctor hasn't have the time to go through that with them and he'd just quickly run through it and given them hand-outs. (FG.1, p.6)

One of the answers to the question on a vision for primary health care nursing was:

> Having our own little bus and doing our own recalls...Reach those people and provide a service like that. (FG.1, p.21)

The responses confirmed the primary health care nurse participants were very passionate about their role and their community. This altruistic tendency was admirable but not conducive to the agenda of moving primary health care nursing forward to achieve the goals identified in the Primary Health Care Strategy. Ironically at Ministry encounters, nursing has frequently been criticised for only thinking about nursing needs and for not framing their arguments through patient or person centred discourse (J. Carryer, personal communication, 3 August, 2013).

The premise that nurses are silenced because they do not have a language for articulating their practice suggests the need to revisit the interpretation of nurse's silence as reluctance on their part to talk about what they do rather than their inability to communicate (Canon, 2008). Another manager commented on the nursing voice within the hospital setting:

> I think people such as yourself have input but my impression from the outside looking at primary care is I don't think that nurses would have that same degree of input and I do think, and I am looking at both PHOs, I am thinking that it is the owners of those PHOs that have a stronger role in that there is lesser role for groups like nurses within them to have their say. (I.4, p.3)

Another manager identified the need for the nurses to be engaged in order to move the profession forward:

> We must be engaging nurses at all levels and all places within the organisation to promote forward movement because the risk of not doing that is that's it is going to be done to us. (I.6, p.7)

A different manager acknowledged that nurses should be able to ask the questions and feel confident that they will be heard:

> I think people have to be secure in what they do and they have to feel confident that they're allowed to ask the dumb questions and they're got to feel confident that there's actually room for them to be let in. (I.7, p.15)

This same manager also noted that there have been nurses who have demonstrated their ability to influence outcomes and that this situation was improving:

> There have been a lot of people who have influenced how things can be done differently and we have showcased and had a good effect and a consistently good effect with outcomes that have made a difference to this area and I think they're starting to come to fruition more and more and more now. We are getting better at what we're doing we're getting smarter about what we're doing. (I.7, p.20)

Despite long standing discussion of disempowerment of nursing there is no clear reason as to why nursing so frequently remains on the decision-making margins. When nursing is not in a position of control, then decisions are made by non-nurses for the profession. Overall, the nursing based managers were able to articulate a vision for primary health care and primary health care nursing. In spite of this, while better positioned to speak for nursing, their voice was not necessarily acknowledged. This is explored further in the next chapter under governance and leadership.

However, it was acknowledged by the following two comments from another manager that nurses do get rebuffed:

> I think nurses do get knocked back very quickly. You have to be quite tough to put up with the fallout from having an opinion ....… and you can definitely understand that because we are far from having a voice let alone an equal voice, let alone a heard one. So you can understand that if everyone does that there'd never have been a Florence Nightingale and you know we would still all be dying from dirty wounds because there wasn't a doctor there came up with that it was a nurse (I.3, p.17).

> I think probably nurses are used to being put in their place and not sort of self promoted... You know probably a bit knocked back but they equally so have to move on from that. (I.3, p.8)

This manager suggests that silence disengages the profession. This was not the situation for all nurses. It was identified that there was a small cohort of nurses who did want to move the profession forward as suggested by the following nurse manager:

> There is a population of nurses that will want to contribute to change and who want to have a positive view forward and we need to be helping them model as to how that will look. (I.6, p.7)

Those that do want to make change happen cannot do this on their own and eventually give up, as suggested by the following nurse:

> They go away from the institution absolutely defeated. They don't want to be putting any more of their energy and time into it because they just get slapped down the whole time. So you know a lot of it is that attitude it has to change in the whole institution. I think once that actually happens, then as nurses we could actually get ahead and do what we actually need to do. (FG.2, p.19)

This same nurse also states nurses don't have a platform from which to speak:

> But then nurses speaking out too, we don't have the platform, well we are told we do have the platform but when you get on that platform and speak out you get slapped. It can be very threatening and intimidating and then you're looking at supporting your family, you know you've got younger kids and that. I've seen nurses that have come into the industry, you know, really fighting spirit and that after fifteen years or even more they are burnt out. (FG.2, p.10)

There are risks associated with speaking out to which this nurse alludes. Canon (2008) states nurses need to be aware that by not articulating their practice and underlying knowledge, they are participating in maintaining the status quo. Further, the author argues that nurses see power dynamics as constraining their practice and by remaining silent they contribute to their invisibility. However, nurses must be knowledgeable and empowered to be part of the decision-making; a line of reasoning that is evident throughout the three data chapters.

The willingness of some nurses to participate was not recognised by decision-makers. Some nurses challenged old models of behaviour, but they required support. Nurses are not very good at helping each other in developing themselves or their profession. Instead, some have a tendency to denigrate others who attempt to step out of the confines of the limitations nurses have come to accept (Farrell, 2001; French, 2004; Hutchinson, Vickers, Wilkes & Jackson, 2010). This behaviour suggests resistance to change within the profession. The following nurses, including one nurse manager, confirmed this situation as follows:

> Tall poppy syndrome, why we haven't developed …. I've been told if I put myself up on a pedestal it's a long way to fall. (FG.2, p.17)

> They say too that nurses eat their young but they also eat each other because, especially if you look as if you are slowly climbing. You think you've got friendships back there but then when you get up to a point, they weren't actually your friends. They certainly do eat each other. (FG.2, p.19)

> We have this wonderful professional ability to take off the heads of anyone who seeks to stand up and possibly talk on behalf of nurses. You know our profession does it to ourselves, having said that the system does it to it. And we have got to stop doing that; we have got to stop horizontal bashing and actually support each other. (I.6, p.3)

Those who speak up or attempt to change the status quo quite soon feel the wrath of their peers and become defeated, according to one nurse:

> They don't want to be putting any more of their energy and time into it because they just get slapped down the whole time, so you know a lot of it is that attitude it has to change. (FG.2, p.19)

Rather than encouraging those nurses to strive to develop both as an individual and professionally, they are held back by their peer group to the point of experiencing horizontal violence. Horizontal violence is a typical feature of oppressed group behaviour alongside disenfranchising work practices, generational and hierarchical abuse (Farrell, 2001).

What this section demonstrates is that while nursing was considered a key player in the Primary Health Care Strategy, nurses were disempowered by a multitude of factors that hindered their development and the role they could have played in improving the health of populations. Despite attempts by some nurse leaders, unless an increasing number of primary health care nurses are engaged in the changes occurring around them and/or part of the decision-making, then the effective deployment of this workforce will not occur. Next, reform weariness is considered as detrimental in the receptive context for change and in some ways demonstrates covert resistance.

7.6 Reform weariness.

The roll out of the Primary Health Care Strategy was not about rebranding. It was not a new logo or a different look for the same level of functioning. It required a significant paradigm shift and as such, it was quite different from previous reform in New Zealand. The unpredictability of the possible consequences of implementing the Strategy created uncertainty and has resulted in concealed resistance.

In New Zealand the government is the foremost provider of funding for health service delivery (New Zealand Parliament, 2009; Quinn, 2009). This serves to increase the susceptibility to relentless restructuring. The three year electoral cycle also compels politicians to produce change within those three years (Gauld, 2008). With fewer obstacles in the pursuit of major policy alteration in New Zealand, it has become easy to bring about significant legislative and structural change (Aston & Tenbensel, 2010). Reforms which had not worked

previously are often slightly modified and reintroduced (Parker & Glasby, 2008). Accordingly, Parker and Glasby (2008) state history repeats itself and the process of reform is commonly circular. This repetitive cycle of change was recognised by the following manager:

> I mean there are things come around. You know if you went through all the health reforms you have had diversity and you have had national bodies, your big structures and diversity. So you come into a recession that we have now and times are tough on a wide scale ....So probably if we sat back it's like a railway track that comes around again. (I.9, p.6)

Health structures might have a new look or a different name, but if the root of the problem is not addressed, nothing really changes. Politicians use history to justify policies rather than learn from history when creating them (Timmins, 2008). Still, policy change is dependent upon the political viability of any new structures and the degree to which politicians are influenced by public opinion (Gauld, 2008). Governments have an agenda to stay in power (Carroll et al., 2011). Like all previous policy change, the Labour-led coalition did not enforce desired behaviour within the existing health structures and systems. Political interference and constant change became a hindrance to service delivery as the following participants identified:

> There seems to be so much politics that gets in the way of health delivery really. (FG.3, p.15)

> Again politics get in the way of good ideas and health care. (I.7, p.8)

> You are getting the consecutive governments, Labour party and National party, although they come with their baggage for them it is trying to grasp you know what the hospitals are doing and then unbundle hospital care to put these things into primary care and are we doing the right thing. (I.9, p.1)

Reform-minded governments have imposed constant restructuring since the 1970s (Blank, 1994; Gauld, 2001). Just as the health sector was recovering from one bout of disruptive restructuring another would arrive (Gauld, 2009a). The frequency and impact of the changes was noted by one of the nurse participants employed in the health sector for a number of years:

> Things are constantly changing you know they might only move a little bit but they are moving....You have got to be quite flexible to take up new things and run with them. (FG.3, p.5)

I found limited literature specifically on health reform weariness, although this notion might be identified under other search terms. Nor is it addressed in the diffusion of innovation theory. The constant restructuring of the health sector over the last thirty years probably contributed to limited tolerance of the Primary Health Care Strategy as an instrument for change. Intolerance of the multiple changes to health policy in New Zealand was written in the 2002/03 District Annual Plan:

> Other primary care providers have expressed skepticism about the implementation, given the multiple changes in health policy over the last decade (TDH District Annual Plan, 2002/03, p.49).

One of the managers identified the need for continuity in the focus on primary health care:

> So you know you need the continuity of that sort of policy to keep the momentum going. (I.9, p.1)

The impact of political directives can divert implementation activity away from the innovation toward second guessing what they were required to do rather than concentrating on local priorities (Greenhalgh et al., 2005). Parker and Glasby (2008) contend constant change makes systems highly change-resistant; the workforce becomes increasingly cynical and short-term in their focus. The innovation performance of organisations is then far below their potential. Lindsay, Perkins, and Karanjikar (2009) argue innovation fatigue stifles innovativeness. One of the nurses talked about the constant turnover of contracts although she did not seem too perturbed by the constant change:

> Just different contracts like you know. I suppose that is the nature of our environment is that contracts come and contracts go. (FG.3, p.5)

Parker and Glasby (2008) suggest instead that investment on reorganisation would be better spent on supporting the workforce to move from being policy victims to policy entrepreneurs to deliver sustainable transformation.

7.7 Concluding statement

The Primary Health Care Strategy strongly challenged traditional structures and processes and resulted in layers of resistance. The antecedents addressed in this chapter demonstrate a significant lack of receptivity in Tairawhiti toward the system wide paradigm shift the Strategy required. A reluctance to embrace change and a desire to maintain the comfortable conditions that already existed manifested itself across all levels of the health sector. Resistance was based on age old traditions and attitudes, related to funding, hegemonic interests and the required move away from biomedicine toward population health, and a collaborative multidisciplinary approach.

The DHB was not ready to adopt the broader intent of the Primary Health Care Strategy, nor were the individuals in the workforce ready. GPs demonstrated resistance to the proposed changes and managed to firmly retain power and control. The majority of nurses were unaware of the changes taking place around them, seemingly content with the status quo and yet not content as revealed in the data. Accordingly, nursing continued to focus on attempting to meet patient needs through traditional models of care. Reform weariness was also evident and negated the appetite for change. The high complexity and critical dependence on simultaneous adoption by multiple users of the Strategy meant only the acceptable parts of the Strategy were implemented to any degree of success. As a result, enthusiasm for primary health care development lay dormant.

Chapter Eight: Primary health care nursing investment

8.1 Introduction

Chapter's Six and Seven provided analysis of data on attributes that influenced Tairawhiti readiness to implement the principles of the New Zealand Primary Health Care Strategy. In this chapter I examine the changes that did or did not take place for primary health care nursing. The Strategy presented an opportunity for nursing to reposition itself with new ways of delivering services in primary health care settings and communities in order to effectively improve the health of New Zealanders (Expert Advisory Group on Primary Health Care Nursing, 2003). It was about aligning the current primary health care nursing workforce to identified population health need, enhancing the generic skills of all nurses working in primary health care and achieving effective utilisation of advances in nursing practice.

As mentioned in Chapter Three, an Expert Advisory Group on Primary Health Care Nursing (2003) defined the vision and goals for primary health care nursing in New Zealand (*Investing in Health).* The five goals identified in that document are used as the framework of this chapter. They are: aligning nursing practice with community need, innovative models of nursing practice, governance, leadership and education/career development. Underpinned by the diffusion of innovation theory, the data provides new insights into what change did and did not occur, the drivers behind those changes and the barriers that prevented the full utilisation of the primary health care nurse workforce in Tairawhiti.

8.2 Aligning nursing practice with community need

The people of Tairawhiti had the most to gain by improved access to primary health care services and a reduction in inequalities. Fee reduction was only a small contribution and did little to increase primary health care nursing participation. It was persistently difficult for people to enrol with a GP in

Tairawhiti. General practices were fully subscribed and most refused to take new registrations as validated by the following manager's comment:

> I think they then become lucky if they can enrol with anyone at all and that becomes their only option and I then believe what we talk about inequality is all about different ways. I believe that access is still a problem for some. (I.3, p.1)

This doctor shortage was also established by one nurse participant:

> I've been with the organization for about nine years now, and when I started there were a lot of doctors you don't have that now; the numbers have really dwindled. (FG.1, p.2)

A doctor shortage juxtaposed with a burgeoning aging population and those living with chronic conditions should have instigated closer examination and repositioning of the nursing workforce to fill this void. Laurant et al. (2005) assert doctor-nurse substitution has the potential to reduce a doctor's workload depending on the particular context of care. Both Cumming and Gribben (2007) and Goodyear-Smith and Janes (2008) state that in some parts of New Zealand at least, the doctor shortage has resulted in nurses taking on more roles traditionally performed by GPs. This is evidenced by the substantial growth in the development of nursing roles and nursing capability within some PHO environments. The following PHO based manger acknowledged this potential:

> We have a diminishing medical practitioner workforce, we have an aging population who have complex needs they don't always need x level of services they could have. We don't have to traditionally deliver the services we have, we could look at new models of care which are nurse led and it seems that the Primary Health Care Strategy was permissive to create that environment. (I.5, p.5)

This excerpt confirms that despite increasing demand, diminishing medical workforce and the potential nursing offered, change was not instigated. Traditional models of care continued in most parts of Tairawhiti. The nurses themselves identified nurse led services as providing a solution to the doctor shortage and meeting the needs of the community:

> I think we need to develop more nurse led clinics because nurses are comfortable about the skills that they have. (FG.2, p.7)

As this comment suggests, there were nurses who were comfortable with their skill mix. This was obvious in the more remote rural areas of the Tairawhiti district which faced increased difficulty in attracting a medical workforce, so nurses were required to expand their roles:

> Someone had to step up into the gap and shortage and because nurses are women who are passionate. We are passionate about our people who we are looking after and there is a whole void in there then we usually step up. (FG.2, p.8)

This confidence did not apply to all nurses in Tairawhiti, another nurse (practice nurse) viewed 'stepping up' to fill the doctor shortage void as negative:

> Well to me, you know it looks like there are less doctors so let's make these nurses come up to scratch and fill the gaps.... However, we are putting our neck on the chopping board. (FG.5, p.7)

The comment "putting our neck on the chopping board" related to the perceived threat to their nursing registration. In the general practice setting there is limited support for nursing in a predominantly doctor centric business model.

As mentioned previously, fear and learned helplessness has negated the ability of nurses to expand their role. However, if using evidence-based practice and working within the very enabling nursing scope of practice, then expanding nursing practice is safe and effective. Scopes of practice for nursing are set by the Nursing Council of New Zealand. Within that scope, registered nurses are "accountable for ensuring that all the health services they provide are consistent with their education and assessed competence, meet legislative requirements and are supported by appropriate standards" [14]

[14] (http://nursingcouncil.org.nz/Nurses/Scopes-of-practice/Registered-nurse).

Overall, there appeared to be inconsistencies in understanding of the potential the nursing workforce offered. As a consequence nurses were not being utilised according to their skill set as suggested by the following manger:

> I think that you know, in that respect primary care is not taking good enough advantage of practice nurses. (I.4, p.8)

This manager inferred there was greater capacity within the practice nurse role, the comment interestingly but not surprisingly confined to practice nurses. Equally so, it was understood by two managers that development in the practice nurse role in Tairawhiti had occurred, albeit inconsistent and piecemeal:

> Within practices themselves we've actually seen an increase in the development of practice nurse's role. This is my understanding, not based on huge knowledge of research or anything. (I.6, p.2)

> I guess in a lot of ways local bits did come into it, and the chances of actually getting the nursing workforce to do things in a different way did occur, the innovations funding money was certainly one of those. Nurse led clinics have certainly come on board since then, but it has been very ad hoc approach, not as systematic as it should have been. It has been very much dependent on the champions for moving those sorts of things along rather than the whole district wide thing. (I.7, p.2)

There was obviously some expansion in the role but whether this utilisation was consistently applied across the district, and to the level of ability and effectiveness, was doubtful. The Expert Advisory Group on Primary Health Care Nursing (2003) states models of nursing practice vary according to populations and geographical area. Cumming et al. (2005) confirm that nationally, variability of expansion of the practice nurse role is determined by the GP as the employer. It is noted that where nursing development did take place, it was more noticeable in practices where the PHO had embraced the principles of the Primary Health Care Strategy to improve the health of their enrolled population and in the management of chronic conditions (Cumming et al., 2005; Finlayson et al., 2009). Care Plus in particular activated an

expansion of the primary health care nursing role in the general practice setting.

As mentioned in Chapter Three, Care Plus was introduced into PHOs in 2004 and provided extra primary care visits for patients with chronic conditions to improve their care management (MoH, 2004). Nationally Care Plus became a nurse led service in some practices (CBG Health Research Ltd, 2006). One of the manager participants confirmed the increase in consultations by nurses for Tairawhiti patients with chronic conditions:

> Probably the only kind of big addition I see to their roles changing is the addition of the chronic care stuff. The diabetic annual reviews and Care Plus and chronic care, I mean they should have been looking after their chronic care patients before. But now there is more. (1.1, p.8)

Four nurses confirmed nurse led clinics were operating:

> It's really come into vogue where practice nurses actually do have their own clinics and also they're starting to have, like the doctors will have their client list, now the nurses are getting their own client lists. (FG.2, p.6)
>
> Definitely looking at us working on more chronic care, we are taking over a lot of that so they can see more patients as well. So there are nurse led clinics. (FG.4, p.2)
>
> We are already doing nurse led clinics. (FG.4, p.2)
>
> There are nurses that are ready are putting their hands up and saying 'give me a go, I'm happy to do a clinic, and I've got the skills to be able to do it'. (FG.2, p.7)

There is research showing that that primary care currently delivered by physicians could be carried out by nurses at a much lower cost with similar outcomes (International Council of Nurses, 2008a; Laurant et al., 2005). Nurse led health services have a positive effect on health care delivery by offering a comprehensive role in case management, reducing inequalities, and improving health outcomes for clients (Finlayson et al., 2009; Hoare et al., 2011; Laurant et al., 2005; Marshall et al., 2011). Nurse led clinics are associated with higher

levels of patient satisfaction, longer consultations and higher rates of investigations compared to doctor led clinics (Laurant et al., 2005). Despite the evidence, one of the biggest barriers to nurse led services is the perceived restrictions imposed by the current funding structures; more income is generated for the practice by seeing a doctor as opposed to a nurse (Finlayson et al., 2009). Docherty et al. (2008) concur that the support for nursing autonomy, professional recognition and accountability is not reflected by the funding structures.

GPs continue to argue that there is no financial incentive to use nurses fully and that the nurses are there to support the doctor (Finlayson et al., 2009). By arguing for the vulnerability of personal investment in their businesses, GPs have retained the right to significantly determine the nature of nursing services (Carryer, 2004; Docherty et al., 2008; Kent et al., 2005). General practice has been moulded around the GP with few decisions made by nurses for nursing, which has hindered the development of practice nursing at a national level and restricted advanced nursing practice (Arroll et al., 2004).

In a New Zealand practice nurse cost benefit analysis, Hefford et al. (2010) identified that the actual role of practice nurses varied markedly between practices; the financial impacts were also variable and complex. Variables included nurse cost per minute, duration of the nurse consultation, revenue per nurse consult event, and the percent of nurse consults requiring GP time. If there was the same remuneration for the same task, regardless of who provided the service, there would likely be an increased use of nurse time. The authors conclude that the same effect could be achieved by a no fee policy or capitation only.

Another variable was limited understanding of the nursing potential. One manager acknowledged a vague understanding of the different perspective nursing offered:

> The nurses would be coming from a family perspective wouldn't they? (I.10, p.8)

Eggleton and Kenealy (2009) state the difference to the consultation was not who performed the consultation, whether nurse or doctor, but the length of time spent with the patient. Starfield (1998) argues it is the interaction between practitioner and patient that contributes to the establishment of long-term relationships and facilitates effectiveness. A number of nurses acknowledged the benefits of the relationships they had established with their patients:

> We are the ones who develop the relationship with people. Unlike the GPs who get a snippet in a 10 minute consult. We are the ones who establish the meaningful relationship; we really get to know them. (FG.3, p.2)

> You build a relationship with them and you see them more than once most times. (FG.2, p.3)

> You make a connection and you can see the changes. As primary health care nurses we probably have more of an impact in this community because if you do something good then that person you spoke to tell their whanau about what you did with that young person, you know that all sets it up for next one. (FG.2, p.20)

Finlayson et al. (2009) confirm that in many areas there has been an increased acceptance by the community of nursing's input as first port of call. Additional research has identified that the skills valued by clients (such as explaining, listening and understanding their needs) while not readily quantifiable, are time consuming and considered fundamental to working in the community (Carryer, Budge, Hansen, & Gibbs, 2010; Carryer, Snell, Hunt, Perry, & Blakey, 2008; Holdaway, 2002; International Council of Nurses, 2008a; Lindberg, Ahlner, Ekström, Jonsson, & Möller, 2002; Vukic & Keddy, 2002). One manager and two nurses identified the comprehensiveness of the nursing services provided:

> If someone goes to the doctor they get antibiotics. If a nurse saw them under a standing order you are not simply giving a bottle of antibiotics....So what becomes a bottle of antibiotics from the GP surgery, becomes a whole education package and integrating care under a standing order. (I.3, p.10)

> Instead of just giving them the ointment for school sores you are telling them is that this is what you need to do, you need to cover them, you need to stay away from school for the next three days, you need to have hygiene you need to have antibiotics as well. (FG.2, p.16)

> It encompasses a lot really like 1 day you could be a nurse and the next minute you are a social worker and kind of integrate with other services. (FG.3, p.1)

Health care providers also speak in a specific language which requires nurses to translate, coordinate, protect, advocate and navigate service users through the illness to health care continuum (Jost, Bonnell, Chacko, & Parkinson, 2010). The complexity of patient participation is not always recognised. The concept of collaboration, partnership, shared decision-making and person centred planning, emphasise the need to pay attention to the quality and nature of patient relationships (Millard, Hallett & Luker, 2006).

Yet, despite good evidence, the benefits of doctor/nurse substitution will not be realised in practice if doctors continue to provide the same types of care which has been transferred to nurses (Laurant et al., 2005). One of the nurses identified that doctors continue to concentrate on menial jobs:

> Why do the doctors have to concentrate on some of those [tasks] that they term “menial jobs”? (FG.2, p.7)

This was further illustrated when one of the nurses commented that doctors had patients returning to see them unnecessarily:

> If we refer our clients to the GP for elevated blood pressure or whatever and then they will be seen by the GP, and then the GP will say oh yes well come back here for another blood pressure. But you would think they could refer back to us to carry that support on and do those visits rather than them being tied down to things like that. FG.3, p.6)

The nurse in the above excerpt carried out the initial assessment then referred the patient to the GP. She believed the patient should have been re-referred back to their nurse led service for on-going monitoring. What this example affirms is a lack of a planned patient centred approach.

Double handling continued as many practice nurses prepared prescriptions and medical certificates for signing by the doctor. As well, some nurses were required to pursue money owed; tasks that could be undertaken by an administrator. One nurse in particular expressed anger that a great deal of her work time was still spent dealing with cash:

> I am a trained nurse, what the hell am I doing dealing with cash, that's a cashier's role. (FG.5, p.19)

This may be a continuation of effect from the old practice nurse subsidy scheme introduced in 1970. A subsequent review of the subsidy scheme identified that in some practices, nurses were engaged in receptionist and other non-nursing duties in addition to supporting the GP (Department of Health, 1987). The review noted that it was the relationship between the individual GP and practice nurse which determined the extent to which the practice nurse was utilised. It could be argued that GPs saw (and some continue to see) the practice nurse subsidy as providing them with assistance rather than providing increased care to patients. The subsidy left a legacy of invisibility for practice nursing that has continued to limit the confidence and voice of nursing in the practice setting (Pullon, 2008).

The primary health care nurse role required definition to determine priorities and reallocate tasks; it required a systems wide approach, which included clarification of capacity, responsibilities, areas of practice, and suitable employment arrangements in primary health care nursing. This would have allowed greater flexibility and innovation in service delivery (Workforce Taskforce, 2008). Greenhalgh et al. (2005) argue that capacity processes must be in place to support innovation implementation. At the same time, the authors state that capacity can be difficult to define and measure. They define it as the sum of resources available for the management and delivery of the implementation process and measured in terms of financial resource, staffing, training and technical assistance. Funding staffing numbers according to workload is an important determinant in the success of any introduced programme. For example Care Plus funding was limited and the additional

work had a negative impact on nursing workload in Tairawhiti according to the following nurse's comments:

> Increased work load….. more work and less nurses. (FG.4, p.5)
> My breaks are always interrupted every single day if I even have them. (FG.5, p.16)
>
> That impacts on your mahi [work]. Because the less nurses the more mahi you got to do. (FG.1, p.2)
>
> We are already really highly impacted on with the work load so were made to do the work but we don't get compensated for the extra work. (FG.1, p.15)

These participants are noting that nurses were expected to focus attention on chronic care in addition to their current workload. As mentioned previously in Chapter Two, following the implementation of an innovation there is an initiation of a chain reaction of indirect consequences. The consequences can either be desirable or undesirable depending on whether the effects of an innovation in a social system are functional or dysfunctional (Rogers, 2003). The above excerpts suggest that consequences were undesirable.

In primary health care, dysfunctional systems exist because of power and control based on profession, gender, philosophy of care, and funding streams (O'Connor, 2012). The continual dominance of the medical profession over the deployment of the nursing workforce has been reinforced throughout history (Blue & Fitzgerald, 2002; Carryer, 1997; Gough & Richards, 1998; Harvey, 2011). These influences were recognised by the following nurse manager:

> There's just so much more that influences the nursing workforce ...to challenge what's been done. Because it is not meeting their needs now and it hasn't done for quite a while. (I.7, p.17)

Canon (2008) states there must be promotion in the practice environment whereby the nurse's practice and knowledge is valued and articulated to recognise the significant contributions they can make to the healthcare of individuals and society. One nurse identified there had been a change in GP attitude towards nurses:

> The thing that I've noticed too, the change, is the change of the GP attitude and when I first started in the autonomous role....none of the GPs wanted to recognise the nurse diagnosing and advising them. Some of them still have that attitude. I think it is an ego thing. (FG.2, p.9)

Two mangers also suggested that there had been a slight change in attitude toward the role of nurse practitioners:

> I think in the last year or two there has been support from all quarters for recognising the value of nurse practitioners. I think in the past doctors would be quite negative cause they would see it as probably nurses having a bit too much power and knowledge which is never a good thing and I think lots of doctors think this, even though they would still remain the cheaper option and flexible and everything. (I.3, p.9)

> There are GPs around New Zealand that are employing nurse practitioners in places where they have got a good client base and they are able to afford to do it. It shouldn't be any different here really. (I.7, p.11)

Whether this shift had occurred in Tairawhiti is debatable. Across New Zealand, there are still GPs who perceive nursing roles as an increasing threat (Thompson, 2006). There has been some progress since the initial introduction of nurse practitioners, yet there are still a significant number of GPs who feel uneasy about the changing roles and boundaries that the position creates (Carryer, Boddy & Budge, 2011; Finlayson et al., 2009). Evidence suggests this perception is not unusual (Griffin & Melby, 2006; McMurray, 2011; Wilson, Pearson & Hassey, 2002). Tension was evident in Tairawhiti when one of the doctors interviewed stated:

> In some ways some nurses perceive themselves trying to become a mini doctor. (I.2, p. 6)

This often repeated participant comment reflects both poor knowledge and personal and professional anxiety on the part of the GP. Being relatively new in New Zealand, the nurse practitioner role remains one of the most contested and poorly understood nursing positions. One of the nurses clarified the situation perfectly by stating about nurse practitioners:

> It’s not a mini doctor – it is a maxi nurse. (FG.1, p.15)

Nurse practitioners have extensive clinical and contextual knowledge of their specialty area, enabling them to respond to the health needs of their communities, and to develop appropriate and cost-effective services (Finlayson et al., 2009). Incorporating the best of nursing into the care they provide, nurse practitioners use similar decision-making processes as that of a doctor (Offredy, 2002). Nurse practitioners are qualified to make independent and/or collaborative decisions with individuals, families/whanau or communities (Dierick-van Daele et al. 2009; McElhinney, 2010; MoH, 2002).

As mentioned in Chapter Three, the performance of a nurse practitioner role is comparable with that of medical practitioners not only in terms of access to care and cost, but also in quality and the ability to diagnose, manage health issues, and prescribe medication (Alexander, 2004; Cooper et al., 2010; Dierick-van Daele et al., 2009; Flinter, 2012; Hughes, 2006; McElhinney, 2010; Poghosyan et al., 2012). One manager confirmed that English GPs had worked with nurse practitioners previously and a better understanding of the capability of the nurse practitioner role:

> I think because we’ve probably got a fair sprinkling of English GPs that have worked with nurse practitioners and nurse clinical specialists in primary care a lot and they know how it can run differently. They have a bit more faith and their capabilities in the nurses. (I.7, p.10)

The intention of advanced nursing is to practice from a nursing perspective, drawing on both their clinical experience and the knowledge, values and research of the nursing profession (NZNO, 2011). The MoH (2002) identified that nurse practitioners were ideally placed to provide many of the programmes and services needed to achieve the objectives of the Primary Health Care Strategy. In doing so, the potential for transformative practice was offered by contributing to health gains through the provision of responsive, innovative, effective, efficient and collaborative health care service (MoH, 2002). It remains to be seen whether nurse practitioners will be significant players in the delivery of primary health care .

Finlayson et al. (2009) argue that nurses themselves acknowledge the potential of the nurse practitioner role. Correspondingly the authors suggest nurse leaders are excited about the potential of nurse practitioners in addressing population health needs. This was confirmed locally by the following nurse manager:

> The way I see a nurse practitioner role, they become like a clinical and educational specialist in a certain area. It could be something like diabetes or long-term conditions or whatever. They are treating patients, they have prescribing rights, but they are also responsible for taking forward policy, high level stuff. (I.3, p.10)

The role of the nurse practitioner in primary health care has the potential to enhance access to services and choice of provider, develop innovative ways of reaching communities and meet health needs for under-served populations (Finlayson et al., 2009). The strongest support is in rural areas where the nurse practitioner is seen as an answer to the problem of medical recruitment (Love, 2008).

In New Zealand the nurse practitioner experiences the same challenges faced by nurse practitioners internationally (Institute of Rural Health, 2004). The only nurse practitioner in Tairawhiti was based in primary health care and did face significant challenge as one of the managers corroborated:

> I don't think that [nurse's name] was really able and has been able to deliver on the full potential of her role as a nurse practitioner. I don't know why that is, and I think it will definitely be about where that fits within primary care. (I.4, p.6)

This manager was referring to specific concerns such as the inability to access laboratory services, contractual arrangements with DHBs and legislative barriers. Nurse practitioners in New Zealand experience considerable challenges establishing delivery of their services (Carryer, Gardner, Dunn, & Gardner, 2007; Carryer et al., 2011; Institute of Rural Health, 2004). These include the insufficient recognition of the strengths of the nurse practitioner role, opposition to the role of the nurse prescriber, the current lack of equity in

the funding distributed by Health Workforce New Zealand, and the personal and financial burdens of the nurse practitioner status (Carryer, et al., 2007, 2011; Finlayson et al., 2009; Nurse Practitioner New Zealand Position Paper-8 November 2012).

The current funding is perceived as tied to GPs and is not conducive to employing nurse practitioners (Carryer, et al., 2007, 2011; Finlayson et al., 2009; Nurse Practitioner New Zealand Position Paper-8 November 2012). Technically, nurse practitioners are able to receive capitation funding yet this has proved difficult for most. The issue is not capitation as such, but the inability until very recently of nurse practitioners to receive general medical subsidy payment (GMS) for non-enrolled patients, or administrative GMS on which the accessing capitation payment rests[15].

Nurse practitioners are disadvantaged by organisational and individual interpretation of who can access funding streams (Nurse Practitioner New Zealand Position Paper-8 November). Another area of concern is the differences in ACC payments to nurse practitioners and GPs. MoH et al. (2009) reports that nurse practitioners must be able to access funding within PHOs so that they can work as independent members of multidisciplinary teams.

The lack of financial incentives for organisations to recruit nurse practitioners locally was perceived as a significant barrier. Two nurses from the same organisation believed that their employer could not afford the additional salary required to employ a nurse practitioner:

> We haven't got any money. You know I would apply to be a nurse practitioner if there was money. (FG.1, p.15)
>
> There is no pathway in place that proves that if we all went off and became nurse practitioners that we were going to get

[15] In August 2013 the MoH announced that GMS payments would be able to be claimed by nurse practitioners, registered nurses and pharmacists. At the time of writing, the implementation details remain unclear.

> employed if it costs a hundred and twenty [thousand] to start with. (FG1, p.15)

More realistically one manager suggested that, while they might cost more, than a registered nurse, they were worth the additional salary if existing patient needs were not being met:

> Any nursing position that might cost a little more than the average never gets good support to begin with until we get doctor shortage and then suddenly they are probably very good value for money. I think the world wide doctor shortage can only be good for nurse practitioner positions. At the end of the day somebody has got to do the work, it is not going to go away. So I think that should be seen as an opportunity to have a nurse practitioner doing that job. (I.3, p.9)

The only nurse practitioner in Tairawhiti had her role disestablished under the auspices of the then new Midland Health Network for undisclosed reasons. There were pockets of local support for development of the nurse practitioner role in Tairawhiti but positions were non-existent across the district in all settings. One of the nurses attributed this to lack of support by the DHB:

> At DHB level there is lack of support for the nurse practitioner pathway. (FG.2, p.11)

The DHB was also accused of reticence with the entire nursing workforce; one manager suggested the DHB should have taken a stronger lead in directing the change required:

> I think probably the DHB could have taken a bit more of a lead, but you know the political climates of PHOs and just the different systems of secondary care to primary, who is in charge, and who the fund holders are. All of those things have huge implications on how any of these things work. (I.7, p.2)

This participant acknowledged the complexity of factors influencing decision-making. These factors were not addressed prior to, or following, the release of the Primary Health Care Strategy. DHBs were not in a position to dictate to PHOs what type of service delivery was required and, as new structures, there was probably an element of distrust between both organisations. Supportive

funding streams, employment arrangements and service delivery patterns were also not in place to align the nursing workforce with community need.

The Expert Advisory Group on Primary Health Care Nursing (2003) argued for nurses to be fully involved in the development of models of service delivery to determine the most appropriate nursing response to identified population health need. This did not occur in Tairawhiti. As a consequence there was limited progress in advancing primary health care nursing, the extensive contribution that nursing can make to reducing health inequalities remained unrealised. The existence and experience of innovative models of nursing practice in Tairawhiti will now be examined.

8.3 Innovative models of nursing practice

It was envisaged that there would be new and innovative models of primary health care nursing practice to improve access, contribute to improved health outcomes and reduce health inequalities (Expert Advisory Group on Primary Health Care Nursing, 2003). To support this, in 2003 the MoH announced contestable funding would be made available over three years for the development of primary health care nursing innovation projects throughout New Zealand (Primary Health Care Nurse Innovation Evaluation Team, 2007). From the proposals, the MoH looked for innovations to support the development of innovative models of primary health care nursing practice to deliver on the objectives of the Primary Health Care Strategy.

The MoH eventually funded eleven models of primary health care nursing across the country in a variety of settings (Primary Health Care Nurse Innovation Evaluation Team, 2007). Tairawhiti was successful in its bid for funding and the Tairawhiti Innovation Nursing Team (TINT) was formed in a partnership between the Tairawhiti DHB, two PHOs (Ngati Porou Hauora and Turanganui PHO) and Employ Health (a privately owned occupational health nursing service). The model was developed following a workshop held with 30 Tairawhiti nurses (Community and Public Health Advisory Committee (CPAHC) minutes, 28 March 2003). The innovation involved nurse led services targeting two high-risk groups: a forestry work site where 320 people

worked, and domestic purposes beneficiaries from Work and Income New Zealand (Primary Health Care Nurse Innovation Evaluation Team). The following extract from CPAHC meeting minutes validates the potential of the innovation to address issues of access:

> The funding will have enabled the successful development and refinement of a new model of primary health nursing care which addresses access and appropriateness issues for a known high-risk low-user group (CPAHC minutes, 28 March 2003, p.34).

Relating this back to the diffusion of innovation theory, the term trialability is used when an innovation is experimented with on a limited basis (Rogers, 2003). TINT was an example of an innovation being funded for a trial period. Rogers (2003) also states when an innovation is trialled it should represent less uncertainty and increase the chance for successful adoption. The Tairawhiti innovation was considered a success in that it achieved all the goals set by the Ministry demonstrating services can be developed jointly to address health inequalities (Primary Health Care Nurse Innovation Evaluation Team, 2007). It was held up as an example for other districts and emulated in at least one other DHB:

> TINT was where we were doing care for DPB [Domestic Purposes Benefit] parents ...I think it did actually work really well. A similar service was set up in Hastings and Flaxmere from what was seen here. We had lots of inquiries about how we were doing it; we were on international nurse's websites about what we were doing. We had quite a lot of interest and there were a lot of presentations. (I.7, p.8)

When the knowledge required can be codified and transferred from one context to another then the innovation will be more easily adopted (Greenhalgh et al., 2004; Rogers, 2003). Rogers (2003) describes this as the innovation characteristic termed observability. This is the extent to which results of an innovation are visible to others. The more visible the results the more likely it will be adopted. For TINT, the observability potential was significant.

In spite of this, TDH determined TINT had not sufficiently demonstrated its impact on health outcomes, even though it met the objectives initially set by TDH (Primary Health Care Nurse Innovation Evaluation Team, 2007). This was confirmed by the following manager:

> We didn't get a very good write up from the DHB but basically I don't think they actually read our reports. They just said we couldn't prove any outcomes. (I.7, p.9)

This is one of the issues when providing a nursing service where outcomes are not always readily obvious; especially in the short-term. As a result a decision was made not to continue funding the project and TINT was subsequently transferred to Ngati Porou Hauora and then called HINT (Hauora Innovation Nursing Team). One year later HINT was disestablished due to the inability to secure funding for continuation of the service, as confirmed by the following statement from one of the managers:

> We were making really good ground on that as well before Ngati Porou lost the contract and you know we had 16 businesses working with us with other big companies lining up to come on board and then our funding got pulled out from under our feet. That was a huge opportunity getting into the workforce that doesn't get into the doctors and we had loads of opportunities for preventative early intervention and prevention to actually make a big difference there. (I.7, p.9)

The nurses involved were left disillusioned by the entire process. The potential for nursing to make an impact on reducing inequalities remained unrecognised. What this demonstrates is that successful trialability of an innovation on its own was not enough to support innovation where there is strong resistance to change and little perceived relative advantage to the funding organisation. Greenhalgh et al. (2005) state that trialability should be relatively simple and consistent if applied to an individual innovation as TINT was.

TINT's success and later demise represented a wasted opportunity. Observability and trialability were not enough to demonstrate the true value primary health care nursing offered in reducing inequalities and meeting

health outcomes. This was a proven successful primary health care nursing initiative and yet, was not financially supported once the innovation funding expired. Hamer (2010) states it is not uncommon for initiatives to cease as soon as the short-term funding runs out.

The greatest barriers to innovation in nursing include a narrow or short term focus, a lack of structured processes, and a shortage of resources (Primary Health Care Nurse Innovation Evaluation Team, 2007; Hughes, 2006). The current funding models tied to GPs are not conducive to nurses working in innovative and expanded roles which would provide their communities with more effective care (Finlayson et al., 2009). An overview of New Zealand health workforce development clearly identified that existing funding arrangements in primary health care are a definite barrier to innovative practice (MoH, 2006).

Since TINT there were other innovative projects, as suggested by the following two comments from managers:

> There have been all sorts of different projects like outreach nursing. We have a pilot program up the coast with the nurses going out and visiting people as part of their normal rural health nurse mahi [work]. But they had an assessment sheet where they were checking for all sorts of other things. If the patient was a woman they ask if she has had her mammogram, has she had cervical screening. So it was like a big warrant of fitness check; maximising domiciliary visits to cover everything. (I.1, p.3)

> We had another innovation that started for a little while. The Ministry of Social Development had tried to access private mental health care for their long-term sickness beneficiaries. They felt that if they had mental health issues and they were able to address some of those, the people would gain confidence and skills, a belief in them and actually pick themselves up out of where they were. It was a really good idea, it was just really unfortunate the clients they gave us weren't in a place to be motivated and basically said yes to get the social welfare off their back. They didn't want to actually comply with the whole idea at all, so that failed miserably. (I.7, p.8)

Both examples represented holistic care to needy populations. One outreach service was successful while the other, as suggested by the last participant,

was not well thought through before implementation. What was positive about these two examples is that there were nurses willing to try new ways of working. Since then a successful outreach immunisation service has been developed. In more than 80 integrated care projects undertaken following the introduction of the Primary Health Care Strategy, Sheridan (2005) found nurses overall practice could not be considered innovative. Further, the author identified overwhelmingly that an individual focus at the expense of community and systems population based practice was retained. Overall, there is little evidence of innovation in nursing's approach to primary health care. With respect to local projects, two managers in the current study suggested there were still further opportunities for primary health care nursing based innovations:

> I actually think there are a lot more opportunities, there are lots of solutions. I think everybody's just got to be really mindful that there's more than one way to skin a cat. (I.7, p.7)

> Some of the new horizons haven't been looked at you know. Nurses haven't had a chance to look at different things or doing things differently because they haven't had access to postgraduate training, haven't had that opportunity of getting into that academic framework and actually meeting other nurses. (I.4, p.11)

Analysis of the last comment in particular suggests that the barriers were related to nurses not having an expanded worldview. This participant believed that exposure through postgraduate education and face-to-face contact with nurses outside of Tairawhiti through education might alter that perception. Looking more closely it implies lack of innovativeness sat within nursing rather than constraints that surround them.

Innovativeness is defined by Rogers (2003) as the degree to which an individual adopts a new idea compared with other members within a system or organisation and is dependent on socio-economic status, personality, communication, behaviour and so forth. Greenhalgh et al. (2005) contend that a favourable history of relationships between the professional groups, supportive cultures and the opportunity to access new ideas are all essential in

adopting new ideas. Individuals must feel supported in providing the context to encourage creativity (Shalley & Gilson, 2004). This support must come from top management and requires continued commitment to enable successful implementation of innovations (Greenhalgh et al., 2005).

It became apparent that the nurses were resourceful with the ability to use their experience and expertise in meeting the needs of their community within the constraints in which they practiced:

> I think it is about what we try to do in our practice. If we identify there is a need or a gap within our contract, if we can fill the need we do it. (FG.3, p.9)

This is consistent with services provided by Iwi organisations which are not always recognised for the additional unrecognised and unfunded services they provide (Abel et al., 2005; Boulton, 2005).

To summarise, there were examples of primary health care nurses' attempts to provide innovative services to high need communities. Their attempts were constrained by significant barriers and not recognised for the change they effected. This reflects the historical perception of the low value of nurse led initiatives and services some of which were explored in the previous chapter on resistance to change. The ability to instigate innovation and influence change was significantly stifled.

8.4 Governance

Governance was identified in *Investing in Health* (2003) as essential to the repositioning of primary health care nursing. It was expected that nursing, alongside different stakeholder groups, consumers, providers and Māori, would have a presence in the governance arrangements of PHOs and DHBs. This was considered crucial in the robust management of these organisations (Expert Advisory Group on Primary Health Care Nursing, 2003; MoH, 2007a; Sheridan, 2005). Governance in health care can be operationalised in practice settings by stakeholders influencing decision-making and participating collectively in the steering of an organisation (Expert Advisory Group on

Primary Health Care Nursing, 2003). Participation in the decision-making is a powerful asset to the sustainability of innovation (Martin et al., 2012). When nurses participate at governance level with the ability to impact on planning and funding decisions, then change is more likely to be sustainable (Calverley, 2012). Nurses must be among the leaders in enabling change to occur (McMurray, 2007b).

The concept of governance includes the ability of nurses to control, direct and influence their own practice and ensure nursing's contribution to improving health outcomes and reducing inequalities in health status. This is in line with international best practice (Expert Advisory Group on Primary Health Care Nursing, 2003; Finlayson et al., 2009). The necessity for nurses to participate at a higher level and set direction in Tairawhiti was confirmed by the following nurse based manager:

> What is required though to help move to the next level is seeing more nursing direction if you like. (I.8, p.3)

This substantiates what was widely known: nursing's participation at a governance level was limited. One of the nursing based managers identified the difference in intent between nursing and management forums and confirmed nurses must have their say:

> The nursing forum is about nursing practice and nursing standards and all the rest of it. The management forum is about how they afford to continue to provide service at a level that they want to. I think there is a role for nurses to stand up and say it is actually not acceptable for me to not be able to deliver care and that's about the power of nurses. Going forward, I wouldn't guarantee that nurses in hospitals are going to have any governance voice either. (I.6, p.5)

This nurse manager was suggesting nursing must start to set their own direction. There were nurses who knew how to do this but as a group of professionals, they were not effective as suggested by one of the PHO based mangers:

> To be flatly honest I think the nurses that know how to grab the bull by the horns in any environment will continue to do so. I looked at teaching and as a collective they had a strong union and when they want things changed, not just about their contract, when they have got stuff they want to do they get themselves together and they make a difference. Primary care nurses may be members of NZNO [New Zealand Nurses Organisation], but as a collective they don't gel in the same way perhaps as others do like others nurses within secondary care, teachers or firemen or whatever. As [person's name] would say, I'm going to lead this who is with me, even the ones who weren't remotely interested would say well I am not interested but I am absolutely happy to support you doing it. (I.5, p.19)

This participant identified that primary health care nurses as a cohort did not function as a collective and were not united in their cause as other health professionals, or even other nursing specialties were. A contributing factor is the smaller numbers of nurses working within each primary health care setting. Traditionally practice nurses have worked in isolation alongside a solo GP or in a small group of GPs with a small number of nurses and with limited opportunity to interact with other nurses. According to the following manager's comments, the previously mentioned integrated family centres were thought to provide an opportunity for a collective voice for nursing:

> I think that the fact in primary care has been one or two GPs with one or two practice nurses in one small practice with a quite small defined bunch of patients.....It will change the dynamics there because now you've got ten GPs and you might have ten practice nurses. You have actually got a body of nurses that can band together and force change. (I.4, p.11)

Given the complexity of the working environment, whether larger multidisciplinary integrated family centres will encourage practitioners to work together to affect change is yet to be seen. At the policy table there needs to be a unified message in order to advance the nursing profession (Donovan, Diers, & Carryer, 2012). For many nurses, the concept of governance is a theoretical concept and far removed from day to day patient care (Bassett & Westmore, 2012).

Nurses must develop the skills to represent wider interests at governance level to reflect professional nursing interests within organisations (Expert Advisory Group on Primary Health Care Nursing, 2003). One nurse stated she was a member of a PHO Board but she was there as a representative of her employing organisation as opposed to representing nursing:

> I was a board member representing [organisation name]. We had two positions and I was one of the two, so it was more of our organisation's position rather than nursing. Just because I was a nurse and I happened to be there it wasn't kind of nursing role as such. (FG.4, p.21)

This nurse would still use her nursing knowledge and skills in the decision-making but as her comment suggests, she was not there to drive nursing forward. Since DHBs were formed, there have been a very small number of nurses on TDH advisory committees over the years. At the time of writing there were two nurses on the aged and disability advisory committee (ADSAC). A focus group participant suggested that while nurses were becoming more assertive, they remained disempowered to affect change:

> I think we still, we are getting to be a bit more assertive but we don't seem to have a big say as yet. It is further up than that, it is political and from the top. I think GPs and nurses from my practice overall they get to make decisions but they are governed by further up by Pinnacle, by the DHB and by the Ministry. (FG.4, p.21)

This excerpt evokes a sense of powerlessness for nurses in controlling their working environment that has stemmed from all the layers above them. Nursing is inextricably caught up in the dominance of the medical workforce. The language of health care, medicine and nursing embeds assumptions about the types of relationships health professionals have with other members of the team as well as the amount of power attributed to each profession and about the value of its contribution to patient care (Mills & Hallinan, 2009; Piji-Zieber, 2013). Such powerful discourses become embedded in significant institutional bases, while marginalised discourses such as nursing lack conferred authority (Blue & Fitzgerald, 2002; Carryer, 1997; Gough & Richards, 1998; Harvey, 2011). When a dominant group has power and

control over an oppressed group that continues to be reinforced, this then upholds that power imbalance as natural and normal (Foucault, 1977), thus shaping the values and preferences of populations.

Governance typically resides with doctors (Calverley, 2012; Chreim, Williams, Janz, & Dastmalchian, 2010). This gives the medical profession a significant role in influencing change by the allocation of resource and in channelling the process and content of change. That this was the case was confirmed by one of the PHO based managers:

> I read "all in good hands" and 'what makes good clinical governance' and they are having a meeting on the 29th of June in Wellington. I would think wow that is fantastic, isn't it great, we are getting ahead but no actually all that's about doctors. I would read all of that and at no time does it mention doctors but that is what it means. (I.5, p.18)

Attree (2005) identifies tensions as a result of differences between organisation and professional modes of governance which then leads to power imbalances between professionals and their managers. Shared governance and collective leadership diffuses assumed power (Chreim et al., 2010; Robertson-Malt & Chapman, 2008). However, the likelihood of a swift shift in power is doubtful (Overcash, Petty, & Brown, 2012). Nurses are frequently excluded from holding or exerting any form of power (Attree, 2005; Sargison, 2001) and often not recognised as equal members of the professional health care team (Brown, 2012; WHO, 2000). Their vulnerability was articulated by two of the managers:

> Not rocking the boat, you know, not biting the hand that feeds you, not creating problems or stepping outside your perceived domain. (I.4, p.12)

> There has got to be the environment whereby primary health care nurses can have a voice and a view. Because again it is a very old fashioned traditional doctor closed shop; an environment where you know voices are not being heard. (I.3, p.17)

The following manager identified that there were a number of issues that required resolution before a shift was likely:

> I think there is still a little bit of water to travel under the bridge before we can really say that we are all comfortably sitting around the table together. (I.6, p.6)

The nursing profession has come a long way from the historical perception of handmaiden. Yet, the legacy of this status is woven deep into the consciousness of actors in the health system (Piji-Zieber, 2013). Previous and quite recent research in Tairawhiti identified that a number of practice nurses still saw themselves as "doctor handmaidens" (Adamson et al., 2005). Five years on, this study also surfaced perceptions that nurses considered this an acceptable part of their role:

> My understanding is the practice nurses are quite often the general dogsbodies, hand maiden to the GP. So they took the bookings, they took the money, they did the odd dressing and a few bits and pieces that were considered nursing tasks and made sure that the GPs had a meal break and had a cup of tea. (I.6, p.2)

Insufficient nursing input into the working environment aggravates nurse's impressions of lack of control (Adamson et al., 2005). For governance to work effectively nurses must feel their voices are heard and acted upon (Robertson-Malt & Chapman, 2008). The authors also state that nurses are able to ignite the creativity required in a participatory governance model but this requires open and clear communication channels and a high level of trust and respect. The lack of control reported by nurses is described as professional impotence and affects their ability to influence key decisions over their own nursing practice (Attree, 2005).

The Primary Health Care Strategy set out an expectation that nursing clinical and strategic involvement would contribute to the expected change. Implementation processes and key players failed to consider the structural and attitudinal barriers that were left in place. The increase in the voice of nursing expected from the Strategy faded over time; the intent reconstructed into a different meaning as suggested in the following manager's excerpt:

> So if you have got the nurses who were at the table and are now not at the table, if you think about allied health who are clinicians who don't even feel they have got anywhere close to the table

> they are waiting outside in the foyer that is interesting...But since that time, the things that have been constructed to mean something else. The language and the construct are not the same. (I.5, p.18)

The longstanding unequal distribution of power created a high level of resistance as confirmed in Chapter Seven. GPs had no desire or need to share governance and authority. Hughes (2010) concurs that the ability of nurses to influence policy and decision-making is limited by medical dominance. However, one of the nurses from a focus group identified that there was a nurse in her organisation who:

> [Name of nurse] is quite good at that governance stuff. (FG.3, p.7)

The singling out of one nurse during data collection is testimony to the rarity of such a person. That nurses in one location contributed at a strategic and policy level was confirmed by the manager from that same organisation:

> They [the nurses] are the focal point of participation and contribution at strategic level, at policy level for the organisation. (I.9, p.3)

This data reveals one location where nursing input at a strategic level is noted. However it may be highly relevant that this particular organisation, at the time of data collection, did not provide medical services and therefore did not employ medical personnel.

The Primary Health Care Strategy offered a significant challenge to the social strata of power. As such it was incompatible with collective understanding and that significantly reduced the likelihood of widespread adoption of the principle of shared governance. Compatibility in innovation requires compatibility with a person's socio-cultural values and beliefs, previously introduced ideas or offers the individuals gain from the innovation (Greenhalgh et al., 2005; Rogers, 2003). There was a great need for primary health care nurses in governance positions at DHB and PHO level in

Tairawhiti. Primary health care nursing leadership was required to support this as discussed next.

8.5 Primary health care nursing leadership

Investing in Health (2003) identified that primary health care nurses needed clear, accessible, integrated nursing leadership to encourage and promote change and facilitate the development of new roles and models of practice (Expert Advisory Group on Primary Health Care Nursing, 2003). Leadership is fundamental in encouraging organisational members to break out of their conventional thought patterns and routines to be more accepting of innovation (Greenhalgh et al., 2005). Long et al. (2011) agree that to enable change to take place successfully, leadership capacity within the health system must be developed.

From the outset, the Primary Health Care Strategy was compromised by the overall paucity of primary health care nursing leadership across Tairawhiti. One primary health care based manager confirmed this was the case in their organisation at least:

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

This comment implies the funding model did not provide for primary health care nursing leadership. Outside of the PHO capitation funding, the DHB also contracted with some providers for nursing specific services such as well child and mental health. The sum provided covered the cost of service delivery, not for nursing leadership. Another manager confirmed that a lack of formal nursing leadership positions had a negative impact on recruitment and retention:

> That is something that has been lacking and tying that together and having a person in a leadership role and having the time to actually do that, has been something that has been lacking. I think part of the problem with that is the recruitment and retention of nursing staff within an organisation is because they haven't had that strong nursing identity. (I.4, p.4)

This participant was able to describe the poor outcome from the lack of strong nursing leadership. Leaders in organisations are critical in creating the environment that facilitates the adoption of an innovation (Greenhalgh et al., 2005). Strong leadership and good strategic vision enable systems to respond more easily and quickly to innovation and secure the necessary influence (Greenhalgh et al., 2005; Hamer, 2010; Martin et al., 2012). The health care reforms in New Zealand called for a leadership response that offered nursing a future underpinned by the values and principles that would enable nursing to function effectively (Bamford-Wade & Moss, 2010). It remains essential that nursing leadership must be enabled to contribute a nursing voice to policy and strategy at both national and district levels (Nelson, Connor et al., 2009).

In 1976 a summary report on the role of nursing in primary health care recommended nurses should be involved at national, regional and local levels in the decision-making process in health care (WHO, 1976). The report urged nurses to have a fundamental role in the planning, delivery and evaluation of primary health care. Thirty years later the WHO reported that nurses have failed to influence national health policies (WHO 2000). In New Zealand the situation continues. One participant suggested that the Ministry do not value nursing input as recognised by the following nurse manager:

> We still see within the Ministry of Health for example the whole National Health Board, there are nurses on it, but they are outnumbered. Nurses outnumber doctors significantly and nurses are outnumbered by the same significant amount and all of the major strategy groups and that's just an indictment of where nursing is viewed and that is perpetuated by nurses themselves. (I.6, p.3)

The current executive leadership structure in the MoH is predominantly made up of doctors. Again, the Ministry's executive team is guided by a team of clinical director's and clinical advisors, most of whom have medical backgrounds[16]. Nursing leadership and representation at this level is minimal and the hierarchy is translated down to DHB level where:

[16] At the time of writing there has been a recent but significant increase in the staffing establishment of the Chief Nurses Office in the Ministry of Health

> There is no acknowledgement that nursing is a key role. We still see DHBs that do not have nurses reporting to chief executives. (I.6, p.3)

Prior to the Primary Health Care Strategy there were significant gaps in nursing leadership within primary health care settings. In most instances nurses were not in a position to influence or determine the nature of services provided (Ministerial Taskforce on Nursing, 1998). To address this, integrated nursing leadership was identified as a necessity for promoting change and facilitating the development of new roles and models of practice (Expert Advisory Group on Primary Health Care Nursing, 2003). Consequently a recommendation was made to DHBs to work towards establishing primary health care nursing management/leadership at a regional and district level to provide this professional nursing oversight and support the development of the primary health care workforce.

Nationally, numerous authors argued for director of primary health care nursing to be based within each DHB (Carryer, 2004; Expert Advisory Group on Primary Health Care Nursing, 2003; Finlayson et al., 2009). Within their geographical location this role would ensure active participation of local primary health care nurses in leadership, development, and decision-making. It was expected that the primary health care director of nursing would oversee the professional development of primary health care nurse groups as well as support a new graduate programme for the continuation of the workforce (Carryer, 2004; Finlayson et al., 2009).

Overall, there was regional diversity and varied investment in primary health care nurse leader roles (Sheridan, 2005). One of the PHO based managers confirmed this to be the case in Tairawhiti:

> But you would argue that in the seven years that I've been involved, advancing primary care nursing from a leadership perspective and a collective perspective from the ground up, from the grass roots again is not equitable and it is quite variable. (I.5, p.13)

In Tairawhiti there was eventual recognition of the value of having a local primary health care nurse leader role. In 2008 a primary health care nurse leadership role was established and funded out of the previously mentioned additional "reducing inequalities" pool of funding. In the proposal for the position it was stated in the Board minutes that TDH had not:

> .. had an opportunity to fully advance primary health care nursing in this district (TDH Board minutes, 21 August, 2007).

The value of this role was confirmed by the following manager:

> I think one of the biggest things for me and I do feel quite passionately about this, there has been some movement and recognition for primary health care nursing in the primary health care nurse leader's position. (I.3, p.5)

I was the successful applicant appointed to the role. The position was physically located with planning and funding and provided the opportunity for a primary health care nursing presence and a voice on a number of working groups, including the strategic planning and funding committee. This was seen as important according to one of the nursing based managers:

> I think any role that you have got leadership has potential there because that voice to be heard in different forums. (I.3, p.5)

The position also sat within the DHB nursing and quality team. There were a number of advantages in that it opened up a whole new professional resource for primary health care nurses which had previously been unavailable. However, the title "nurse leader-primary and community" secured the position within the nursing hierarchy, sitting under the TDH director of nursing as opposed to being a director of nursing position in primary health care. This, in effect, reduced the autonomy of the role.

The director of nursing in Tairawhiti has the responsibility for leading and directing the entire nursing workforce within the wider DHB catchment area. Based within the hospital setting, secondary care issues dominate the role as suggested by the following manager's comment:

> I feel the traditional way of having a director of nursing covers everyone and basically has always had the view that secondary care is the most important part of nursing. (I.3, p.5)

After my appointment as "nurse leader-primary and community" there was a strong focus on the formation of relationships with primary health care nurses across the district. Of note, a local primary health care nursing advisory group was established, primary health care nursing forums were held and a primary health care nurse's newsletter to keep nurses informed was developed. A new graduate programme in primary care was implemented and more educational opportunities were offered to primary health care nurses who had previously been excluded from attendance. The value of the role was acknowledged by one of the managers as providing support to primary health care nursing across Tairawhiti:

> The current primary health care nurse leader she actually does organise things and get people together. My experience of being at the shared education, shared networking meetings are that everyone has got tremendous value out of it. You can actually see it growing and you can see the participation growing and people actually wanting it and wanting more of it. (I.3, p.8)

This generated a feeling of inclusiveness. However, this nursing based manager also acknowledged the difficulties in driving change forward describing it as a "chipping away":

> You have got your primary health care nurse leader chipping away, and I mean it is chipping away because you can't change an establishment overnight it's very hard. But now there is a channel for those things to be taken forward. (I.3, p.17)

For leadership to positively impact on practice the conditions have to be right (Taylor, 2009). It is doubtful whether inroads were made in addressing existent nursing issues in some settings. As an advisory role nursing development could be encouraged and support provided to the few nurse leaders that did exist, but the role was limited to that. There was little authority to direct change in general practice. DHB based nurse leaders have no authority to dictate the practice nurse role. Equally so, the current business

model in the general practice setting was not conducive to nursing leadership within that setting.

Finlayson et al. (2009) confirm that the majority of PHOs lack any formal nursing leadership. Leadership in the general practice team sits with the owner(s) (Calverley, 2012), and is not necessarily relative to the cost benefit or efficiency of the service being provided (Cordery, 2008). The lead nurse, if there is was one at all, typically includes the management and development of portfolios, coordination of professional training, managing trainee nurses, service development and participating in the senior practice team (Love, 2008).

In Tairawhiti there was some confusion whether there was formal nursing leadership in PHOs at the time of data collection as the following excerpts illustrate:

> I think nurses do get recognised within their practice but do they? They get recognised for making sure things get done. I am not sure they necessarily feel that they provide the leadership role in its broadest context within that practice. The tenets of leadership are not available to all of those people within the general practices. They might even get the role, and they might even be given the mandate, but I don't even know if they comprehend or are clear that it means they can do this, this and this. (I.5, p.13)

> Nowadays the nursing leadership is not a formally recognised role, it is the senior nurses. (I.1, p.7)

> Probably people have that role put upon them or it is assumed and it is usually based on experience and confidence. (I.8, p.3)

What these comments suggest is that nursing leadership is assimilated into the workload of the more experienced nurses capable of performing this role. There was not any obvious recognition of the forces working against nursing leadership, especially within privately owned general practices. Whether the nursing leadership roles were acknowledged formally or not, or even understood by the nurse leaders themselves, was unclear. Leadership most often falls upon the most senior or experienced nurses. Hippeli (2009) states that nurses are often granted leadership positions because of good clinical

skills not because of good management skills. Consistent measures of leadership are lacking and much of the research examining the leadership characteristics of the individuals holding a formal leadership role (Greenhalgh et al., 2005; Shalley & Gilson, 2004).

Speaking up and/or stepping up to a leadership role is fraught with challenges; the repercussions are significant in terms of expectations and time pressures, especially where the leadership role is additional to existing workload. To be effective and strategic, nurse leadership roles must have dedicated leadership time. Without this, the role is compromised in its ability to drive change, reducing the creativity and capacity of nursing.

Nursing leadership in primary health care is faced with on-going challenges with nursing fragmentation, variable investment in nursing infrastructure, interdisciplinary relationship issues, and limited training to develop new leaders (Calverley, 2012). Advanced clinical and leadership positions are restrained by legislation, funding shortages, and lack of on-going clinical career pathways (MoH, 2001). Additionally, there has been strong resistance by medicine in relinquishing the power and control exerted over the nursing workforce. The smaller numbers of practice nurses working within one general practice meant there was not the power in numbers to expect those nurse leaders to stand against traditional medical hierarchical structures. There was no relative advantage to GPs for supporting a nurse leadership impetus. One of the nurses identified the difficulties previous nurse leaders faced within their organisation:

> I think in our organisation we have some really great leaders, you know they're there but they don't step up to the leadership role because they have already got enough bricks on their head. (FG.1, p.8)

Conversely, one of the nursing based managers commented that generally nurses were becoming more confident and speaking out:

> I think in general, nurses are becoming more confident and actually challenging things and asking stuff and actually having

> an opinion to put forward because they are more informed and are getting braver about saying what they think in general. It's not leaps and bounds for everybody, but all the little steps make a difference. (I.7, p.12)

This manager states the confidence of nursing was growing through the knowledge and skills they were developing. Kean and Haycock-Stewart (2011) argue that formal leadership positions should not prevent anyone at any level of an organisation taking a lead to bring about change. However, Calverley (2012) asserts that a lone voice does not offer the strength and influence required to present a powerful position and recommends a unified and collective standpoint.

What this section demonstrates is that without strong leadership, primary health care nursing practice will remain under-developed. Primary health care nurse leaders face numerous challenges in their clinical, strategic and professional leadership. Until this is addressed, primary health care nurses will not have the ability to meet the needs of populations experiencing the increasing burden of illness and disability associated with chronic conditions (Sheridan, 2005). Next, education and career development of the nursing workforce is examined.

8.6 Education and career development

The fifth goal of *Investing in Health* was education and career development (Expert Advisory Group on Primary Health Care Nursing, 2003). A strategic workforce development approach necessitates a long-term view to address issues before they become embedded and more difficult to resolve and, to ensure initiatives and actions are sustainable over time (Health Workforce Advisory Committee, 2005). In Tairawhiti, primary health care nursing workforce development was ad hoc, inconsistent and unplanned. This was suggested by the following manager:

> I don't think that anybody actually has a plan that says we have a need for fifty nurses in Tairawhiti to upgrade their assessments skills or learn about the better management of diabetes or whatever..... I might be wrong. (I.4, p.4)

The level of vagueness in this comment is of interest. It suggests the lack of a district wide plan around nursing development and some lack of concern as well. This is not surprising given health service delivery is a mix of private and public services where stakeholders tend not to work together for common good to support a strategic wide methodology. There was no shared vision or no change to the way services were to be delivered. There was no requirement for a strategic workforce development approach. It was unclear whether each organisation had a long-term workforce development plan, or whether it was reactionary and/or based on individual need. One manager noted their organisation's support for each individual nurse to develop in their role:

> What we do is each individual nurse has the opportunity to forecast their particular training needs against, what is expected of them in their role, in their job description and then to enhance that. They also negotiate some individual growth workforce development not slanted toward nursing. So it might be communication, stress techniques all those sort of things which grow the character of the individual acknowledging this also grows the profession. (I.9, p.3)

This support was confirmed by one of the nurses in that same organisation:

> We work for a very supportive organisation that recognises the value of on-going learning. (FG.3, p.3)

Apart from very limited one off nursing innovation and scholarship funding, no additional funds were made available to develop the potential of primary health care nursing. In an update to *Investing in Health* (2007) it was identified that the relationship of education and professional development to the quality of nursing practice is unquestionable (NZNO & College of Nurses Aotearoa NZ, 2007). The document also states that nurses in many locations still do not have access to funded continuing nurse education. This then negatively affects the quality of practice, reduces confidence and creates reluctance to take on new roles. However, the lack of educational opportunities did not appear to be so much of a barrier in Tairawhiti. The availability of educational opportunities for nursing had increased considerably in recent years as confirmed by a nursing manager:

> I mean the smorgasbord courses available to nurses now is just phenomenal and the different methods of learning. There is full-time, part-time, online, all those things which makes it easier. (I.8, p.2)

It was acknowledged that TDH had been proactive in bringing courses to Gisborne, such as workshops on diabetes and cervical screening, and in recognising the needs of the primary health care workforce:

> I think hospitals seem to be putting on initiatives or things to support the community. For example like the diabetes link group so the aim is to educate the practice nurses to do that. (FG.5, p.10)

In more recent years, the hospital librarian at Gisborne Hospital assisted in and provided access to electronic journals for all nurses in Tairawhiti. The sharing of TDH resource represented a significant change in attitude from hospital centric to a community wide nursing approach. There appeared to be real commitment by TDH staff to support the nursing workforce across Tairawhiti.

There were nurses who vigorously pursued all professional development opportunities available, while others had very poor uptake for various reasons. This is consistent with previous research which identified that primary health care nurses face numerous barriers to participation in education (McKinlay, Clendon, O'Reilly, 2012; MoH, 2003; Rolls, 2005). However, education can only be meaningful if the practitioner owns their learning and is able to fit it into the working life without excessive bureaucratic constraint (Howe, 2000). If the education is perceived as having little relative advantage, uptake will be lower:

> Yeah I think we are all doing postgrad education, for myself I am updating all the time. However at this stage, I am not interested in doing advanced papers because for me it is like learning another language. I would rather be doing the action rather than the learning so for me to go to little seminars, I have done so much training in my life that I am adequately trained. (FG.5, p.4)

Analysis of this excerpt suggests that this nurse understood postgraduate education as being all the education nurses undertook following their

registration as opposed to formal postgraduate tertiary based education. Without nursing leadership or adequate nursing infrastructure in primary health care, it is understandable that nurses might not be exposed to understanding of postgraduate education. Accordingly, Kenny and Duckett (2003) state there is a need for theoretical and operational preparation in understanding postgraduate education.

The Expert Advisory Group on Primary Health Care Nursing (2003) recommended postgraduate education to support all levels of primary health care practice. To support this, CTA (Clinical Training Agency now called Health Workforce New Zealand) funding was extended in 2006 to include nurses working in primary health care. This annual funding round covers the cost of participation in postgraduate programmes that are clinically focused and meet set specifications linked to government priorities (Health Workforce New Zealand[17]). It generally covers course fees, the cost of the backfill as well as travel and accommodation for compulsory on-campus courses. Despite this funding opportunity, the uptake of postgraduate education by primary health care nurses in Tairawhiti was notably less than the hospital based nurses employed by TDH as suggested by one of the nurses:

> There is nobody doing postgrad in our area. (FG.4, p.2)

Calverley (2012) confirms that promoting the uptake of postgraduate education amongst primary health care nurses is not easy. One particular manager expressed disappointment with the poor uptake, especially since scholarships were made available by their organisation:

> [organisation name] have offered postgrad nursing scholarships and nursing scholarships for professional development every year in this town for the past 8 years and I only know of two who have availed themselves of the opportunity. I don't know how many avail themselves access to CTA funding opportunities. (I.5, p.10)

[17]http://www.healthworkforce.govt.nz/sites/all/files/1B57%20Postgraduate%20Nursing%20Training%20specification.doc_1.pdf

However, one of the primary health care nurses experienced difficulties in attending the campus courses as her employer was unable to find nursing replacement to cover her role while absent from the workplace:

> I had that problem a few years ago when I did that CTA funded education...CTA funding is part of that to pay somebody to replace you but we have difficulty getting somebody so we can't take the time off. (FG.1, p.9)

Yet there is considerable evidence to support the benefits of postgraduate education (Barnhill, McKillop, & Aspinall, 2012; Caldow et al., 2006; King, King, Willis, Munt & Semmens, 2012; Calverley, 2012; McDonald, Willis, Fourie, & Hedgecock, 2009; Pullon & Fry, 2005). Postgraduate education goes beyond skill and knowledge development and includes development of the nurse's sense of identity and ability to envision a greater nursing contribution (Miskelly & Duncan, 2013). Caldow et al. (2006) argue postgraduate education encourages independent thinking and confidence and correlates with a decline in the perception of the nurse as a "handmaiden". This then creates tension as highly educated nurses face strong opposition from their medical counterparts as one of the nurses confirmed:

> ...there are still doctors out there who find well educated nurses intimidating. (FG.3, p.8)

That such an attitude existed was validated by one of the managers, also a doctor:

> And in some respects nurses have a higher level of education and know more about physiology and biochemistry etc. At some levels for me there has been a bit of disconnect in the process. In the old days nurses were in many ways a patient advocate and spent more time with the patient so they could understand how the patient felt and sometimes have the option to just sit with someone, be with someone was itself therapeutic. (I.2, p.6)

This doctor reveals the traditional belief that for nurses knowledge and caring are somehow unable to co-exist. It is never suggested that the same might apply to medicine. Attitudes such as this are archaic and obstructive to the

development of an effective, progressive and collaborative primary health care nursing workforce. It links with the previous data that relate to the oppression of the nursing workforce by doctors. Therefore, education is a most important avenue for change (Diaski, 2004) as the following comments suggest.

> I know that the extension of post graduate clinical training to primary care has added in a ready way for individual nurses to develop. (I.4, p.3)

> I think a big thing is our workplace enables us to up-skill and develop ourselves. We have had the diabetes training in Hamilton. Amazing, the turn around, the nurses are able to know what they are reading in blood results, and, communicating that to the people. (FG.1, p.6)

Another avenue for nursing development is the local professional development recognition programme (PDRP). One manager assumed the nursing PDRP process would have encouraged each nurse to identify their own educational and professional development needs:

> I assumed the establishment and maintenance of your portfolio would encourage you to be more organised about your professional development…. I am assuming if you are working in an environment where you employer perhaps doesn't do performance appraisals in a way their portfolios are looked at and praised in areas they've identified for improvement and professional development discussed in a way that is organised then, everyone just shrugs their shoulders. (I.5, p.11)

PDRP supports the recognition of level of expertise, guides career development and assists nurses in identifying their educational needs. The assessment processes is based on the submission of a practice portfolio. Portfolios are effective and practical in increasing personal responsibility for learning and supporting professional development (Tochel et al., 2009). Though, primary health care nurses in Tairawhiti had a poor uptake of the formal PDRP process compared to secondary care as confirmed by the following nursing manager:

> I guess there are still a lot of practice nurses that don't have portfolios and I am continually trying to push the ante to

> recognise that professional development; and in meeting that as a council requirement. (I.7, p.6)

Participation in the PDRP process is not compulsory and without nursing leadership, managerial support and the opportunity to grow collegial professionalism or a strategic vision, the usefulness of the PDRP process would lack relative advantage. The writing process also created significant apprehension and difficulty amongst some of the nurse participants as the following comment illustrates:

> The portfolio, it is hard talking their language. I have never ever spoken that language and now I have to, and that is the biggest barrier. I just don't speak that language and it is the hardest thing to get your head around. (FG.5, p.5)

PDRP for primary health care nurses has become more feasible in the past few years with support available from the TDH education coordinator for individuals or groups of nurses wanting to participate in the PDRP process. TDH had extended their programme to allow primary health care nurses in Tairawhiti to submit their portfolios through them locally. To support this process, a website was developed where all the TDH PDRP documents and information on nursing education development was made available. The TAIMNED[18] website was launched in 2009 and stands for Tairawhiti midwifery and nursing education. Such development was a positive sign that nurses were working together to develop nursing. The same level of support was required for nursing students and new graduate nurses to ensure the long term sustainability of the primary health care nursing workforce.

The local nursing school contributed to greater stabilisation of the nursing workforce in Tairawhiti, a district that had previously experienced a serious nursing shortage. The nurse entry to practice (NETP) programme in primary health care was launched in Tairawhiti in 2009. In the first year, two new graduate nurses were placed with Ngati Porou Hauora and one with an aged care provider. The second year, there were three placements into aged care facilities. Prior to this, many nurses and employers were still of the opinion

[18] http://www.taimned.co.nz/

that new graduates require hospital consolidation of practice prior to working in the community and primary health care settings (Ministerial Taskforce on Nursing, 1998):

> Now you can go straight into the community on the new graduate programme ... the undergraduate programme is explored a lot more than it used to be from when I first did my training. You get a lot more exposure in primary health care. (FG.4, p.6)

Application of the programme in primary health care across Tairawhiti was limited for a number of reasons. There is a low turnover of primary health care nurses and therefore fewer vacancies to fill. When a primary health care nursing position does become available, the employer prefers a more experienced nurse. This is understandable given the fact that many primary health care nursing positions require the nurse to be an autonomous practitioner and necessitates a high level of competence and knowledge to be effective. New graduate nurses have only a six week supernumerary period before they are considered part of the workforce. The following nurse was concerned that new graduates were required to work on their own which she considered unsafe:

> I wouldn't want any of those nurses to be scared from nursing because they got out in a dangerous situation that they didn't have enough knowledge to know about it I guess. (FG.3, p.17)

There is on-going debate over who is going to fund new graduate positions so that they became supernumery to current work load. There is an increasing expectation by non-TDH organisations that TDH should fund them. TDH believed individual organisations should fund their own new graduates as they are part of a workforce driven by a business model. There is financial support through TDH by way of Health Workforce New Zealand funding that pays the backfill for preceptors and new graduate attendance at study days. The sum prescribed is inadequate and does not encourage external providers to employ a new graduate nurse.

There is thus lack of commitment toward a strategic nursing workforce development approach, not only in meeting the intent of the Primary Health Care Strategy, but in meetings the health needs of the Tairawhiti population both now and in the future. It is indicative of organisations working in isolation rather than collectively for the common good.

8.7 Concluding statement

This chapter presented data using the framework provided in *Investing in Health* for activating primary health care nursing (Expert Advisory Group on Primary Health Care Nursing, 2003). The first goal to align nursing practice with community need gained minimal traction in Tairawhiti. Two potential activators of change included the shortage of doctors and Care Plus. The doctor shortage should have, but did not, encourage the effective deployment of the nursing workforce. However, Care Plus funding increased the role of nurses in the area of chronic conditions and did, in some instances, instigate the development of nurse led services. Nonetheless, traditional models of service delivery continued with limited gain for nursing, or for the population of Tairawhiti.

The development of innovative models of nursing practice looked promising when Tairawhiti was successful in its bid for innovation funding provided by the MoH. An evaluation of TINT indicated this was a successful nurse led service that worked with hard to reach populations to reduce inequalities. Despite this, once the funding expired, so did support for the project leaving those involved disillusioned by the process. The outreach vaccination service continues to be successful in Tairawhiti but other innovations have failed due to lack of support or poor design. Innovativeness has been stifled by significant barriers that reflect historical perceptions of nursing capability.

Investing in Health (2003) identified the need for nurses to control, direct and influence their own practice to ensure nursing's contribution to improving health outcomes and reducing inequalities in health status. Participation at governance level provides the ability for nursing to impact on planning and funding decisions, making change more sustainable. This was the least

developed goal identified by the Expert Advisory Group on Primary Health Care Nursing (2003). It was completely at odds with existing beliefs; there was no relative advantage to GPs or any other person in power to share their authority. To expect the historical social strata of power to change following the release of the Primary Health Care Strategy was unrealistic given there was no local strategic approach that had all people in agreement.

Developing primary health care nursing leadership had some recognition with the introduction of the primary health care nurse leader position. However, with no direct line management responsibility, the ability to influence practice was negligible. Overall, the paucity of nursing leadership across primary health care in Tairawhiti meant nursing innovation and development was not activated to any meaningful degree; non-nursing managers continued to make decisions for nursing practice.

The fifth goal identified in *Investing in Health* (2003): education and career development probably had the most traction of all five goals. There was better access to educational support through TDH, increased funding for postgraduate education and placements of new graduates in primary health care. Yet, postgraduate education uptake was poor and there were no career frameworks in place. The absence of a strategic workforce development approach meant the intent of the Primary Health Care Strategy was not met.

What these three chapters validate was limited support for development for the effective deployment of the primary health care nursing workforce in Tairawhiti. Underpinned by the diffusion of innovation theory, these three chapters provided new insight into the impact of the Primary Health Care Strategy on this nursing workforce. Each emergent theme gave understanding of the challenges and opportunities offered by the Strategy as acknowledged by the participants. Each theme was significant in terms of supporting the case that nurses were not utilised to the best of their ability.

A whole system strategic approach and a receptive context for change was a prerequisite for Primary Health Care Strategy implementation. As confirmed

throughout, there were significant levels of resistance across Tairawhiti that negatively influenced the deployment capacity of the nursing workforce. There was no buy in from the DHB or general practice to meet the principles of the Strategy. The new PHO environment did little for driving nursing forward, at the same time the nursing workforce was not active. Funding incentives increased relative advantage and the move to a PHO environment, but did not increase the need to change existing practice. Service delivery continued within a biomedical framework with the focus on episodes of ill health as opposed to the broader population health approach. Overall, the instigation of widespread service change was undermined.

Next, Chapter Nine concludes the thesis by further discussing the general themes in relation to current literature. I present limitations of this research and opportunities for further research before making recommendations towards the effective deployment of primary health care nurses.

Chapter Nine: Conclusion

9.1 Introduction

This final chapter provides a discussion and summation of the study. This research exposed the limitations of the Primary Health Care Strategy when applied to a DHB district in New Zealand. I begin this chapter by revisiting the intent, method and importance of the research. A précis of the Strategy is provided before a summation of the more significant changes which took place in Tairawhiti is presented. This is followed by discussing why the changes did or did not occur as anticipated before providing recommendations for addressing the issues identified. Suggestions for future research are offered and the chapter concludes by discussing the limitations of the study.

9.2 Revisiting the intent of the research

The intent of this research was to evaluate the impact of the implementation of the Primary Health Care Strategy on the primary health care nursing workforce in Tairawhiti from 2001-2010. I sought to make visible the factors that supported or impeded the nursing workforce in Tairawhiti from being full partners and participants in this Strategy. This research was underpinned by the following two questions:

1. What change has occurred within the primary health care nursing workforce in Tairawhiti since the implementation of the Primary Health Care Strategy, how and why did this come about?
2. What factors influenced the deployment of primary health care nurses in Tairawhiti?

In order to answer these two questions I utilised Stake's (1995) definition of a single instrumental case study. Data were collected from multiple sources including the collection and analysis of documents relevant to the case under investigation as available on the TDH, Ngati Porou Hauora and Turanganui PHO websites. In addition, all archived public Board and statutory advisory

committee minutes from 2002-2010 and district annual plans were reviewed as available from Tairawhiti DHB. Data were also collected from in-depth individual interviews with ten managers at TDH and the two PHOs and from five focus groups with primary health care nurses in Tairawhiti. These voices and document sources provided a rich tapestry of perceptions and worldviews that contributed to the analysis.

The diffusion of innovation theory offered by Rogers (2003) and Greenhalgh, et al. (2004, 2005) informed the guiding framework. This framework facilitated locating the meaningful components of the impact of the implementation of the Primary Health Care Strategy on the nursing workforce in Tairawhiti. Different innovations are adopted by individuals or organisations at different rates while some are not adopted at all (Greenhalgh, et al., 2005; Rogers, 2003). Likewise, the adoption of an innovation by an organisation is a very complex process and influenced by political, social, cultural, technological and economic environments (Greenhalgh et al., 2005). Diffusion of innovation research helps expose, then explores, the reasoning that underpins the complex adoption process. It was this complexity that I wanted to understand in order to determine the barriers and opportunities for the effective deployment of primary health care nurses in Tairawhiti.

9.3 The Primary Health Care Strategy

The vision of the Primary Health Care Strategy was a move towards a greater emphasis on population health and community engagement, health promotion, prevention, and the need to involve a range of professionals (Barnett & Barnett, 2001; MoH, 2001; Workforce Taskforce, 2008). The Strategy signalled a shift in focus from the provider to the community and required doctors and nurses to work in different ways (McPherson & McGibbon, 2010). People were to become part of a local comprehensive primary health care service that was easy to access and where their on-going care would be coordinated to improve, maintain and restore health. The priorities of the Alma Ata Declaration (WHO, 1978) determined that the focus was on actively working to reduce health inequalities especially for Māori, Pacifica people and those others living in lower socio-economic environments (Hefford et al.,

2005). Development of the primary health care workforce was also a priority to ensure key directions were met (MoH, 2001).

The Primary Health Care Strategy was a high level, high profile document supposedly designed to be open ended in nature (Finlayson et al., 2011; Love, 2008). Apart from PHO development, the Strategy had no clear ministerial directives on how it should be operationalised. As a result, interpretation and implementation varied significantly across the country. This was complicated by the diverse range of both public and private health service delivery models, the consequential mix of stakeholders, various funding streams and the complex relationship between primary and secondary care (DHBNZ, 2009). Doctors, originally side-lined from the policy formation in 2000 (Ashton & Tenbensel, 2010), managed to continue to exert their power and authority to drive PHOs (Gauld, 2008). They protected their interests and continued governance over their private businesses (Ashton & Tenbensel, 2010; Docherty et al., 2008; Gauld, 2008, 2009a).

Fragmented funding models did not provide sufficient incentives or flexibility for the workforce to achieve the changes envisioned in the Strategy (Workforce Taskforce, 2008). The short term nature of many contracts discouraged investment in service development, training and infrastructure. Across New Zealand there was also significant variability in DHB, PHO and provider capability and capacity. Each PHO and DHB had a different way of doing things, lack of critical mass and undeveloped clinical structures lead to fragmentation between DHBs, PHOs, and NGOs (PHCAC, 2009). There continued to be poor integration between primary and secondary care with a limited multidisciplinary approach (Gauld, 2009a).

To conclude, despite the introduction of both the New Zealand Health Strategy and Primary Health Care Strategy, many of the key features and concerns with the health care system remain unchanged (Gauld, 2008). The national situation applies strongly to the position in Tairawhiti and is discussed next.

9.4 The setting

The promissory benefits of a robust primary health care system are significant (Abel et al., 2005; MoH, 2001; Starfield, 2006; WHO, 2008). The relative advantage of increased primary health care to the population of Tairawhiti was extremely high. There was genuinely strong support from participants for the need to reduce inequalities in health, given the health status of the local population. Māori are the most affected and Tairawhiti has the highest proportion of Māori of any DHB. The people of Tairawhiti face the highest rates of deprivation in New Zealand with lower levels of education, lower average incomes, higher unemployment rates and higher benefit use (TDH, 2011).

Initially, the propensity to act was high in Tairawhiti, as evidenced by specific activity around PHO formation. Small pockets of change followed mostly related to new funding mechanisms. Capitation and additional funding significantly reduced patient fees, increased consultation rates and improved access to first contact appointments. There were more programmes that emphasised chronic care engagement and an increased awareness of inequalities. However, the opportunities afforded by capitation funding failed to move primary health care providers in Tairawhiti from an acute episodic care approach to a population health focus. Despite heavy financial investments there was no real transformation in priorities or confirmation of the need to change existing practice. Clearly, relative advantage was not enough on its own.

Tairawhiti DHB did not significantly alter its functional relationships. PHOs were not active in the development of services. Initiatives were sporadic and drawn out, the change expected was not produced. The data did suggest Iwi providers were more receptive toward a primary health care approach than the DHB or primary care. The principles of the Primary Health Care Strategy had a better fit with Māori whose definitions of health are more encompassing of the holistic physical, spiritual and family/whanau philosophies (Durie, 1998). In spite of this, the apposite deployment of the primary health care nursing workforce did not occur as anticipated. Overall, the Strategy was a lost

opportunity circumvented in Tairawhiti for a multitude of reasons. The lack of impact on nursing services was a similar casualty.

9.4.1 Locating the impediments to change

The Primary Health Care Strategy required change at an unprecedented level across the health sector but did not take into account the potential constraints of existing institutions and structures (Gauld & Mays, 2006). Altering part of a system without addressing all of the issues does not work; organisational, financial, clinical and relational changes were required. Furthermore, the Strategy was one of many documents released around the same time and each came with an expectation that DHBs would implement the objectives locally. The multiple strategies did not necessarily come with additional financial resource and this may have contributed to lack of relative advantage in moving forward. There were vested interests involved and a poorly operationalised Primary Health Care Strategy document enabled these to prevail.

Greenhalgh et al. (2005) argue that capacity processes must be in place to support innovation. In order for this to occur there must be careful assessment and planning in the conceptualisation and implementation phases of policy change. With regard to this research, the perceived complexity of an innovation can be reduced if the innovation is broken down into more manageable parts (Greenhalgh et al., 2004). Without a local strategy in place to identify steps to break the document into specific actions, and without timeframes or measures to determine progress, this implementation was destined to fail. This was exacerbated by poor diffusion processes.

9.4.2 Local diffusion processes

Adoption does not happen at an individual level, there are often multiple stakeholders involved in an innovation process (Leeuwis, 2011). Therefore, communication plays a vital role in innovation development, design and adoption. Diffusion is a particular type of communication that is concerned with new ideas which are spread to the members of a social system (Rogers, 2003). The intent is to bring about the desired behaviour change. One of the

key findings from this research was that making sense of the Primary Health Care Strategy by both organisations and individuals in Tairawhiti was flawed. There was failure to successfully engage all potential key stakeholders in articulating a shared vision or common purpose to support the roll out of the Strategy.

Ineffective diffusion and dissemination resulted in limited stakeholder understanding and as a consequence, there was little evidence of actions taken in moving toward a state of readiness. There was a gap in understanding by the Tairawhiti Board and key stakeholders as intended adopters of the Primary Health Care Strategy and this had a negative effect on the adoption decision-making process across the district. Managers interviewed displayed variable knowledge of the Strategy which ranged from basic understanding through to in-depth comprehension. Conversely, very few primary health care nurse participants had any awareness of the Strategy at all. Lack of any planned meaningful engagement with the nursing workforce in the implementation had significant consequences; the most serious being that primary health care nurses were unaware of the changes that occurred around them and were excluded from the decision-making.

Rogers (2003) states an innovation decision process begins when an individual is exposed to an innovation and gains an understanding of how it functions. An innovation which is perceived as easy to implement is more likely to be adopted (Rogers, 2003). There was no active or planned effort to persuade others to adopt the Strategy. In addition, there did not appear to be a key person or cluster of people to drive forward in Tairawhiti. However, Leeuwis (2011) argues that focusing on the role of deliberate communication is a limited approach, and that the everyday communicative exchanges among societal agents are likely to be of critical significance in connection with the re-ordering of social relationships. Societal norms, value systems and accepted behaviour within organisations influence the diffusion process by affecting interpersonal communication channels and stifling innovation (Lindsay et al., 2009).

Leeuwis (2011) contends the different interpretations of an innovation have to do with prior knowledge and other contextual issues such as the historically grown relationship between the communicating parties, configurations of interests and representations, and the influence of others not directly involved in the interaction. Further, the author argues the everyday communication among stakeholders is critical for the re-ordering of social relationships and the emergence of space for change in networks. The place of employment appeared to impact on access to information which meant that different people knew different things at different times. As the information passed through the various hierarchical structures it was interpreted differently with personal values and biases added to the message.

Face-to-face communication is essential to provide the support required to reach individuals to whom they are not strongly tied by friendship or other relations (Ray, 1987). Further, active meaningful engagement and involvement has been found to be a critical factor in the receptivity of organisational members to innovations (Leonard-Barton & Sinha, 1993). Communication is much more than distributing information. The Primary Health Care Strategy required engagement, discussion and debate, until a shared understanding was reached.

This defective diffusion process was also aggravated by a lack of shared understanding of the terminology; primary care was frequently interchanged with primary health care. Primary health care is broader than primary medical care (Adamson et al., 2005; Carryer, 2004; Docherty, 2004; Holdaway, 2002; Keleher, 2001). However, primary health care in New Zealand continues to be regarded as largely synonymous with general practice (National Health Committee, 2000). This particular perception has been at the heart of the challenges experienced and contributed to the difficulty in articulating a shared vision with common purpose across a range of stakeholders.

In concluding this section, the importance of organisations having the capacity to absorb new knowledge and be receptive and ready to change cannot be underestimated (Smith et al., 2008). The change process deserves greater

attention in health care settings (Chreim et al., 2010). Understanding the role that communication plays in innovation should not be underestimated (Leeuwis, 2011). Gaining the support of staff was a challenge; numerous authors would argue that professional interest groups and stakeholders must be allies (Finlayson et al., 2011; Mays & Cumming, 2004; Smith et al, 2008). It is the context of the relationship that distinguished the interaction in primary health from those occurring in other areas of the health system (Starfield, 1998). Without doubt, limited understanding of the intended outcomes of the Primary Health Care Strategy impeded a shared vision across the health sector. Communication also plays a key role in overcoming resistance to reducing uncertainty.

9.4.3 Resistance to change

A receptive context for change requires congruence between the philosophy and principles of the innovation and the recipients who are being asked to adopt (Greenhalgh et al., 2004). The authors argue that organisations with a better receptive context for change are more able to assimilate innovation. Where there is a high amount of risk or uncertainty about adopting an innovation it is less likely to be adopted. Radical innovations, like the Primary Health Care Strategy, require greater external knowledge when implementing multiple goals (Damanpour, Walker & Avellaneda, 2009). Resistance and scepticism threaten organisational change within health care systems (Gollop et al., 2004).

People respond to the suggestion of change in different ways (Gough & Richards, 1998). Attitudes and behaviour can quickly stifle innovation (Lindsay et al., 2009). There are those who take advantage of the opportunities and those who demonstrate active resistance. The majority of people have no prior desire to change. Changing roles and professional responsibilities create a culture of uncertainty and lack of predictability which has the potential to threaten innovation (Williams & Sibbald, 1999). Most resistance arises from those who benefitted most from the status quo and want to maintain control of their environment (Abel et al., 2005; Gollop et al., 2004; Smollan, 2011). Maintaining the status quo is easier and more comfortable. Hayes (2007)

affirms that any innovation creates insecurity from a fear of the unknown and a fear of losing benefits.

Governments had unsuccessfully attempted to change the structure of the New Zealand health care system prior to the Primary Health Care Strategy (Gauld, 2009a). Likewise, and accounting for a number of contextual factors, there were multiple layers of resistance to the proposed changes suggested in the Strategy, especially change that threatened traditional practice (Abel et al., 2005; Barnett & Barnett, 2004a; Gauld & Mays, 2006; Gauld, 2009a; Smith, 2009). The multifactorial system wide shift required change to the way people think about and deliver services (Controller and Auditor General New Zealand, 2008). The Strategy had strong political overtones and aroused negative emotions in a significant number of key stakeholders. As a result, an uneasy relationship developed between the Minster of Health, DHBs and GPs (Barnett & Barnett, 2004a). Tairawhiti was no exception. The framework between DHBs and PHOs was prescriptive with high compliance requirements and minimal delegation of authority. A number of its principles were incongruent with existing structures and processes, therefore lacking significant drivers of change.

Despite the initial buy-in, there were multiple layers of resistance across the health sector in Tairawhiti. Tairawhiti DHB did not progress with the full intent of a primary health care philosophy. This was demonstrated by Board inactivity in implementing the principles of the Primary Health Care Strategy. Their focus remained on maintaining crucial hospital services and primary health care development was not a priority. District annual plans identified proposed primary health care actions but these were not followed through by a local strategic plan to direct primary health care development. Change that did take place was piecemeal and the lack of visible activity supported the notion that the DHB instigated actions were based on what suited their needs at the time. Pressure to deliver on organisational service and financial targets overrode the appetite to work more with primary health care, especially where it involved a significant shift in resources (Ryall, 2007).

Most GPs resisted any threat to their status quo as they have done for more than seventy years. Nationally GPs fought strongly against the government to ensure the primary care structures and systems met the needs of their private sector business model (Gauld, 2008). Locally, GPs demonstrated an initial willingness to work alongside the DHB when the primary health care steering group was first formed. Enthusiasm was short-lived when differences in values and beliefs became apparent.

The bold intention to redesign the financing and delivery of primary health care services had implications for the professional and business autonomy of general practice (Mays & Cumming, 2004). The new population based capitation funding sought to overturn the traditional fee-for-service mind-set. The national funding model increased practice and medical incomes but charging a fee-for-service continued to be the focus of practice delivery for a large number of general practices (Cumming & Gribben, 2007; Finlayson et al., 2011).

GPs also resisted moving away from episodic care and deeply entrenched biomedical beliefs. This was supported by the historical and persistent appeasement of the medical workforce which has enabled controlling behaviour resulting in "almost unlimited authority derived from the ways in which it is made authoritative" (Carryer, 1997, p.12). Medical dominance is supported at various levels in western society; over the content of their own work, over the work of other health professionals and as experts in all matters relating to health (Willis, 2006). This then reached into medicine's power, authority and dominance in determining health systems by influencing policy. This has significantly influenced the decision-making, pace and extent of change in health care (Mays & Cumming, 2004).

Integration was also resisted, especially by doctors who wished to remain at the helm when professional boundaries and employment practices were threatened. Integration and collaboration are appreciably complex (Lockhart-Wood, 2000). Fraught with interdisciplinary disagreement, tension is associated with integration around the role of each professional (Cioffi,

Wilkes, Cumming, Warne, & Harrison, 2010; Fagin & Garelick, 2004; O'Neill & Cowman, 2008). As with the national context, some GPs were anxious and suspicious of expanding nursing roles and were not accepting of nurses as equal members of the primary health care team (Finlayson et al., 2009). Flat structures, as opposed to traditional hierarchical structures, are more conducive to collaboration by equalising the power dynamics (Alford, 2005; Sanson-Fisher, 2004). This requires clear roles, professional respect of the knowledge and skill set in clinical decision-making and overcoming weak professional standing and gender barriers (Buttaro and al., 2003; Cioffi, et al., 2010; O'Neill & Cowman, 2008; WHO, 2000).

Health systems internationally have been slow in providing patient centred care defined by the patient journey and care coordination across services, rather than in buildings and location (Wells & Jackson, 2011). It was not until the advent of "Better, Sooner, More Convenient" direction in health policy that there was talk of integrated family centres. However, the subsequent conversations still focussed on buildings and not the patient journey.

GPs were not willing to share their governance and authority or relinquish the power and control exerted over the nursing workforce; there was no relative advantage in doing so. With this long history of being treated as special (McPake & Normand, 2008), it is well documented that the dominance of the medical workforce reduces the confidence of the nursing voice (Carryer, 2004; Chiarella & McInnes, 2010; Fagin & Garelick, 2004; Furedi, 2006; Finlayson et al., 2009; Lockhart-Wood, 2000; Mays & Cumming, 2004; O'Connor, 2012; Piji-Zieber, 2013; Willis, 2006).

Established and expected behaviour patterns in a given social system serve to define the range of tolerable behaviour expected from individuals (Fagin & Garelick, 2004; Foucault, 1977; Harvey, 2011; Rogers 2003; Willis, 2006). The contemporary concerns for nursing stem from the historical expectation of how doctors and nurses work alongside each other (Fagin & Garelick, 2004). The relationship between doctors and nurses used to be clear and transparent; doctors were considered superior because they had the knowledge to make ill

people better while nurses were accessories to that endeavour and not necessarily very knowledgeable (Radcliff, 2000). A certain amount of gendered legacy persists in that the nursing workforce remains predominantly female (Cutcliffe & Wieck, 2008; Smith & Mackintosh, 2007; Tracey & Nicholl, 2007).

Fear and lack of confidence in nurses could be perceived as an unwillingness to embrace change (Finlayson et al., 2009). However, without shared governance and collective leadership and the ability to impact on planning and funding decisions or influence their own practice and allocate resource, significant change for nursing 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 et al., 2009; Robertson-Malt & Chapman, 2008).

Reay, Goodrick, Casebeer and Hinings (2013) state fundamental change is rarely accomplished without "ruffling feathers". Opponents then negatively influence the diffusion process and restrict movement for others. Consequently, managing resistance is essential for managing change (Dickson & Coulter Smith, 2013). Jun (2006) contends that problem solving is achievable through democratic processes and by engaging people in the discussion to realise their values, ideas and experiences. Without a supportive culture, the adoption of new ideas is greatly reduced (Greenhalgh et al., 2005).

9.4.4 Nursing input into the Strategy

The significant potential contribution of the role of primary health care nurses in Tairawhiti was not recognised and this undermined widespread service change. Without a system wide approach to redefine priorities based on patient centred care, primary health care nursing was not reorganised to make the best use of this professional workforce in a manner congruent with the principles of the Primary Health Care Strategy.

Innovative models of primary health care nursing practice were expected following the release of the Primary Health Care Strategy (Expert Advisory

Group on Primary Health Care Nursing, 2003). The Ministry funded 11 projects nationally and Tairawhiti was successful in gaining some of this funding. Subsequently TINT was formed in a partnership between the Tairawhiti DHB, Ngati Porou Hauora PHO, Turanganui PHO and Employ Health. After the Ministry funded the nurse led innovation, the programme failed to attract on-going funding from the DHB, despite this being an expectation with all 11 innovation projects. This was potentially avoidable.

The Expert Advisory Group on Primary Health Care Nursing (2003) was more supportive of using funding to develop leadership and infrastructure for primary health nursing rather than funding new models of care where no supporting infrastructure existed. Conversely, the MoH was keen to go straight to service model development (J. Carryer, personal communication, 1 August, 2013, member of the Expert Advisory Group on Primary Health Care Nursing). Tairawhiti at the time had no primary health care nursing infrastructure and thus no context in which to develop new service models.

Leaders are critical in creating the context for change; a significant predictor of whether or not an innovation can and will be implemented effectively (Greenhalgh et al., 2005; Sanson and Fisher, 2004). The paucity of formal nursing leadership in primary health care in Tairawhiti greatly compromised the opportunity for nurses to impact on the direction of health service provision. A primary health care nursing leadership role was established in 2008. However, as an advisory position, there was no direct line management responsibility and no authority to affect significant change in primary health care. This meant nursing innovation and development was not mobilised to any meaningful degree.

Additional existing nursing leadership was assimilated into the workload of experienced nurses who, because of the business model in general practice, also did not have the authority to influence change. This was consistent with what occurred nationally (Adamson et al., 2005; Expert Advisory Group on Primary Health Care Nursing, 2003; McKenna & Keeney, 2004; McMurray, 2007b; Taylor, 2009). Lone nursing voices juxtaposed with fragmentation,

variable investment in nursing infrastructure and interdisciplinary relationship issues, did not provide the strength and influence required to generate change (Calverley, 2012). Poorly supported primary health care nursing leadership structures resulted in non-nursing managers making decisions for nursing practice. Arguably the most damaging effect of this was the demonstrated failure to capture the full potential of the primary health care nursing workforce.

There were nurses who wanted to drive nursing forward but, as a collective, they were ineffective. Generally, nurses were ill-equipped to promote and practice primary health care in a broader community sense. Supportive funding streams, employment arrangements and service delivery patterns were not in place to align the nursing workforce with community need. Capitation especially, proved completely at odds with the development of the nursing workforce and there were a number of reasons for this. First, capitation offset the previous practice nurse subsidy creating further risk to the provision of the practice nurse role. It was often noted that general practice owners could see nursing costs as an overhead to be minimised (Hefford et al., 2005). Second, capitation (and SIA funding) was intended to provide the opportunity for more nurse led services (Carryer et al., 2010; Hefford et al., 2005; Finlayson et al., 2009). Co-payments could be requested from the patient for each consultation, and while charging for nursing services was important to general practice (Love, 2008), these generated much less than a general practitioner.

Third, the new funding streams (such as SIA and Care Plus) theoretically provided the opportunity for nurses to take a lead in organising care for certain patients. In Tairawhiti, Care Plus led to the introduction of some nurse led services which increased nursing management of long-term conditions. Still, there was no payment mechanism to incentivise practices to improve patient outcomes or change the way services were delivered (Hoare et al., 2011). Thus the expansion of the primary health care nurse role continued to be based around practice income rather than population health needs. Carryer (2004) argued that PHO funding streams must directly purchase nursing services in

the broadest sense and that without national consistency, there could only be a continuation of the current piecemeal provision.

A strategic workforce development plan was also required to ensure initiatives and actions were sustainable for the long-term. There is a recognised relationship between education/professional development and quality of nursing practice (NZNO & College of Nurses Aotearoa NZ, 2007). Workforce development in Tairawhiti was ad hoc, inconsistent, and lacked a strategic approach to meet the intent of the Primary Health Care Strategy. Still, there were significant gains in the availability of educational opportunities and support for primary health care nursing in Tairawhiti. TDH also had a proactive role in bringing relevant courses to Gisborne.

A number of nurses vigorously pursued the educational opportunities available, while others did not. Despite access to funding, postgraduate education had a poor uptake as did the application of the professional development recognition programme (PDRP[19]). The nurse entry to practice (NETP) programme also had limited success with two new graduate nurses placed with an Iwi provider in the first year and more placed in aged care in subsequent years. Limited funding, minimal primary health care nursing vacancies, autonomous independent primary health care nursing roles and the compulsory supernumerary period of six weeks, all negatively influenced NETP uptake.

The Primary Health Care Strategy in Tairawhiti was an innovation which proposed, amongst other things, to more effectively deploy nurses and make the best use of nursing potential to help reduce health inequalities, achieve population health gains, and prevent disease. The Strategy was to provide an opportunity for evolutionary change with nursing repositioning itself for new ways of delivering services in primary health care settings. However, the innovation's instigators failed to take into account a number of operational and attitudinal factors about nursing. This included nursing's history, gendered

[19] Professional development and recognition programme

nature, employment positioning, lack of leadership structure and very limited championing of supported workforce development.

Dominant assumptions about the centrality of general practice to the implementation of the Strategy meant many stakeholders saw primary health care nursing as limited to the practice nurse role. This compromised a broader and more relevant appreciation of the full capacity of primary health care nursing locally and nationally. This supports the arguments behind the diffusion of innovation theory: for an innovation to be compatible it must fit with a person's socio-cultural values and beliefs, previously introduced ideas or the individuals gain from the innovation (Greenhalgh et al., 2005; Rogers, 2003).

9.5 Significance of this research

All research is conducted in order to advance knowledge (Aiken, 2011). As mentioned in the preface, it was important to me that the knowledge gained from this research was useful and could be translated into practice. The true value of this research is the identification of important factors directly related to the implementation of the Primary Health Care Strategy and its failure to create the intended impact on the nursing workforce in Tairawhiti. I believe this study can make a significant contribution to understanding how health services organisations and the individuals within those organisations respond to policy change.

Research on the Primary Health Care Strategy's implementation in New Zealand to date is reported in multiple documents and the findings in this research echoed a number of themes from previous primary health care nursing research (Adamson, et al., 2005; Arroll et al., 2004; Calverley, 2012; Carryer, 2004, 2011; Carryer et al., 1999, 2007, 2010, 2011; Docherty, 2004; Docherty et al., 2008; Finlayson et al., 2009, 2011; Flinter, 2012; Hefford et al., 2010; Holdaway, 2002; Kent et al., 2005; McKinlay et al., 2012; Nelson, Wright et al., 2009; Primary Health Care Nurse Innovation Evaluation Team, 2007; Sheridan, 2005). However, there is no single account which collates and reports the information collected about progress toward the goals of the

Strategy's vision statement (Controller and Auditor General New Zealand, 2008) in a specific DHB area.

Most of the studies on the implementation of the Primary Health Care Strategy have concentrated on PHO formation and fee reduction. My research contributes new understanding on the depth of issues in the diffusion of the Primary Health Care Strategy in Tairawhiti. 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. Yet, as this research demonstrates, such factors are powerful predictors of whether an innovation will be adopted or not.

The findings of this study provided insight on the role of communication as part of policy development and successful implementation. The diffusion of innovation theory proved valuable to support this understanding. The study identified how and why individuals and social groups within organisations respond to a Ministry directed policy change. The special focus was on explaining how the Primary Health Care Strategy was diffused and implemented and how this, in turn, influenced the deployment of the primary health care nursing workforce. Therefore, this case gives rise to knowledge which contributes to the cumulative knowledge of primary health care nursing workforce development.

This study demonstrated the necessity for the nursing workforce to be active in the health planning and decision-making. It provided new insights into what change occurred for primary health care nursing in Tairawhiti together with drivers of those changes and the barriers preventing the full utilisation of the primary health care nurse workforce. Increased understanding of the challenges and opportunities offered by the Primary Health Care Strategy, as acknowledged by the participants, was provided. This was significant in that it supported the case that nurses' knowledge and experience was not utilised to the fullest potential.

9.6 Recommendations

A key objective in the design of this research was to be able to make recommendations to those involved in the decision-making. The section is divided into recommendations regarding policy and recommendations for practitioners.

9.6.1 Policy recommendations

This research demonstrates that policy development must include in its design, programmes that are congruent with the values and goals of major stakeholder groups. If this is not achieved, then effort must be made towards reaching a common understanding. The major weakness identified in this piece of research was that the principles of the Primary Health Care Strategy did not align with the existing health services in values, beliefs and vested interests. The identification of common values requires engagement in balanced and constructive conversations to increase mutual understanding, respect and commitment to shared gains in personal and population care (Buetow, 2008).

I recommend that the concepts of the diffusion of innovation theory are used to guide and implement policy change in the future. An essential part of any implementation plan is effective engagement with all the stakeholders. The flawed diffusion process demonstrated this was one of the most significant factors in the poor implementation results. Having a dedicated primary health care project manager in each DHB to lead implementation would have been beneficial at the outset. Breaking an innovation down into parts increases the likelihood of adoption. Therefore, an implementation plan is required and should include identification of what, who is responsible, timelines and evaluation. Work pressures and the immediacy of the clinical situation must also be taken into consideration.

9.6.2 Practitioner recommendations

Government and local decision-makers must provide the necessary resources to ensure that nursing workforce and education are supported to make

empowering practice possible (International Council of Nurses, 2008a). The International Council of Nurses (2008b) argues if progress is to be made in primary health care, it is critical that nurses are actively engaged in the change. Nurses must be part of the decision-making; they must lead and coordinate care, while their roles in policy must be seen as legitimate and essential.

Nurses themselves must appreciate and demonstrate their value by producing sound evidence of their contribution to health care. They must become aware of and engage in the changes taking place around them and seize opportunities to further advance their service delivery. Primary health care nurse leaders must be developed in order to motivate, support and propel this vital workforce forward.

There is now a move to focus on national and local change to improve service delivery, reduce inequality and improve the health of the New Zealand population. In order to do this there needs to be a strong commitment to working together from a place of mutual respect. Breaking down the barriers that create resistance is essential to enable the development of more trusting relationships (Higgins, 2008; Johnson & Goyder, 2005).

9.7 Suggestions for future research

The outcome of my research generated questions for further research. The literature has already identified the prevalence of research and commentary on both the Primary Health Care Strategy and primary health care nursing. Considerable research is still required to document the evidence for credible cost-effective primary health care nursing interventions so that the future of primary health care nursing can be consolidated. This knowledge can then be utilised to persuade decision-makers of the cost-effectiveness and value of primary health care nursing.

Another knowledge gap identified is the impact of political directives on implementing change. Policy change in health is affected by a number of very complex factors. Full understanding of these factors and involvement of

stakeholders in the planning is vital to success. In addition, the significant contribution of the socio-organisational forces on implementing policy change needs further investigation. Future research could examine the multifaceted levels of resistance to change and determine what mitigation might be implemented to address this. The need to inquire further about the role opponents play on the diffusion process is essential. The wider impacts of skill-mix change also need exploration. Further, health reform weariness must also be better understood. Once these factors are better appreciated, the knowledge should be incorporated into all strategic planning.

9.8 Limitations

Firstly the data is temporally and contextually bound. Secondly this was a single case study and this is viewed by some as a less desirable form of inquiry (Flyvbjerg, 2004; Griffiths, 2004; Yin, 2003). Perceived limitations in the use of a single case study are overridden by the fact that this methodology allowed the capturing of multiple realities to provide evidence transferable to other primary health care nursing settings. A further limitation is critique of the level of subjectivity of qualitative research (Flyvbjerg, 2004; Griffiths, 2004). However, the process of this study was to explore, not to quantify. The quality and depth of understanding obtained provided valuable, constructive and rich data that facilitated a number of recommendations as discussed previously.

A further limitation is the purposive selection of individual participants and, while they were considered experts in their field, I may have inadvertently excluded valuable information by not including others. However, for the purposes of this study, participants selected did provide appropriate representation and therefore a valuable perspective.

There is also a risk that more credence was given to the opinions of some participants over others. However, I recognised the value of all the information gained. Opinions were confirmed, where ever possible, from supporting literature which was important in mitigating this risk. In addition,

the sample size was small so it is difficult to determine if the results were indicative of the population, or of just the sample itself.

Finally, the diffusion of innovation theory as a theoretical lens may be considered a limitation. The traditional use of this theory is in the implementation of a new product or service, as opposed to policy change. Its usefulness as a way to explain and predict the success or failure of innovations being adopted remains to be verified. The literature on diffusion of innovations does not include timing as an antecedent for diffusion. Instead, the focus is on the system, the climate and the fit with the adopter's needs and values (Greenhalgh at el., 2005). The authors also state that there is little systematic research into the development of system readiness or the steps taken by organisations to assess, prepare and anticipate the impact of an innovation.

The diffusion of innovation theory does not explore resistance to change as a phenomenon. The section on recommendations identified further research is required here. In addition, little is covered in the diffusion of innovation theory literature on health reform weariness. Overall though, I believe the use of the diffusion of innovation theory proved insightful and therefore valuable as a policy implementation evaluation tool. It provided conceptual clarity in designing and measuring the impact of change in a health setting. Therefore, I propose all the above considerations had minimal impact in terms of the findings.

9.9 Concluding statement

An innovation is not successfully diffused until it is used by a large number of people making fundamental change in the way they conduct their activities (Szabo, 2002). Given this, it was very clear that the effective deployment of primary health care nurses did not occur as anticipated. The potential impact of this workforce on reducing inequalities and improving the health in this community was a lost opportunity for nursing and for the community who needed them. The Strategy promised so much, but delivered so little.

Bringing about the multifactorial system wide shift that the Strategy required inevitably met with multiple sources of resistance. I argued that despite the directive to implement the Strategy in Tairawhiti, very little has changed for primary health care nursing and for the way community services are delivered. I contend that primary health care nurses are not effectively deployed in the Tairawhiti region to make the best use of nursing's knowledge and skills to reduce inequalities and improve the health of a very vulnerable community. The Strategy confronted hegemonic power bases and structural barriers in the health system; these negatively impacted on planned implementation thereby confirming the presence of covert issues.

Overall, this study reinforced the importance of a planned approach to change, early attention to detail and the necessity for meaningful engagement following policy change or when strategic documents are released. There was no doubt that those working both in primary and secondary care were poised for change (DHBNZ, 2009). Now is the time to action that change. With appropriate significant investment, an enabling legislative and practice environment, nursing can play a key role in improving the health status of populations. "Delivering quality services will not happen by chance. It will happen only by choice, determined action and nursing leadership" (International Council of Nurses, 2008b, p26)

Post Script

Since data collection, a number of significant changes have occurred both nationally and locally to move primary health care development forward. Alliance contracting came into effect from 1 July 2013. The agreements set out the new minimum requirements that all PHOs will be expected to meet, as well as their core functions, and the expected outcomes including actively working to develop, co-ordinate, and integrate services ("New PHO Agreement to support better care in the community", 2013**)**. Agreements now include key elements which will strengthen the way services are provided including clarifying responsibility for provision of after-hours and holiday services, greater openness about service information and how public money is spent. There is clearer guidance on when practices can move between PHOs and a new integrated performance framework will reward improved performance ("New PHO Agreement to support better care in the community").

In reality, the establishment of alliance agreements could be seen as an admission by the Ministry that DHBs failed to understand the relationship they needed to have with PHOs. It is also possible to interpret agreement alliancing as a subtle attempt to override GP private business and to gain more control over what goes on in primary care settings. These alliance agreements have been used in the health sector since the development of the Better, Sooner, More Convenient Business Cases in 2010. They are considered fundamental to creating an integrated environment. They are based on an alliance with an alliance leadership team (ALT), which are not new for Tairawhiti. Midland Health Network and Midland DHBs have had an alliance leadership framework in place since the formation of Midland Health Network in 2010.

Most importantly the alliance agreements are intended to ensure close collaboration to allow the DHB and PHO leadership to focus on the district population in exactly the manner intended by the Primary Health Care Strategy. They are expected to create a higher trust and lower bureaucracy

environment. They also purport to provide a mechanism for clinical leadership in the development of health services. The new framework takes a whole of health system approach and strengthens accountability by the DHB and PHO for the quality and appropriateness of services delivered to their populations; previously the provider held all the accountability. There is also an expectation that the DHB will be actively engaged in quality, patient safety, performance improvement and value for money. Alliances are expected to have jointly agreed DHB Annual Plans which must also reflect government priorities and health targets. In Tairawhiti, PHOs have been involved in the district annual planning process for a number of years.

Tairawhiti DHB has begun integrating more with primary health care following the development of the Tairawhiti Integrated Committee in 2012. This committee is made up of representation from the three PHOs, GPs, TDH chief executive, clinical directors, planning and funding, and nurse leader primary and community. Since its inception, significant inroads have been made in working together on a number of initiatives. Some of the initiatives were a result of a combined clinical leadership forum which identified a range of issues restricting integrated care. Prior to this, integration occurred on specific projects but did not take the overall planned approach this new committee has embarked upon.

There has also been a little movement in recognising the need for nurse practitioners. Significant progress has been made in developing a case for a nurse practitioner in aged care. What's more, the difficulty in accessing GP services is creating an increased awareness about the potential utilisation of the nursing workforce. Given the successes to date it is hopeful some of the objectives identified in the Primary Health Care Strategy might finally be realised.

References

Abayomi, B. (2011). *Disruptive innovations at the bottom of the pyramid. Can they impact the sustainability of today's top companies?* Unpublished master's thesis for master's degree. Netherlands: Tilburg University.

Abel, S., Gibson, D., Ehau, T., & Tipene Leach, D. (2005). Implementing the Primary Health Care Strategy: A Māori health provider perspective. *Social Policy Journal of New Zealand, 25*, 70-87. Retrieved from http://www.msd.govt.nz/aboutmsdandourwork/publicationsresources/journals-and-magazines/social-policy-journal/spj25/implementing-the-primary-health-care-strategy25-pages70-87.html

Adam, B. (2003). The challenges of running a District Health Board. In R. Gauld (Ed.), *Continuity amid chaos. Health care management and delivery in New Zealand* (pp.27-48). Dunedin: University of Otago Press.

Adamson, M., Willacy, S., Ewart, J., Williams, D., Mather, K., Dymock, R., Kay, N., & Robertson, H. (2005). *Research report on potential career pathways and preferred leadership structures for nurses in the primary health sector of the Tairawhiti District Health Board region.* Unpublished report. Gisborne, Tairawhiti District Health.

Adkins, L. (2002). Reflexivity and the politics of qualitative research. In T. May (Ed.), *Qualitative research in action* (pp.332-348). London: Sage Publications.

Aiken, L. (2011). Nursing: Saving lives, improving patient care outcomes. In A. S. Hinshaw & P. A. Grady (Eds.), *Shaping health policy through nursing research* (pp.215-229). New York: Springer Publishing Co.

Akenroye, T O. (2012). Factors influencing innovation in healthcare**:** A conceptual synthesis. *Innovation Journal, 17*(2), 1-21.

Alexander, I. M. (2004). Characteristics of and problems with primary care interactions experienced by an ethnically diverse group of women. *Journal of the American Academy of nurse practitioners, 16*(7), 300-310.

Alford, K. (2005). *Discussion paper no 1. Comparing Australian with Canadian and New Zealand primary health care systems in relation to indigenous populations. Literature review and analysis.* Melbourne: Onemda Victoria Koori Health Unit.

Allsop, J. (2006). Medical dominance in a changing world: The UK case. *Health Sociology Review, 15*(5), 444-457.

Appignanesi, R., Garratt, G., Sardar, Z., & Curry, P. (2004). *Introducing postmodernism.* Royston: Icon Books Ltd.

Arford, P. H. (2005). Nurse-physician communication: An organisational accountability. *Nursing Economics, 23*(2), 72-77.

Arroll, T., Kenealy, H., Docherty, B., Scott, D., Scragg, R., & Simmons, D. (2004). Diabetes care: Practice nurse roles, attitudes and concerns. *Journal of Advanced Nursing, 48*(1), 68-75.

Ashton, T., & Tenbensel, T. (2010). Reform and re-reform of the New Zealand system. In G. H. Okama Kieke (Ed.), *Six countries, six reform models* (pp.83-110). Singapore: Word scientific.

Attree, M. (2005). Nursing agency and governance: Registered nurse's perceptions. *Journal of Nursing Management, 13*, 387-396.

Bailey, P., Jones, L., & Way, D. (2006). Family physician/nurse practitioner: Stories of collaboration. *Journal of Advanced Nursing, 53*(4), 381-391.

Baker Laughlin, C., & Beisel, M. (2010). Evolution of the chronic care role of the registered nurse in primary care. *Nursing Economics, 28*(6), 409-414.

Bamford-Wade, A., & Moss, C. (2010). Transformational leadership and shared governance: An action study. *Journal of Nursing Management, 18*(7), 815-821.

Barbour, R. (2007). *Doing focus groups.* Thousand Oaks: Sage Publications Ltd.

Barnett, R., & Barnett, P. (2001). Primary health care in New Zealand: Problems and policy approaches. *Social Policy Journal of New Zealand 21*, 49-66. Retrieved from http://www.msd.govt.nz/aboutmsdandourwork/publicationsresources/journalsandmagazines/social=policyjournal/SPJ21/21-primary-.

Barnett, R., & Barnett, P. (2004a). Primary health care in New Zealand: Problems and policy approaches. *Social Policy Journal of New Zealand, 21*, 49-66.

Barnett, P., & Barnett, R. (2004b). Reform and change in health service provision. In P. Davis & K. Dew (Eds.). *Health and society in Aotearoa New Zealand.* (2nd ed.) (pp.178-193). Victoria: Oxford University Press.

Barnhill, D., McKillop, A., & Aspinall, C. (2012). *Nursing Praxis in New Zealand, 28*(2), 27-36.

Bassett, S., & Westmore, K. (2012). How nurse leaders can foster a climate of good governance. *Nursing Management, 19*(5), 22-24.

Batten, L. S. (2008). *'Lady, is this civilisation?' A case study of community participation in a health development programme in Aotearoa New Zealand.* Unpublished doctoral dissertation. Palmerston North: Massey University.

Bauer, J. C. (2010). Nurse practitioners as an underutilized resource for health reform: Evidence-based demonstrations of cost-effectiveness. *Journal of the American Academy of Nurse Practitioners, 22*(4), 228-23.

Baumann, O., & Martignoni, D. (2011). Evaluating the new: The contingent value of a pro-innovation bias. *Schmalenbach Business Review, 63,* 393-415.

Baxter, P., & Jack, S. (2008). Qualitative case study methodology: Study design and implementation for novice researchers. *The Qualitative Report, 13*(4), 544-559.

Berg, B. L., & Lune, H. (2012). *Qualitative research methods for the social sciences* (8th ed.). Boston: Pearson Education Inc.

Berryman, S. N., Palmer, S. P., Kohl, J. E., & Parham, J. S. (2013). Medical home model of patient-centred health care. *MEDSURG Nursing, 22*(3), 166-96.

Blank, R. H. (1994) *New Zealand Health Policy. A comparative study.* Auckland: Oxford University Press.

Block, D. (2013). Disruptive innovation: Contributing to a value-based health care system. *Physician Executive, 39*(5), 46-52.

Blue, I., & Fitzgerald, M. (2002). Interprofessional relations: Case studies of working relationships between registered nurses and general practitioners in rural Australia. *Journal of Clinical Nursing, 11*(3), 314-321.

Boateng, W. (2012). Evaluating the efficacy of focus group discussion (FGD) in qualitative social research. *International Journal of Business and Social Science, 3*(7), 54-57.

Boulton, A. F. (2005). *Provision at the interface: The Māori mental health contracting experience.* Unpublished doctoral dissertation. Palmerston North: Massey University.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, (3)*2, 77-101.

Brown, V. K. (2012). *A qualitative exploration of environmental and relational factors affecting service user involvement from the perspective of community mental health nurses.* Unpublished master's thesis for master's degree. Palmerston North: Massey University.

Buckley, S., McDonald, J., Mason, D., Gerring, Z., Churchward, M., & Cumming, J. (2009). *Report to the Ministry of Health. Nursing services in New Zealand secondary schools.* Wellington: Victoria University.

Buetow, S. (2008). Pay-for-performance in New Zealand primary health care. *Journal of Health Organization and Management, 22*(1), 36-47.

Burns, J., & Scapens, R. W. (2000). Conceptualizing management accounting change: An institutional framework. *Management Accounting Research, 11*(1), 3-25.

Burnes, B. (2004). Kurt Lewin and complexity theories: Back to the future? *Journal of Change Management, 4*(4), 309-325.

Burr, V. (2005). *Social constructionism* (2nd ed.). Sussex: Routledge.

Buttaro, T. M., Trybulski, J., Bailey, P. P., & Sandberg-Cook, J. (2003). *Primary Care. A collaborative practice* (2nd ed.). Missouri: Mosby.

Caldow, J., Bond, C., Ryan, M., Campbell, N., San Miguel, F., & Lee, A. (2006). Treatment of minor illness in primary care: A national survey of patient satisfaction, attitudes and preferences regarding a wider nursing role. *Health Expectations, 10*(1), 30-45.

Calverley, R. (2012). *BSMC: Is there room for me: an exploration of nursing leadership in primary health care*. Unpublished master's thesis for master's degree. Auckland: Massey University.

Cameron, D. M. (2011). *Exploring the process of implementing a smoking cessation intervention in pregnancy training program for midwives.* Unpublished master's thesis for master's degree. Queensland: University of Technology. Retrieved from http://eprints.qut.edu.au/46259/.

Canon, C. J. (2008). The link between nursing discourses and nurses' silence. Implications for a knowledge-based discourse for nursing practice. *Advances in Nursing Science, 31*(4), 296–307.

Carcary, M. (2009). The research audit trail. Enhancing trustworthiness in qualitative inquiry. *The Electronic Journal of Business Research methods, 7*, 11-24. Retrieved from www.ejbrm.co.

Carroll, P., Casswell, S., Huakau, J., Howden-Chapman, P., & Perry, P. (2011). The widening gap: Perceptions of poverty and income inequalities and implications for health and social outcomes. *Social Policy Journal of New Zealand, 37*, 111-122.

Carryer, J. (1997). *A feminist appraisal of the experience of embodied largeness: A challenge for nursing.* Unpublished doctoral dissertation. Palmerston North: Massey University.

Carryer, J. (2004). Nursing participation and governance in primary health organisation development: Or talking primary health care and thinking primary care. *Vision, 12*(4), 4-14.

Carryer, J. (2005). The primary health strategy: Time for a stock take. *College of Nurses Aotearoa (NZ) Inc*. Retrieved from http://www.nurse.org.nz/primary_health/phn_ph_strategy.htm.

Carryer, J. (2011). Collaboration between doctors and nurses. *Journal of Primary Health Care, 3*(1), 77-79.

Carryer, J., Boddy, J., & Budge, C. (2011). Rural nurse to nurse practitioner: An ad hoc process. *Journal of Primary Health Care, 3*(1), 23-29.

Carryer, J., Budge, C., Hansen, C. & Gibbs, K. (2010). Providing and receiving self-management support for chronic illness: Patients' and health practitioners' assessments. *Journal of Primary Health Care, 2*(2), 124-129.

Carryer, J., Dignam, D., Horsburgh, M., Hughes, F., & Martin, J. (1999). *Locating nursing in primary health care. A report for the National Health Committee.* Wellington: National Health Committee.

Carryer, J., Gardner, G., Dunn, S., & Gardner, A. (2007). The capability of nurse practitioners may be diminished by controlling protocols. *Australian Health Review, 31*(1), 108-11.

Carryer, J., Snell, H., Hunt, B., Perry, V. & Blakey, J. (2008). Long-term conditions care in general practice settings: Patient perspectives. *New Zealand Family Physician, 35*(5), 319-323.

Casey, D. (2009). Nurses' perceptions, understanding and experiences of health promotion. *Journal of Clinical Nursing, 16*(6), 1039-1049.

Cassie, J. (2005). *Duties and Liabilities, Crown Entities Act 2004.* Wellington: New Zealand Law Society.

Cavusoglu, H., Hu, N., Li, Y., & Ma, D. (2010). Information technology diffusion with influentials, imitators and opponents. *Journal of Management Information Systems, 22*(2), 305-334.

CBG Health Research Ltd (2005a). *Care Plus Process Report.* Retrieved from http:/www.moh.govt.nz/moh.nsf/0/497267FEBFE21E91CC256F1E0082FC53/$File/CarePlusProcessReport.doc

CBG Health Research Ltd. (2005b). *Improving access to primary health care: An evaluation of 35 reducing inequalities projects. Overview prepared for the Ministry of Health*. Wellington: Ministry of Health.

CBG Health Research Ltd. (2006). *Review of the implementation of Care Plus.* Wellington: Ministry of Health.

Checkland, K., Harrison, S., McDonald, R., Grant, S., Campbell, S., & Guthrie, B. (2008). Biomedicine, holism and general medical practice: Responses to the 2004 general practitioner contract. *Sociology of Health and Illness, 30*(5), 788-803.

Chiarella, M., & McInnes, E. (2010). Who to turn to? 'Knowing the ropes' in an unbounded health care system. *Contemporary Nurse, 36*(1-2), 10-20.

Chreim, S., Williams, B. E., Janz, L., & Dastmalchian, A. (2010). Change agency in primary health care context: The case of distributed leadership. *Health Care Manager Review, 35*(2), 187-189.

Christianson, T., Laegreid, P., Roness, P. G., & Rovik, K. A. (2007). *Organisation theory and the public sector. Instrument, culture and myth.* London: Routledge.

Cioffi, J., Wilkes, L., Cumming, J., Warne, B., & Harrison, K. (2010). Multidisciplinary teams caring for clients with chronic conditions: Experiences of community nurses and allied health professionals. *Contemporary Nurse, 16*(1-2), 61-70.

Clarke, J. (2004). Public health nursing in Ireland: A critical overview. *Public Health Nursing, 21*(2), 191-198.

Controller and Auditors-General of New Zealand. (2008). *Ministry of Health: Monitoring the progress of the Primary Health Care Strategy*. Retrieved from http://www.oag.govt.nz/2008/primary-health.

Cooney, A. (2011). Rigour and grounded theory. *Nurse Researcher, 18*(4), 17-22.

Cooper, J. M., Loeb, S. J., Smith, C. A. (2010). The primary care nurse practitioner and cancer survivorship care. *Journal of the American Academy of Nurse Practitioners, 22*(8), 394-402.

Cordery, C. J, (2008). *Dimensions of accountability: Voices from New Zealand primary health organisations*. Wellington: Victoria University of Wellington.

Costley, C., Elliott, G. C., & Gibbs, P. (2010). *Doing work based research: Approaches to enquiry for insider-researchers.* London: Sage Publications.

Courvisanos, J. (2009). Political aspects of innovation. *Research Policy, 38*, 1117–1124.

Crampton, P. (2001) Policies for general practice. In P. Davis & T. Ashton (Eds.). *Health and public policy in New Zealand* (pp.201-218). Auckland: Oxford University Press.

Crampton, P., Hoek, J., & Beaglehole, R. (2011). Leadership for health: Developing a canny nanny state. *The New Zealand medical Journal, 124*(1329), 66 -72.

Crampton, P., Salmond, C., & Kirkpatrick, R. (2004). *Degrees of deprivation in New Zealand. An atlas of socioeconomic difference* (2nd ed.). Auckland: David Bateman Ltd.

Crampton, P., Sutton, F., & Foley, J. (2002). Capitation funding for primary care services: Principles and prospects. *New Zealand Medical Journal, 115* (1155). Retrieved from http://journal.nzma.org.nz/journal/115-1155/43/content.pdf.

Creswell, J. W. (2007). *Qualitative inquiry & research design. Choosing among five approaches* (2nd ed.). California: Sage Publications.

Creswell, J. W. (2009). *Research design* (3rd ed.). United Kingdom: Sage Publishers.

Crotty, M. (1998). *The foundations of social research. Meaning and perspective in the research process.* New South Wales: Allen & Unwin.

Cucciniello, M., & Nasi, G. (2014). Evaluation of the impacts of innovation in the health care sector: A comparative analysis. *Public Management Review, 16*(1), 90-116.

Cumming, J. (2011). Integrated care in New Zealand. *International Journal of Integrated Care*, (Spec 10th Anniversary Edition), *11*, e138. Retrieved from http:///www.ijic.org/index.php/ijic/article/viewURN%3ANBN%3ANL%3AUI%3A10-1-101655/1496.

Cumming, J., & Gribben, B. (2007). *Evaluation of the Primary Health Care Strategy practice data analysis 2001-2005.* Health services Research Centre/CGB Health Research Limited.

Cumming, J., & Mays, N. (2002). Reform and counter reform: How sustainable is New Zealand's latest health system restructuring? *Journal of Health Services Research and Policy, 7*(1), 46-55.

Cumming, J., Raymont, A., Gribben, B., Horsburgh, M., Kent, B., Mc Donald, J., Mays, N., & Smith, J. (2005). *Evaluation of the implementation and intermediate outcomes of the Primary Health Care Strategy: First report May 2005.* Health Services Research Centre, Victoria University of Wellington. Retrieved from http://www.victoria.ac.nz/sog/researchcentres/health-services-research-centre/docs/reports/downloads/FINAL-Overview-27-May.pdf.

Cutcliffe, J. R., & Wieck, K. L. (2008). Salvation or damnation: Deconstructing nursing's aspirations to professional status. *Journal of Nursing Management, 16*(5), 499-507.

Damanpour, F., Walker, R. M., & Avellaneda, C. N. (2009). Combinative effects of innovation types and organizational performance: A longitudinal study of service organizations. *Journal of Management Studies, 46*(4), 650-675.

Daniels, N. (2004). Justice, health, and healthcare. In T. A. Shannon (Ed.), *Healthcare policy. A reader* (pp.1-25). Oxford: Rowman & Littlefield Publishers Inc.

Davidson, C., & Tolich, M. (Eds.). (2001). *Social science research in New Zealand. Many paths to understanding*. Auckland: Longman.

Davies, H. T. O., Nutley, S. M., & Mannion, R. (2000). Organisational culture and quality of health care. *Quality in Health Care, 9*, 111-119.

Day, E. F. (2011). *Within the current primary health system how easy is it for registered nurses employed by Māori health care providers to work in a holistic way with people who have type 11 diabetes*. Unpublished master's thesis for master's degree. Dunedin: Otago University.

Dearing, J. W. (2009). Applying diffusion of innovation theory to intervention development. *Research on Social Work Practice, 19*(5), 503-518.

Denzin, N. K., & Lincoln, Y. S. (Eds.). (2003). *Collecting and interpreting qualitative materials*. London: Sage Publications.

Denzin N. K., & Lincoln, Y. S. (2005). *The Sage handbook of qualitative research.* (3rd ed.). Thousand Oaks: Sage Publications.

Denzin N. K., & Lincoln, Y. S. (Eds.). (2008). *Collecting and interpreting qualitative materials.* Thousand Oaks: Sage Publications.

Department of Health. (1987). *The practice nurse subsidy scheme: Report of the working party*. Author: Wellington.

Devlin, N., Maynard, A., & Mays, N. (2001). New Zealand's new health sector reforms: Back to the future? *British Medical Journal, 322*(7295), 1171-1174. Retrieved from http://www.bmj.com/content/322/7295/1171full.

Diaski, I. (2004). Changing nurse's dis-empowering relationship patterns. *Journal of Advanced Nursing, 48*(1), 43-50.

Diaz, D. (2007). *Diffusion of innovation: Factors promoting interest in solar photovoltaic generation systems within air force installations.* Unpublished master's thesis for master's degree. Ohio: Department of Air Force Air University, Air Force Institute of Technology.

Dickson, C. A. W., & Coulter Smith, M. A. (2013). Time for change in community nursing? A critique of the implementation of the review of nursing in the community across NHS Scotland. *Journal of Nursing Management, 21*, 339-350.

Dierick-van Daele, A. T. M., Metsemakers, J. F. M., Derckx, E. W. C. C., Spreeuwenberg, C., & Vrijhoef, H. J. M. (2009). Nurse practitioners substituting for general practitioners: Randomized controlled trial**.** *Journal of Advanced Nursing, 65*(2), 391-401.

District Health Boards New Zealand (DHBNZ). (2005). *PHO Performance Management. Data definitions for Performance Pre requisites and Indicators*. Wellington: Author.

District Health Boards New Zealand (DHBNZ). (2009). *Primary health care strategy implementation work programme. Toolkit for change*. Wellington: Author.

Docherty, B. (2004). Nursing participation and governance in primary health organisation or talking primary health care, thinking primary care: Commentary 1. *Vision EIT, 12*(1), 10-11.

Docherty, B., Sheridan, N., & Kenealy, T. (2008). Painting a new picture for practice nurses in a capitated environment: Who holds the brush? *The New Zealand Medical Journal, l21*(1284), 11-14.

Donovan, D. J., Diers, D., & Carryer, J. (2012). Perceptions in policy and political leadership in nursing in New Zealand. *Nursing Praxis in New Zealand, 28*(2), 15-25.

Dovey, S., Tilyard, M., Cunningham, W., & Williamson, M. (2011). Public and private funding of general practice services for children and adolescents in New Zealand. *Social Policy, 103*, 24-30.

Durie, M. H. (1998). *Whaiora: Maori health development* (2nd ed.). Auckland: Oxford University Press.

Durie, M. H. (2005, May). *Indigenous health reforms: Best health outcomes for Maori in New Zealand.* Paper presented at Alberta's Symposium on Health. Alberta, Canada.

Dwyer, S. C. & Buckle, J. L. (2009). The space between: On being an insider-outsider in qualitative research. *International Journal of Qualitative Methods, 8*(1), 54-63.

Eggleton, K., & Kenealy, T. (2009). What makes Care plus effective in a provincial Primary Health organisation? Perceptions of primary care workers. *Journal of Primary Health Care, 1*(5), 190-197.

Expert Advisory Group on Primary Health Care Nursing. (2003). *Investing in health: Whakatohutia te oranga tangata. A framework for activating primary health care nursing in New Zealand. Report to the Ministry of Health from the expert advisory group on primary health care nursing.* Wellington: Ministry of Health.

Ezzy, D. (2002). *Qualitative analysis: Practice and innovation*. New South Wales: Allen & Unwin.

Fade, S. A. (2003). Communicating and judging the quality of qualitative research: The need for a new language. *Journal of Human Nutrition & Dietetics, 16*(3), 139-149.

Fagin, L., & Garelick, A. (2004). The doctor-nurse relationship. *Advances in Psychiatric Treatment, 10*, 277-286.

Farrell, G. A. (2001). From tall poppies to squashed weeds: Why don't nurses pull together more? *Journal of Advanced Nursing, 35*, 26-33.

Fendler, L. (2006). Why generalisability is not generalisable. *Journal of Philosophy of Education, 40*(4), 437-449.

Finch, H., & Lewis, J. (2003). Focus groups. In J. Ritchie & J. Lewis (Eds.), *Qualitative research practice. A guide for social science students and researchers* (pp.170-198). London: Sage Publications.

Finlayson, M. (2001). Policy implementation and modification in P. Davis & T. Ashton (Eds.), *Health and public policy in New Zealand* (pp.59-180). Auckland: Oxford University Press.

Finlayson, M., Sheridan, N., & Cumming, J. (2009). *Nursing development in primary health care 2001-2007.* Wellington: Health Services Research Centre.

Finlayson, M., Sheridan, N., Cumming, J., & Fowler, S. (2011). The impact of funding changes on the implementation of primary health care policy. *Primary Health Care Research and Development, 13*(2*), 120-129.*

Fleuren, M., Wiefferink, K., & Paulussen, T. (2004). Determinants of innovation within health care organizations. Literature review and Delphi study. *International Journal for Quality in Health Care, 16*(2), 107–123.

Flinter, M. (2012). From new nurse practitioner to primary care provider: Bridging the transition through FQHC-based residency training. *The Online Journal of Issues in Nursing (OJIN), 17*(1) Retrieved from http://ana.nursingworld.org/MainMenuCategories/ANAMarketplace/Periodicals/OJIN/TableofContents/Vol-172012/No1Jan2012/ArticlesPrevious-Topics/From-New-Nurse-Practitioner-to-Primary-Care-Provider.aspx.

Flyvbjerg, B. (2004). Five misunderstandings about case-study research. In G. Seale, G. Gobo, J. F. Gubrium & D. Silverman (Eds.), *Qualitative research practice* (pp.420-434). London: Sage Publications.

Foucault, M. (1977). *Discipline and punish: The birth of the prison.* Translated from the French by Alan Sheridan. New York: Pantheon Books.

Foxon, T., & Pearson, P. (2008). Overcoming barriers to innovation and diffusion of cleaner technologies: Some features of a sustainable innovation policy regime. *Journal of Cleaner Production, 16*(1), 148-161.

French, S. (2004). Challenges to developing and providing nursing leadership. *Nursing leadership, 17*(4), 37-40.

Frieden. T. R. (2010). A Framework for public health action: The health impact pyramid. *American Journal of Public Health, 100*(4) 590-595.

Furedi, F. (2006). Symposium: The American way of medicalisation. The end of professional dominance. *Society, 43*(6), 14-18.

Gardner, A., Hase, S., Gardner, G., Dunn, S. V., & Carryer, J. (2006). From competence to capability: A study of nurse practitioners in clinical practice. *Journal of Clinical Nursing* (Online early articles). Doi:1.1111/j.1365-2702.01880.x.

Gauld, R. (2001). *Revolving doors, New Zealand's health reforms.* Wellington: Victoria University.

Gauld, R. (2005). Delivering democracy? An analysis of New Zealand's District Health Board elections, 2001 and 2004. *Australian Health Review, 29*(3), 345-52.

Gauld, R. (2008). Report from the field. The unintended consequences of New Zealand's primary health care reforms. *Journal of Health, Politics Policy and Law, 33*(1), 93-114.

Gauld, R. (2009a). *Revolving doors, New Zealand's health reforms-the continuing saga (*2nd ed.). Wellington: Victoria University.

Gauld, R. (2009b). *The new health policy.* Berkshire: Open University Press.

Gauld, R. (2012). New Zealand's post-2008 health system reforms: Toward re-centralization of organizational arrangements. *Health Policy, 106*(2), 110-113.

Gauld, R., & Mays, N. (2006). Reforming primary care. Are New Zealand's new primary health organisations fit for purpose? *British Medical Journal, 333,* 1216-1218.

Gianiodis, P. T., Ettlie, J. E., & Urbina, J. J. (2014). Open service innovations in the global banking industry: Inside-out versus outside-in strategies. *The Academy of Management Perspectives, 28*(1), 76-91.

Goldman, N. (2001). Social inequalities in health. *Annals of New York Academy of Science, 954*(1), 118-139.

Gollop, R., Whitby, E., Buchanan, D., & Ketley, D. (2004). Influencing sceptical staff to become supporters of service improvement: A qualitative study of doctors' and managers' views. *Quality Safety Health Care, 13,* 108-114.

Goodyear-Smith, F., & Janes, R. (2008). New Zealand rural health care workforce in 2005: More than just a doctor shortage. *Australian Journal of Rural Health, 16*(1), 40-46.

Gough, P., & Richards, J. (1998). The political and policy context. In G. Elwyn & J. Smail (Eds.), *Integrated teams in primary care* (pp.27-36). Milton Keynes: Radcliffe Press.

Govindarajan, V., Kopalle, P. K., & Danneels, E. (2011). The effects of mainstream and emerging customer orientations on radical and disruptive innovations. *Journal of Product Innovation Management, 1*, 121-132.

Graham, H., & Power, C. (2004). Childhood disadvantage and health inequalities: A framework for policy based on lifecourse research. *Child: Care, Health and Development, 30*(6), 671-678.

Grbich, C. (2007). *Qualitative data analysis. An introduction.* London: Sage Publications.

Greenhalgh, T., Robert, G., Bate, P., Macfarlane, F., & Kyriakidou, O. (2004). Diffusion of innovations in health service organisations: Systemic review and recommendations. *The Milbank Quarterly, 82*(4), 581-629.

Greenhalgh, T., Robert, G., Bate, P., Macfarlane, F., & Kyriakidou, O. (2005). *Diffusion of innovations in health service organisations. A systematic literature review*. London: Blackwell Publishing Ltd.

Griffin, M., & Melby, V. (2006). Developing an advanced nurse practitioner service in emergency care: Attitudes of nurses and doctors. *Nursing and Healthcare Management and Policy, 56*(3), 292-301.

Griffiths, C. (2004). *The case of the hybrid umbrella: A study of case studies*. Occasional paper no 3, School of Foundation Studies, AIS St Helens, Auckland, New Zealand. Retrieved from http://www.crie.org.nz/research_paper/C.Griffiths_po3pdf.

Grimshaw, J. M., Eccles, M. P., Greener, J., Maclennan, G., Ibbotson, T., Kahan, J. P., & Sullivan, F. (2006). Is the involvement of opinion leaders in the implementation of research findings a feasible strategy. *Implementation Science.* Published online. Retrieved from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1436013/.

Guba, E. G. & Lincoln, Y. S. (1989). *Fourth generation evaluation.* New York: Sage Publications.

Hain, D. J., & Sandy, D. (2013). Partners in care: Patient empowerment through shared decision-making. *Nephrology Nursing Journ*al, *40*(2), 153-157.

Halcomb, E. J., Patterson, E., & Davidson P. M. (2006). Nursing and healthcare management and policy. *Journal of Advanced Nursing*, (Online Early articles). Retrieved from http://www.blackwell-synergy.com.ezproxy.massey.ac.nz/ doi:10.1111/j.1365-2648.

Hamer, S. (2010). Developing an innovation ecosystem: A framework for accelerating knowledge transfer. *Journal of Management and Marketing in Healthcare, 3*(4), 248-355.

Hancock, D. R., & Algozzine, B. (2006). *Doing case study research. A practical guide for beginning researchers.* New York: Teachers College Press.

Hansson, A., Arvemo, T., Marklund, B., Gedda, B., & Mattsson, B. (2009). Working together – primary care doctors and nurse's attitude to collaboration. *Scandinavian Journal of Public Health, 38*(1), 78-85.

Hansson, A., Friberg, F., Segesten, K., Gedda, B., & Mattsson, B. (2008). Two sides of the coin - general practitioners' experience of working in multidisciplinary teams. *Journal of Interprofessional Care. 22*(1), 5-16.

Harper, D. (2012). Choosing a qualitative research method. In D. Harper & A. R. Thompson, *Qualitative research methods in mental health and psychotherapy. A guide for students and practitioners* (pp.83-98). West Sussex: Wiley Blackwell.

Harrington, S. (2011). Mentoring new nurse practitioners to accelerate their development as primary care providers: A literature review. *Journal of the American Academy of Nurse Practitioners, 2*(3), 168–174.

Harvey, C. (2011). Legislative hegemony and nurse practitioner practice in rural and remote Australia. *Health Sociology Review, 20*(3), 269-280.

Harvey, T. R., & Broyles, E. A. (2010). *Resistance to change. A guide to harnessing its positive power*. Maryland: Rowman & Littlefield Publications Inc.

Hayes, J. (2007). *The theory and practice of change management* (2nd ed.). Hampshire: Palgrave-MacMillan.

Hays, D. G., & Sing, A. A. (2012). *Qualitative inquiry in clinical and educational Settings*. New York: Guilford Press.

Health Workforce Advisory Committee. (2005). *Strategic principles or workforce development in New Zealand.* Author. Retrieved from http://www.hwac.govt.nz/Publications/workforce-Strategicframework.htm.

Hefford, M., Crampton, P., & Foley, J. (2005). Reducing health disparities through primary care reform: The New Zealand experiment. *Health Policy*, *72*(1), 9-23.

Hefford, M., Cumming, J., Finlayson, M., Raymont, A., Love, T., & van Essen, E. (2010). *Practice nurse cost benefit analysis: Report to the Ministry of Health*. Wellington: LECG.

Hennink, M. M. (2007). *International focus group research. A handbook for the health and social sciences*. Cambridge: Cambridge University Press.

Heshmat, S. (2001). *An overview of managerial economics in the health care system.* New York: Delmar Thomson Learning.

Higgins, A. (2008). Collaboration to improve health provision: Advancing nursing practice and interdisciplinary relationships. In J. Ross (Ed.), *Rural aspects of nursing* (pp.215-224). Dunedin: Rural Health Opportunities.

Hippeli, F. (2009). Nursing: Does it still eat its young, or have we progressed beyond this? *Nursing Forum, 44*(3), 186-188.

Hoare, K. J., Mills, J., & Francis, K. (2011). The role of government policy in supporting nurse-led care in general practice in the United Kingdom, New Zealand and Australia: An adapted realist review. *Journal of Advanced Nursing*, *68*(5), 963-980.

Hodder, I. (1994). The interpretation of documents and material culture. In N. K. Denzin, & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (pp.393-402). Thousand Oakes: Sage Publications.

Holdaway, M. A. (2002). *A Maori model of primary health care nursing*. Unpublished doctoral dissertation. Palmerston North: Massey University.

Holloway, I., & Wheeler, S. (2010). *Qualitative research in nursing and health care* (3rd ed.). East Sussex: Wiley-Blackwell.

Holstein, J. A., & Gubrium. J. F. (2008). The constructionist mosaic. In J. F. Gubrium & J. A. Holstein (Eds.), *Handbook of constructionist research* (pp.3-12). New York: Guilford Press.

Howden-Chapman, P. (1999). Socio-economic inequalities and health. In P. Davis & K. Dew (Eds.), *Health and society in Aotearoa New Zealand*, (2nd ed.) (pp.68-82). Auckland: Oxford University Press.

Howden-Chapman, P. (2005). Unequal socio-economic determinants, unequal health. In K. Dew & P. Davis (Eds.), *Health and society in Aotearoa New Zealand* (2nd ed.) (pp.51-68). Victoria: Oxford University Press.

Howe, A. (2000). Primary care education for the NHS: a discussion paper. *Medical Education, 34*(5), 385-390.

Hughes, A. (2010). The challenge of contributing to policy making in primary care: The gendered experiences and strategies of nurses. *Sociology of Health and Illness, 32*(7), 977-992.

Hughes, F. (2006). Nurses at the forefront of innovation. *International Nursing Review 53*(2), 94-101.

Hutchinson, M., Vickers, M. H., Wilkes, L., & Jackson, D. (2010). A typology of bullying: The experiences of Australian nurses. *Journal of Clinical Nursing, 19*, 2319-2328.

Hwang, J., & Christensen, C. M. (2008). Disruptive innovation in health care delivery: A framework for business-model innovation. *Health Affairs, 27*(5), 1329-1335.

International Council of Nurses. (2008a). *Nursing perspectives and contribution to primary health care.* Retrieved from http://www.icn.ch/images/stories/documents/ICN/publications/ind/2008phc.pdf.

International Council of Nurses (2008b). *Delivering quality, serving communities: Nurses leading primary health care*. Retrieved from http://www.icn.ch/images/publications//2008_delivery_quality_servingcommunities_nurses_leading_primary_health_care.

Institute of Rural Health. (2004). *Identifying training and support services required to encourage rural nurses to become rural PHOs.* New Zealand: Author.

Jacobs, K. (2006). Discourse analysis and its utility for urban policy research urban policy and research. *Urban Policy and Research, 24*(1), 39-52.

Jerden, L., Hillervik, C., Hansson, A., Flacking, R. & Weinehall, L. (2006). Experiences of Swedish community health nurses working with health promotion and a patient health record. *Scandinavian Journal of Caring Sciences, 20*(4), 448-454.

Johnson, M., & Goyder, E. (2005). Changing roles: Changing responsibilities and changing relationships: An exploration of the impact of a new model for delivering integrated diabetes care in general practice. *Quality in Primary Care, 13*, 85-90.

Jost, S., Bonnell, M., Chacko. S. J., & Parkinson, D. (2010). Integrated primary nursing. A care delivery model for the 21st century knowledge worker. *Nursing Administration Quarterly, 34*(4), 208-216.

Jun, J. S. (2006). *The social construction of public administration. Interpretations and critical perspectives.* New York: State University of New York Press.

Kean, S., & Haycock-Stuart, E. (2011). Understanding the relationship between followers and leaders. *Nursing Management, 18*(8), 31-35.

Keleher, H. (2000). Repeating history? Public and community health nursing in Australia. *Nursing Inquiry, 7*(4), 258-265.

Keleher, H. (2001). Why primary health care offers a more comprehensive approach to tackling health inequities than primary care. *Australian Journal of Primary Health, 7*(2), 57-61.

Kelo, K., Martikainen, M., & Eriksson, E. (2013). Patient education of children and their families: Nurses' Experiences. *Pediatric Nursing, 39*(2), 71-9.

Kenny, A., & Duckett, S. (2003). Educating for rural nursing practice. *Journal of Advanced Nursing, 44*(6), 613–622.

Kent, B., Horsburgh, M., Lay-Yee, R., Davis, P., & Pearson, J. (2005). *Nurses and their work in primary health care: The National primary medical care survey (NatMedCa): 2001/02 Report 9*. Wellington: Ministry of Health.

Kerstetter, K. (2012). Insider, outsider, or somewhere in between: The impact of researchers' identities on the community-based research process. *Journal of Rural Social Sciences, 27*(2), 99-117.

King, M., King, W., Munt, R., & Semmens, F. (2012). The experiences of remote rural and aboriginal health workers who undertook postgraduate diabetes course to improve the health of indigenous Australians. *Contemporary Nurse, 42*(1), 107-117.

Kock, T. (2006). Establishing rigor in qualitative research: The decision trail. *Journal of Advanced Nursing, 53*(1), 91-103.

Larson, A. L. (2000). Sustainable innovation through an entrepreneurship lens. *Business Strategy and the Environment, 9*, 304–317.

Larson, E. N. (2013). Deviants or consenting adults: A human rights approach to defining and controlling deviant behaviour. *Sociology Mind, 1*(1), 1-6.

Laugesen, M. J. & Gauld, R. (2012). *Democratic governance and health. Hospitals, politics and health policy in New Zealand*. Dunedin: Otago University Press.

Laurant, M., Reeves, D., Hermens, R., Braspenning, J., Grol, R., & Sibbald, B. (2005). Substitution of doctors by nurses in primary care. *Cochrane Database of Systematic Reviews, 4*. Retrieved from http://onlinelibrary.wiley.com/o/cochrane/clsysrev/articles/CD001271/sct0.h.

Lawler, J. (1994). *Behind the scenes. Nursing, somology and the problem of the body*. Edinburgh: Churchill Livingstone.

Leeuwis, C. (2011). Rethinking communication in innovation processes: Creating space for change in complex systems. *Journal of Agricultural Education and Extension*, *17*(1), 21-36.

Leonard-Barton, D., & Sinha, D. K. (1993). Developer-user interaction and user satisfaction in internal technology transfer. *Academy of Management Journal, 36*, 1125-1139.

Liamputtong, P. (2011). *Focus group methodology. Principles and practice*. London: Sage Publications Ltd.

Liamputtong, P., & Ezzy, D. (2006). *Qualitative research methods* (2nd ed.). Melbourne: Oxford University Press.

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. California: Sage Publications.

Lindberg, M., Ahlner, J., Ekström, T., Jonsson, D., & Möller, M. (2002). Asthma nurse practice improves outcomes and reduces costs in primary health care**.** *Scandinavian Journal of Caring Sciences, 16*(1), 73-78.

Lindsay, J., Perkins, C., & Karanjikar, M. (2009). *Conquering innovation fatigue. Overcoming the barriers to personal and corporate success.* New Jersey: Wiley & Sons.

Lock, A., & Strong, T. (2010). *Social constructionism. Sources and stirrings in theory and practice*. Cambridge: Cambridge University Press.

Lockett-Kay, J. E. (2005). *Community participation in the establishment of a primary health organisation in the Horowhenua: A longitudinal case study*. Unpublished doctoral dissertation. Palmerston North: Massey University.

Lockhart-Wood, K. (2000). Specialist nursing: Collaboration between nurses and doctors in clinical practice. *British Journal of Nursing, 9*(5), 276-80.

Long, D., Forsyth, R., Ledema, R., & Carroll, K. (2006). The (im)possibilities of clinical democracy. *Health Sociology Review, 15*(5), 506-519.

Long, P. W., Lobley, K., Spurgeon, P. C., Clark, J. C., Balderson, S., & Lonetto, T. M. (2011). The CLCF: Developing leadership capacity and capability in the clinical professions. *The International Journal of Clinical Leadership, 17*, 111-118.

Longino, C. F., & Murphy, J. W. (1995). *The age old challenge to the biomedical model. Paradigm strain and health policy*. New York: Baywood Publishing Company Inc.

Love, T. (2003). Continuing changes in primary care: Issues for independent practice associations and primary health organisations. In R. Gauld (Ed.), *Continuity amid chaos: Health care management and delivery in New Zealand* (pp.68-82). Dunedin: University of Otago Press.

Love, T. (2008). *Evolution in practice: aspects of change and development in New Zealand primary health care.* Wellington: DHBNZ.

McAvoy, B. R., & Coster, G. D. (2005). General practice and New Zealand health reforms-lessons for Australia? *Australia and New Zealand Health Policy, 2*(26) doi10.1186/1743-8462-2-26. Retrieved from http://anzhealthpolicy.com/content/2/1/26.

McCabe, J. L., & Holmes, D. (2009). Reflexivity, critical qualitative research and emancipation: A Foucauldian perspective. *Journal of Advanced Nursing, 65*(7), 1518-1526.

McDonald, S., Willis, G., Fourie, W., & Hedgecock, B. (2009). Graduate nurses' experience of postgraduate education within a nursing entry to practice programme. *Nursing Praxis New Zealand, 25*(3), 17-26.

McElhinney, E. (2010). Factors which influence nurse practitioners ability to carry out physical examination skills in the clinical area after a degree level module - an electronic Delphi study. *Journal of Clinical Nursing, 19*(21-22), 3177-3187.

McGivern, Y. (2006). *The practice of market and social research: An introduction.* New York: Financial Times Prentice Hall.

McKenna, H., & Keeney, S. (2004). Nurse leadership within primary care: The perceptions of community nurses, GP's, policy makers and members of the public. *Nursing Management, 12*(1), 69-76.

McKinlay, E., Clendon, J., & O'Reilly, S. (2012). Is our focus right? Workforce development for primary health care nursing. *Journal of Primary Health Care, 4*(2), 141-149.

McMurray, A. (2007a). *Community health and wellness. A socio-ecological approach.* New South Wales: Mosby/Elsevier.

McMurray, A. (2007b). Leadership in primary health care: An international perspective. *Contemporary Nurse*, *26*(1), 30-36.

McMurray, R. (2011). The struggle to professionalize: An ethnographic account of the occupational position of advanced nurse practitioners. *Human Relations, 64(*6), 801-822.

McMurray, R., & Cheater, F. (2003). Partnerships for health: Expanding the public health nursing role within PCTs. *Primary Health Care Research & Development, 4*(1), 57-68.

McMurray, R., & Cheater, F. (2004). Vision, permission and action: A bottom up perspective on the management of public health nursing. *Journal of Nursing Management, 12*(1), 43-57.

McPake, B., & Normand, C. (2008). *Health economics. An international perspective* (2nd ed.). Oxon: Routledge Taylor & Francis Group.

McPherson, C. M., & McGibbon, E. A. (2010). Rural interprofessional primary health care team development and sustainability: Establishing a research agenda. *Primary Health Care Research & Development, 11*, 301-314.

Madriz, E. (2003). Focus groups in feminist research. In N. K. Denzin & Lincoln, Y. S (Eds.), *Collecting and interpreting qualitative materials* (pp.363-388). California: Sage Publications.

Makinen, H. 2010). *The factors impacting the diffusion of innovation in digitalising accounting.* Unpublished master's thesis for master's degree. Helsinki: Alto University. Retrieved from https://aaltodoc.aalto.fi/bitstream/handle/123456789/423/hse_ethesis_12291.pdf?sequence=1.

Malcolm, L. (2000). Primary care reforms in New Zealand: Key contrasts with Australia. In A. L. Bloom (Ed.), *Health reforms in Australia and New Zealand* (pp. 183-200). Melbourne: Oxford University Press.

Manaia, W. L. (2002). *Change management and Maori health development.* Unpublished doctoral dissertation. Palmerston North: Massey University.

Markides, C. (2006). Disruptive innovation: In need of a better theory. *Journal of Product Innovation Management, 23*, 19-25.

Marshall, B., Floyd, S., & Forrest, R. (2011). Nurses perception of nurse-led healthy lifestyle clinics. *Journal of Primary Health Care, 3*(4), 289-297.

Martin, G. P., Weaver, S., Currie, G., Finn, R., & McDonald, R. (2012). Innovation sustainability in challenging health-care contexts: Embedding clinically led change in routine practice. *Health Service Manage Research, 25*(4), 190-199.

Matheson, D., & Loring, B. (2011). Health inequities are rising unseen in New Zealand. The *New Zealand Medical Journal, 124*(1134), 8-10. Retrieved from Http://www.nzma.org.nz/journal/124-13334/4664/.

Mathias, W. L. (2009). *The shaping of decision-making in governance in the New Zealand public healthcare services.* Unpublished doctoral dissertation. Auckland: Auckland University of Technology.

Mays, N., & Cumming, J. (2004). Experience abroad II: Implementing New Zealand's Primary Health Care Strategy. In R. Wilson, S. E. D. Shortt & J. Dorland (Eds.), *Implementing primary health care reform. Barriers and facilitators* (pp.49-72). Montreal: McGill-Queens University Press.

Mehta, N. (2011). Mind-body dualism: A critique from a health perspective. *Mens Sana Monographs, 9*(1), 202–209.

Millard, L., Hallett, C., & Luker, K. (2006). Nurse-patient interaction and decision making in care: Patient involvement in community nursing. *Journal of Advanced Nursing, 55*(2), 142-150.

Mills, J., & Hallinan, C. (2009). The social world of Australian practice nurses and the influence of medical dominance: An analysis of the literature. *International Journal of Nursing Practice, 15*, 489-494.

Minister of Health (MoH). (2006*). Implementing the New Zealand Health Strategy 2006: The Minister of Health's sixth report on progress on the New Zealand Health Strategy.* Wellington: Ministry of Health.

Minister of Health (MoH). (2009*). Implementing the New Zealand Health Strategy 2009: The Minister of Health's report on progress on implementing the New Zealand Health Strategy, and on actions to improve quality.* Wellington: Ministry of Health.

Ministerial Taskforce on Nursing (1998). *Report of the Ministerial Taskforce on Nursing: Releasing the potential of nursing.* Wellington: Ministry of Health.

Ministry of Health (MoH). (2000). *The New Zealand Health Strategy*. Wellington: Author.

Ministry of Health (MoH). (2000). *Draft MoH Communication Filing 18th December 2000 - Archive 1995-2006.* Unpublished. Wellington: Author.

Ministry of Health (MoH). (2001). *The Primary Health Care Strategy*. Wellington: Author.

Ministry of Health (MoH). (2001). *Primary Health Care Strategy implementation project.* Unpublished. Wellington: Author.

Ministry of Health (MoH). (2002). *Nurse practitioners in New Zealand.* Wellington: Author.

Ministry of Health (MoH). (2003). *Primary health care and community nursing workforce survey-2001*. Wellington: Author.

Ministry of Health (MoH). (2004). *Care Plus: An overview*. Wellington: Author.

Ministry of Health (MoH). (2005). *Evolving models of primary health care nursing practice*. Wellington: Author.

Ministry of Health MoH. (2006). *Health workforce development: An overview.* Wellington: Author.

Ministry of Health (MoH). (2007a). *Governance guide for primary health organisation.* Wellington: Author.

Ministry of Health (MoH). (2007b). *Implementing the New Zealand Health Strategy. The Minister of Health's sixth report on the New Zealand Health Strategy, and the third report in actions to improve quality*. Wellington: Author.

Ministry of Health (MoH). (2009). *Mortality and demographic data 2005.* Wellington: Author.

Ministry of Health (MoH). (2010). *Tatau Kahukura: Māori Health Chart Book 2010, 2nd Edition*. Wellington: Author.

Ministry of Health (MoH). (2011). *Better sooner more convenient health care in the community.* Wellington: Author.

Ministry of Health (MoH). (2012). *Health expenditure trends in New Zealand 2000–2010*. Wellington: Author.

Ministry of Health (MoH), Nursing Council of New Zealand, DHBNZ, & Nurse Practitioner Association New Zealand (NPAC-NZ). (2009). *Nurse practitioners. A healthy future for New Zealand.* Wellington: Author.

Miskelly, P., & Duncan, L. (2013). 'I'm actually being grown up now': Leadership, maturity and professional identify development. *Journal of Nursing Management.* Electronic publication retrieved from: http://pubget.com/paper/23445351/i-m-actually-being-the-grown-up-now-leadership-maturity-and-professional-identity-development.

Mohammed, A. A. (2012). A critique of Descartes' mind-body dualism. *An Online Journal of Philosophy, 6*(1), 95-112. Retrieved from http://eds.b.ebscohost.com/eds/pdfviewer/pdfviewer?sid=746aded9-5c26-45a3-afef-11c749685952%40sessionmgr198&vid=3&hid=101.

Moore, J. (2012). A personal insight into researcher positionality. *Nurse Researcher, 19*(4), 11-4.

Morris, L. (2013). Three dimensions of innovation. *International Management Review, 9*(2), 5-10.

Myles, M. B., & Huberman, A. M. (2004). *An expanded sourcebook. Qualitative data analysis* (2nd ed.). Thousand Oaks California: Sage Publications.

National Health Committee. (2000). *Improving health of New Zealanders by investing in primary health care*. Wellington: Author.

National Health Committee. (2002). *Improving Māori health policy*. Wellington: Author.

Nelson, K. M., Connor, M., & Alcorn, G. (2009). Innovative nursing leadership in youth health. *Nursing Praxis in New Zealand, 25*(1), 27-37.

Nelson, K. M., Wright, T., Connor, M., Buckley, S., & Cumming, J. (2009). Lessons from eleven primary health care nursing innovations in New Zealand. *International Nursing review, 56*(3), 292-298.

New PHO Agreement to support better care in the community (2013). Retrieved from http://www.nationalhealthboard.govt.nz/Newsdesk-May-2013.

Newell, C. (2000). The role of a nursing philosophy in genetics and disability: Reflections on nursing and a philosophy of holism. *Nursing Ethics, 7*(3), 227-236.

Neuwelt, P., & Crampton, P. (2005). Community participation in primary health care in Aotearoa New Zealand. In P. Davis & K. Dew (Eds.), *Health and society in Aotearoa New Zealand* (2nd ed.) (pp.194-210). Victoria: Oxford University Press.

Neuwelt, P., Matheson, D., Arroll, B., Dowell, A., Winnard, D., Crampton, P., Sheridan, N., & Cumming, J. (2009). Putting population health into practice through primary health care. *Journal of New Zealand Medical Association, 122*(1290). Retrieved from http://journal.nzma.org.nz/journal/122-1290/3484/.

New Zealand Nurses Organisation (NZNO). (2011). *Advanced Nursing practice. Position statement.* Retrieved from http://www.nzno.org.nz/LinkClick.aspx?fileticket=3OO5WAuBu4%3d.

New Zealand Nurses Organisation (NZNO) & College of Nurses Aotearoa NZ, (2007). *Investing in Health 2007: An update to the recommendations of the investing in health framework for activation primary health care nursing (2003, Ministry of Health).* Retrieved from http://www.health.govt.nz/our-work/nursing-new-zealand/nursing-resources/nursing-publications/investing-health-2007.

New Zealand Parliament (2009). *New Zealand health system reforms*. Retrieved from http://www.parliament,nz/enNZ/ParlSupport/ResearchPapers/e/d/1/00PLSocRPO903.

Norwood, S. L. (2001). The invisibility of advanced practice nurses in popular magazines. *Journal of the American Academy of nurse practitioners, 13*(3), 129-133.

Nurse Practitioner New Zealand Position Paper-8 November. (2012). *Nurse practitioner identified impediments to practice and strategies for improvement.* Nurse Practitioners New Zealand.

Nursing Council of New Zealand. (2010). *The New Zealand nursing workforce. A profile of nurse practitioners, registered nurses, nurse assistants and enrolled nurses 2010.* Retrieved from http://nursingcouncil.org.nz/Publications/Reports.

Nursing Council of New Zealand. (2011). *The New Zealand nursing workforce. A profile of nurse practitioners, registered nurses and enrolled nurses 2011*. Wellington: Author.

O'Connor, G. T. (1997). Every system is designed to get the results it gets. So taking only one element out of it may not improve anything. *British Medical Journal, 315*(7113), 897-898.

O'Connor, T. (2010). *Productivity: nursing's contribution*. Wellington: New Zealand Nurses Organisation (NZNO).

O'Connor, T. (2012). Primary healthcare - a highly contested area. *Kai Tiaki Nursing New Zealand, 18*(2), 26-27.

O'Donoghue, T. (2007). *Planning your research project. An introduction to interpretivist research in education*. Oxon: Routledge.

O'Dwyer, B. (2004). Qualitative data analysis: Illuminating a process for transforming a 'messy' but 'attractive'' nuisance'. In C. Humphrey & B. H. K. Lee (Eds.), *The real life guide to accounting research: A behind the scenes view of using qualitative research methods* (pp.391-408). London: Elsevier Ltd.

Offredy, M. (2002). Issues and innovations in nursing practice. Decision making in care: Outcome from a study using patient scenarios. *Journal of Advanced Nursing, 40*(5), 532-541.

Olatokun, W. M., & Igbinedion, L. J. (2009). The adoption of automatic teller machines in Nigeria: An application of the theory of diffusion of innovation. *Issues in informing science and information technology, 6.* Retrieved from http:///www.Iisit,org/Vol6/IISITv6p373-39319tokun631.pdf.

Oliver, S., & Peersman, G. (2001). *Using research for effective health promotion*. Philadelphia: Open University Press.

O'Neill, M., & Cowman, S. (2008). Partners in care: Investigating community nurses' understanding of an interdisciplinary team-based approach to primary care. *Journal of Community Nursing, 17*, 3004-3011.

Opalinski, A. (2006). Pouring rights contracts and childhood overweight: A critical theory approach. *Journal of Specialists in Pediatric Nursing, 11*(4), 234-243.

Oren, I. (2006). Political science as history: A reflexive approach. In D. Yanow & P. Schwartz-Shea (Eds.), *Interpretation and method. Empirical research methods and the interpretive turn* (pp.215-227). New York: M. E. Sharpe Inc.

Overcash, J., Petty, L. J., & Brown, S. (2012). Perceptions of shared governance among nurses in a Midwestern hospital. *Nursing Administration Quarterly, 36*(4), E1-E11.

Parker, H., & Glasby J. (2008). Editorial: Transforming community health services: English lessons on not relying on organisational reform. *Health and Social Care in the Community, 16*(5), 449–450.

Patton**,** M. Q. (2002). *Qualitative research & evaluation methods.* Thousand Oaks: Sage Publications.

Pearson, A., Vaughan, B., & Fitzgerald, M. (1997). *Nursing models for practice* (2nd ed.). Oxford: Butterworth Heinemann.

PHCS Implementation Programme. (2009). *Shifting secondary services to more convenient primary care settings. Collected DHB experiences. Summary Report for DHBs.* Retrieved from http://www.phoalliance.org.nz/ wpcontent/uploads/ serviceshifting nationalstocktakedistr-20090407.pdf.

Piji-Zieber, E. M. (2013). Doctor's orders and the language of representation. *Nursing philosophy*, *14*, 139-147.

Pinnacle Group Limited (2010). *Workforce trends – summary of results from the 2009 census of general practitioners, practice nurses and practice management staff in the Midland PHO Network.* Retrieved from http://www. pinnacle .org.nz.

Poghosyan, L., Lucero, R., Rauch, L., & Berkowitz, B. (2012) A nurse practitioner workforce: A substantial supply of primary care providers. *Nursing Economics*, *30*(5), 268-275.

Pohlman, S., Cibulka, N. J., Palmer, J. L., Lorenz, R. A., & SmithBattle, L. (2013). The placebo puzzle: examining the discordant space between biomedical science and illness/healing. *Nursing Inquiry*, *20*(1), 71-81.

Polit, D. F., & Tatano Beck, C. (2006). *Essentials of nursing research. Methods, appraisal and utilization.* Philadelphia: Lippincott Williams & Wilkins.

Primary Health Care Advisory Council (PHCAC), (2009). *Service models to meet the aims of the Primary Health Care Strategy and deliver better, sooner, more convenient primary health care. Discussion paper*. Retrieved from http:///www.moh.govt.nz/moh.nsf/indexmh/phcs-advisory-council.

Primary Health Care Nurse Innovation Evaluation Team. (2007). *The evaluation of the eleven primary health care nursing innovation projects: A report to the Ministry of Health by the Primary Health Care Nurse Innovation Evaluation Team.* Wellington: Ministry of Health.

Pullon, S. (2008). What is the place of general practice within primary health care – in the Aotearoa New Zealand context? *New Zealand Family Physician*, *35*(5), 301-303.

Pullon, S., & Fry, B. (2005). Interprofessional postgraduate education in primary health care: Is it making a difference? *Journal of Interprofessional Care*, *19*(6), 569-578.

Pullon, S., McKinlay, E., Stubbe, M., Todd, L., & Badenhorst, C. (2011). Patients' and health professionals' perception of teamwork in primary care. *Journal of Primary Health Care, 3*(2), 128-135.

Quinn, P. (2009). *New Zealand health system reforms.* Wellington: New Zealand parliamentary library.

Rabinow, P., & Rose, N. (Eds.). (2003). *The essential Foucault. selections from the essential works of Foucault 1954-1984*. New York: The New Press.

Radcliff, M. (2000). Doctors and nurses: New gains, same results. *British Medical Journal, 320.* Retrieved from http://dx.doi.org/10.1136/bmj.320.7241.1085.

Ram, S. (1987). A model of innovation resistance. *Advances in Research, 14*, 208-212.

Ray, E. B. (1987). Supportive relationships and occupational stress in the workplace. In T. L. Albrecht & M. B. Adeknan (Eds.), *Communicating social support* (pp. 172-191). Newbury Park, California: Sage.

Raymont, A., & Cumming, J. (2003). New Zealand's primary health care strategy: What are the costs and how likely are the benefits. *The New Zealand Medical Journal 116*, 1173. Retrieved from http://www.nzma.org.nz/journal/116-1173/415/.

Reay, T., Goodrick, E., Casebeer, A., & Hinings, C. R. (2013). Legitimising new practices in primary health care. *Health Management Review, 38*(1), 9-19.

Reed, P., Conrad, D. A., Hernandez, S. E., Watts, C., & Marcus-Smith. M. (2012). Innovation in patient-centred care: Lessons from a qualitative study of innovative health care organizations in Washington State. *BMC Family Practice, 14*(13), 120-129.

Rhodes, R. M. (2004). *Analysing digital television: Using the diffusion of innovation theory to better inform policy.* Unpublished master's thesis for master's degree Florida: University of Florida.

Roberts, K., & Taylor, B. (2002). *Nursing research processes. An Australian perspective* (2nd ed.). Southbank Victoria: Nelson Thomson Learning.

Robertson, H. (2006). *An impact evaluation: Healthy Messages Calendar (Te Maramataka Korero Hauora).* Unpublished master's thesis for master's degree. Albany: Massey University.

Robertson-Malt, S., & Chapman Y. (2008). Finding the right direction: The importance of open communication in a governance model of nurse management. *Contemporary Nurse: A Journal for the Australian Nursing Profession, 29*(1), 60-6.

Robinson, L. (2009). *A summary of diffusion of innovations.* Retrieved from http://www.enablingchange.co.au/Summary_Diffusion_Theory.

Rogers, E. M. (2003). *Diffusion of innovations* (5th ed.). New York: The Free Press.

Rogers, E. M., & Shoemaker, F. F. (1971). *Communication of innovations. A cross-cultural approach* (2nd ed.). New York: The Free Press.

Rolls, S. (2005). Removing the barriers to nursing education: There are significant barriers to nurses gaining post-registration and post-graduate education. *Kai Tiaki: Nursing New Zealand, 10*(11), 26.

Rowlands, B. (2003). Employing interpretive research to build theory of information systems practice. A/(AMECAN) *Journal of information systems, 10*(2), 3-22.

Royal College of Nursing. (2012). *Going upstream: nursing's contribution to public health. Prevent, promote and protect. RCN guidance for nurses.* Retrieved from www.rcn.org.uk/data/assets/pdf_file/0007/433699/004203.pd

Rubin, H. J., & Rubin, I. S. (2005). *Qualitative interviewing. The art of hearing data* (2nd ed.). Thousand Oaks: Sage Publications.

Ryall, T. (2007). *Better Sooner More Convenient. Health discussion paper.* The Office of the Leader of the Opposition. New Zealand National Party.

Ryan, G. W., & Bernard, H. R. (2003). Data management and analysis methods. In N. K. Denzin & Y. S. Lincoln (Eds.), *Collecting and interpreting qualitative material* (pp.259-309). California: Sage Publications.

Sanson-Fisher, R. W. (2004). Diffusion of innovation theory for clinical change. *Medical Journal Australia, 180*(6), 55-56.

Sarason, S. B. (2004). What we need to know about intervention and interventionists. *American Journal of Community Psychology, 33*(3/4), 275-277.

Sargison, P. A. (2001). *"Essentially a women's work": A history of general nursing in New Zealand, 1830-1930.* Unpublished doctoral dissertation. Dunedin: University of Otago.

Schofield, J. W. (2000). Increasing the generalisability of qualitative work. In R. Gomm, M. Hammersley & P. Foster (Eds.), *Case study method* (pp. 69-97). London: Sage Publications.

Scholz R. W., & Tietje, O. (2002). *Embedded case study methods: Integrating quantitative and qualitative knowledge*. Thousand Oaks: Sage Publications.

Shafique, (M). (2013). Thinking inside the box? Intellectual structure of the knowledge base of innovation research (1988-2008). *Strategic Management Journal, 34*(1), 62-93.

Shalley, C. E., & Gilson, L. L. (2004). What leaders need to know: A review of social and contextual factors that can foster or hinder creativity. *The Leadership Quarterly, 15,* 33-53.

Sheridan, N. F. (2005). *Mapping a new future: Primary health care nursing in New Zealand.* Unpublished doctoral dissertation. Auckland: University of Auckland.

Sheridan, C. L., & Radmacher, S. A. (1992). *Health psychology. Challenging the biomedical model*. Singapore: John Wiley & Sons Inc.

Silverman, D. (2005). *Doing qualitative research* (2nd ed.). London: Sage Publications.

Silverman, D. (2009). *Doing qualitative research. Issues of theory, method and practice* (3rd ed.). London: Sage Publications.

Simons, H. (2009). *Case study research in practice*. London: Sage Publications.

Sloand, E., & Groves, S. (2005). A community-orientated primary care nursing model in an international setting that emphasizes partnerships. *Journal of the American Academy of Nurse Practitioners, 17*(2), 47-50.

Smith, J. (2009). *Critical analysis of the implementation of the Primary Health Care Strategy implementation and framing of issues for the next phase. A paper prepared for the Ministry of Health.* Wellington: Ministry of Health.

Smith, J., & Cumming, J. (2009). *Where next for primary health care organisations in New Zealand?* Retrieved from http://www.health.govt.nz/publications/where-next-primary-health-care- organisations-new-zealand.

Smith, P., & Mackintosh, M. (2007). Profession, market and class migration and the remaking of division and disadvantage. *Journal of Clinical Nursing, 16*(12), 2213-2220.

Smith, J., McDonald, J., & Cumming, J. (2008). *Developing and implementing high impact changes in primary health care in New Zealand. Discussion document prepared for District Health Boards New Zealand.* Wellington: Health Research Centre.

Smollan, R. (2011). Engaging with resistance to change. *University of Auckland Business Review, 3,* 12-15.

Snelgrove, S., & Hughes, D. (2000). Interprofessional relations between doctors and nurses: Perspectives from South Wales. *Journal of Advanced Nursing, 31*(3), 661-667.

Stake, R. (1995). *The art of case study research*. Thousand Oaks: Sage Publications.

Stake, R. (2000). The case study method in social inquiry. In R. Gomm., M. Hammersley & P. Foster (Eds.), *Case study method* (pp.19-26). London: Sage Publications.

Stake, R (2005). *Multiple care study analysis.* New York: The Guilford Press.

Stake, R. (2006). *Multiple case study analysis.* New York: The Guilford Press.

Stake, R. (2010). *Qualitative research: Studying how things wor*k. New York: Guilford Publications.

Stanton, J. (Ed.). (2002). *Innovations in health and medicine. Diffusion and resistance in the twentieth century.* London: Routledge.

Starfield, B. (1978). *Primary care. Reducing health needs, services and technology.* Oxford: Oxford University Press.

Starfield, B. (1998). *Primary Care: Balancing health needs, services, and technology*. New York: Oxford University Press.

Starfield, B. (2006). State of the art in research on equity in health. *Journal of Public Health, 31*(1), 11-32.

Starfield, B., & Mangin, D. (2010). An international perspective on the basis for payment for performance. *Quality in Primary Care, 18*(6), 399-404.

Starfield, B., & Shi, L. (2007). Commentary: Primary care and health outcomes: A health services research challenge. *Health Services Research, 42*(6), 2252-2256.

Statistics New Zealand. (2006). *Census 2006, Gisborne regional community profile.* Retrieved from http://www.stats.govt.nz/Census/2006CensusHomePage/QuickStats/AboutAPlace/SnapShot.aspx?type=region&ParentID=&tab=Housing&id=1000005.

Steven, S. O. (2011). Cartesian Dualism**:** An Evaluation of Wireduan and Gilbert Ryle's Refutations. *An Online Journal of Philosophy, 5(*2), 156-165. Retrieved from http://eds.b.ebscohost.com/eds/detail?vid=2&sid=746aded9-5c2645a3-afef11c749685952%40sessionmgr198&hid=101&bdata=JnNpdGU9ZWRzLWxpdmUmc2NvcGU9c2l0ZQ%3d%3d#db=hlh&AN=74477172.

St John, W., & Shabon, R. (2011). Self-management and professional development in community practice. In W. St John & H. Keleher (Eds.), *Community nursing practice. Theory skills and issues* (pp.333-357). New South Wales: Allen & Unwin.

Streubert-Speziale, H. J., & Carpenter, D. R. (2007). *Qualitative research in nursing. Advancing the humanistic imperative* (4thed.). Philadelphia: Lippincott Williams & Wilkins.

Stufflebeam, A. J., & Shinkfield, D. L. (2007). *Evaluation theory, models, and application.* San Francisco: Jossey-Bass.

Sweet, M. (2010). Revolution the challenging journey. *Australian Nursing Journal, 18*(5), 26-29.

Szabo, M. (2002, June). *Educational reform as an innovation diffusion: Using continuing professional development and instructional technology*. Canadian paper presented at Informing Science Cork Ireland. Retrieved from http://www.quasar.ualberta.cq/IT/research/Szabo/Szabo-educa.pdf.

Tairawhiti District Health (TDH). (2002, 24th May). *Tairawhiti District Health Community and Public Health Advisory Committee (CPHAC) minutes*. Gisborne: Author.

Tairawhiti District Health (TDH). (2002, 28th November). *Tairawhiti District Health Community and Public Health Advisory Committee (CPHAC) minutes*. Gisborne: Author.

Tairawhiti District Health (TDH). *Tairawhiti District Health Board District Annual Plan 2002-2003.* Gisborne: Author.

Tairawhiti District Health (TDH). (2003, 28th March). *Tairawhiti District Health Community and Public Health Advisory Committee (CPHAC) minutes.* Gisborne: Author.

Tairawhiti District Health (TDH). (2003, 28th November). *Tairawhiti District Health Board Minutes*. Gisborne: Author.

Tairawhiti District Health (TDH). (2004, 27th February). *Tairawhiti District Health Board Minutes.* Gisborne: Author.

Tairawhiti District Health (TDH). *Tairawhiti District Health Board District Annual Plan 2004-2005*. Gisborne: Author.

Tairawhiti District Health (TDH). *Tairawhiti District Health Board District Annual Plan 2005-2006*. Gisborne: Author.

Tairawhiti District Health (TDH). (2007, 21st August). *Tairawhiti District Health Board Minutes*. Gisborne: Author.

Tairawhiti District Health. *District Annual Plan for the te Tairawhiti district. Hauora titiro whakamua health looking forward 2007-2008. E tipu e rea: Grow up o tender shoot*. Gisborne: Author.

Tairawhiti District Health (TDH). (2011). *Tairawhiti District Health Annual Plan 2114*. Gisborne: Author. Retrieved from http://www.tdh.org.nz/assets/Documents/TDH-AP-June-Final.pdf.

Tairawhiti District Health (TDH). (2012). *Tairawhiti District Health Māori Health Plan 2012-13. He pou tuarā mo te oranga o Te Tairawhiti. A plan to support and sustain the good health of Māori in Te Tairawhiti*. Retrieved from http://www.tdh.org.nz/assets/Documents/Reviews-and-plans/TDH-Maori-Health-Plan-2012-2013-Final.pdf.

Tarde, G. (1962). *The laws of imitation. Translated from the 2nd French edition by Elsie Clews Parsons with an introduction by Franklin H. Giddens*. Gloucester: Henry Holt & Company.

Taylor, R. (2009). Leadership theories and the development of nurses in primary health care. *Primary Health Care, 19*(9), 40-46.

Temmnink, D., Francke, A. L., Hutten, J. B. F., van der Zee, J., & Abu Saad, H. H. (2000). Innovations in the nursing care of the chronically ill: A literature review from an international perspective. *Journal of Advanced Nursing, 31*(6), 1449-1458.

The Treasury. (2009). *Guidelines for contracting with non-government organisations for services sought by the Crown*. Wellington: The Treasury Kaitohutohu Kaupapa Rawa.

Thomas, P. (2006). *Integrating primary health care: Leading, managing, facilitating*. Abingdon: Radcliffe.

Thomas, E., & Magilvy, J. K. (2011). Qualitative rigor or research validity in qualitative research. *Journal for Specialists in Pediatric Nursing, 16*(2011), 151–155.

Thomas, L. M., Reynolds, T., & O'Brian, l. (2006). Innovation and change: Shaping district nursing services to meet the needs of primary health care. *Journal of Nursing Management, 14*, 447-454.

Thomond, P. & Lettice, F. (2002, July). *Disruptive innovation explored.* Paper presented at 9th International Society for Productivity Enhancement (IPSE) International Conference on Concurrent Engineering. Alberta's Symposium on Health. Cranfield, United Kingdom.

Thompson, L. E. (2006). *Profession and place: Contesting professional boundaries at the margins.* Unpublished doctoral dissertation. Christchurch: University of Canterbury.

Thompson, A. R., & Harper, D. (2012). Introduction. In D. Harper, & A .R. Thompson (Ed.), *Qualitative research methods in mental health and psychotherapy. A guide for students and practitioner* (pp.1-8). West Sussex: Wiley Blackwell.

Thrasher, C. (2002). The primary health care nurse practitioner: Advocate for self-care. *Journal of American Academy of Nurse practitioners, 14*(3), 113-117.

Timmins, N. (2008). When politicians turn to history it is usually to justify their policies rather than to learn real lessons-much to historians' irritation. *Nursing Standard, 22*(17), 22-24.

Tobias, M., & Yeh, L. (2009). How much does health care contribute to health gain and to health inequality? Trends in amenable mortality in New Zealand 1981-2004. *Australian and New Zealand Journal of Public Health, 33*(1), 70-78.

Tobin, G. A., & Begley, C. M. (2004). Methodological rigour within a qualitative framework. *Journal of Advanced Nursing, 48*(4), 388–396.

Tochel, C., Haig, A., Hesketh, A., Cadzow, A., Beggs, K., Colthart, I., & Peacock, H. (2009). The effectiveness of portfolios for post-graduate assessment and education: BEME Guide No 12. *Medical Teacher, 31*(4): 320-39.

Tom, A. (2012). What is social constructionism? *The Grounded Theory Review, 11*(1), 39-46.

Tracey, C., & Nicholl, H. (2007). The multifaceted influence of gender in career progress in nursing. *Journal of Nursing Management, 15*, 677-682.

Tully, E., & Mortlock, B. (2005). Professionals and practices. In P. Davis & K. Dew (Eds.), *Health and society in Aotearoa New Zealand* (2nd ed.) (pp.130-145). Victoria: Oxford University Press.

Ulrich, B. (2010). Gender diversity and nurse-physician relationship. *Virtual Mentor 12*(1), 41-45. Retrieved from http://virtualmentor.ama-assn.org/2010/01/msocl-1001.html.

Unluer, S. (2012). Being an insider researcher while conducting case study research. *The Qualitative Report, 17*(58), 1-14.

Van Wynsberghe, R., & Khan, S. (2007). Redefining case study. *International Journal of Qualitative Methods, 6*(2), Article 6. Retrieved from http://www.ualbeta.ca/~iiqm/backissues/6_2vanwynsberghe.pdf.

Vukic, A., & Keddy, B. (2002). Northern nursing practice in primary health care setting. *Journal of Advanced Nursing, 40*(5), 542-548.

Wade, D. T. (2004). Do biomedical models of illness make for good healthcare systems? *British Medical Journal, 329*(7429), 1398-1401. Retrieved from http://www.BMJ.com/content/329/7429/1308.full.

Walker, B. B., & Collins, C. A. (2009). Developing and integrated primary care practice: Strategies, techniques, and a case definition. *Journal of Clinical Psychology, 65*(3), 268-280.

Waugh, E. H., Szafran, O., & Crutcher, R A. (2011). Introduction. In E. H. Waugh., O. Szafran & R. A. Crutcher (Eds.), *At the interface of culture and medicine.* Alberta: The University of Alberta Press.

Wells, S., & Jackson, R. (2011). Unwarranted variation in healthcare organisation and practice for long-term conditions. *The New Zealand Medical Journal, 124*(1344). 6-9. Retrieved from http://journal.nzma.org.nz/journal/124-1344/4900/

Wennberg, J. E. (2010). *Tracking medicine. A researchers quest to understand health care.* New York: Oxford University Press.

West, C., Stewart, L., Foster, K., & Usher, K. (2013). Accidental insider: Living the PhD study. *Collegian, 20*(1), 61-65.

Whitehead, D., & Irvine, F. (2010). *Health promotion and health education in nursing: A framework for practice.* Basingstoke: Palgrave Macmillan.

Whitfield, K. (2010). *Corporate governance in the New Zealand public health sector.* Unpublished master's thesis for master's degree. Albany: Massey University.

Williams, A., & Sibbald, B. (1999). Changing roles and identities in primary health care: Exploring a culture of uncertainty. *Journal of Advanced Nursing, 29*(3), 737-745.

Willis, E. (2006). Introduction: Taking stock of medical dominance. *Health Sociology Review, 15*(5), 421-431.

Wilson, A., Pearson, D., & Hassey, A. (2002). Barriers to developing the nurse practitioner role in primary care - the GP perspective. *Family Practice, 19*(6), 641-646.

Winnard, D., Crampton, P., Cumming, J., Sheridan, N., Neuwelt, P., Arroll, B., Dowell, T., Matheson, D., & Head, V. (2008). *'Population health' meaning in Aotearoa New Zealand? A discussion paper to support implementation of the Primary Health Care Strategy*. Retrieved from http://www.arphs.govt.nz/Portals/0/Health%20Information/Promoting%20Health%20and%20Wellbenig/Primary%20Health%20Orgs/Population%20Health%20-%20meaning%20in%20Aotearoa%20June08.pdf.

Workforce Taskforce. (2008). *Working together for better primary health care: Overcoming barriers to workforce change and innovation.* Wellington: Ministry of Health.

World Health Organisation (WHO). (21-23 April 1976). *Summary report of the second liaison meeting with nursing/midwifery association on WHO's European nursing/midwifery programme.* Copenhagen: Author.

World Health Organisation (WHO). (1978). *Declaration of Alma Ata.* Retrieved from http//www.euro.who.int/AboutWHO/Policy?20010827.

World Health Organisation (WHO). (2000). *Second WHO ministerial conference on nursing and midwifery in Europe.* Denmark: Author.

World Health Organisation (WHO). (2008). *Primary health care. Now more than ever.* Retrieved from http//www.euro.who.

Yin, R. K. (2003). *Case study research: Design and methods* (3rd ed.). Thousand Oaks: Sage Publications.

Yin, R. K. (2009). *Case study research: Design and methods* (4th ed.). Thousand Oaks: Sage Publications.

Youngwerth, J., & Twaddle, M. (2011). Cultures of interdisciplinary teams: How to foster good dynamics. *Journal of Palliative Medicine, 14*(5), 650-654. doi:10.1089/jpm.2010.0395.

Zucker, D. M. (2001). Using case study methodology in nursing research. *The Qualitative Report, 6*(2). Retrieved from http://www.nov.EDU/SSS/qr/qr6-2/ZUCKER.html.

Zwarenstein, M., & Bryant, W. (2009). Interventions to promote collaboration between nurses and doctors. *Cochrane Effective Practice and Organisation of Care Group,* from http://onlinelibrary.wiley.com/dol/10.1002/14651858.CD000072/ful.

Appendix One

Massey University Ethics Approval letter

MASSEY UNIVERSITY
ALBANY

8 April 2010

Heather Robertson
c/- Dr S Neville
College of Humanities and Social Sciences
Massey University
Albany

Dear Heather

HUMAN ETHICS APPROVAL APPLICATION – MUHECN 10/020
"An evaluation of the impact of the implementation of the Primary Health Care Strategy on the primary health care nursing workforce in Tairawhiti"

Thank you for your application. It has been fully considered, and approved by the Massey University Human Ethics Committee: Northern.

Approval is for three years. If this project has not been completed within three years from the date of this letter, a reapproval must be requested.

If the nature, content, location, procedures or personnel of your approved application change, please advise the Secretary of the Committee.

Yours sincerely

Denise Wilson

Dr Denise Wilson
Chair
Human Ethics Committee: Northern

cc: Dr S Neville, Professor J Carryer
College of Humanities and Social Sciences

Te Kunenga ki Pūrehuroa
Office of the Assistant to the Vice-Chancellor (Research Ethics)
Private Bag 102 904, North Shore City 0745, Auckland, New Zealand Telephone +64 9 414 0800 ex 9539
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Appendix Two

Letter of authorisation to use Tairawhiti in Title

Chief Executive's Office

Tairawhiti District Health
Private Bag 7001 Gisborne
New Zealand
Phone 06 869 0500 Ext 8100
Fax 06 869 0542
E-mail jim.green@tdh.org.nz

2 October 2013

To whom it may concern.

I am writing in respect of the research project: A single case study: an evaluation of the impact of the implementation of the Primary Health Care Strategy on the primary health care nursing workforce in Tairawhiti, completed by Heather Robertson.

I am aware of the content of this thesis. As the Chief Executive of Tairawhiti District Health I give authorisation to have Tairawhiti in the title of the thesis. I fully understand that this will identify Tairawhiti DHB and local providers. I am aware that a copy of this thesis will be available through the Massey University library and will be obtainable via the library website. I give permission for Tairawhiti to be used in any publications that might be written as a result of this piece of research.

Please contact me if you require further clarification.

Yours sincerely

Jim Green
Chief Executive

Appendix Three

Middle and senior managers information sheet

A single case study: an evaluation of the impact of the implementation of the Primary Health Care Strategy on the primary health care nursing workforce in Tairawhiti.

Dated 08.03.2010

My name is Heather Robertson and I am undertaking this research for my doctoral thesis through Massey University. I am employed as nurse leader-primary and community for Tairawhiti District Health. The primary purpose of this study is to evaluate the impact of the implementation of the Primary Health Care Strategy on the primary health care nursing workforce in Tairawhiti. I am seeking information on what change has occurred within the primary health care nursing workforce in Tairawhiti since the implementation of the Primary Health Care Strategy and how this came about. I also want to find out how the Strategy implementation can be improved in Tairawhiti by the effective deployment of the primary health care nursing workforce.

Participant involvement
Along with other middle and senior managers of primary health care services, you are invited to participate in an individual interview. It is estimated the interview will last approximately 1-1½ hours. The interview will be taped by audio-tape then later transcribed onto paper. The tapes and transcripts will be stored for five years in a locked cupboard to keep the information secure. After these five years, the data will then be destroyed.

This thesis will be given to the University for examination and the results published in journals. This research will conform to the ethical requirements of standard scientific inquiry. There is some risk of participant identification due to the smallness of this DHB and whilst I will make every effort to anonymise your responses, I cannot guarantee anonymity.

If you have any particular cultural needs that I need to be aware of please let me know prior to the interview.

Participant rights
You are under no obligation to accept this invitation to participate. Non-participation will not affect future working relationships.

If you decide to participate you have the right to

- Be treated with respect and dignity.
- Be treated in a culturally appropriate manner.
- Decline to answer any particular question during the interview.
- Withdraw from the study at any time up to two weeks after the interview has taken place.
- Ask any questions about the study at any time during participation.

- Request the audiotape to be turned off at any time during the interview.
- Provide information on the understanding that your name or other identifying details will not be used.
- Review the transcript of your interview prior to it being used in the research
- Be given a summary of the project findings once it is concluded.

Contact details:

Researcher: Heather Robertson
Contact Details: Phone (06) 8690570-Ext 8599 or 0211198552
Email: Heather.Robertson@tdh.org.nz

Supervisors: Professor Jenny Carryer
Contact Details: Phone: (06) 356 9099-Ext 7719
Email: J.B.Carryer@massey.ac.nz

Dr Stephen Neville
Contact Details: Phone (09) 414 0800-Ext 9065
Email: S.J.Neville@massey.ac.nz

Committee Approval Statement

This project has been reviewed and approved by the Massey University Human Ethics Committee: Northern, Application 10/020. If you have any concerns about the conduct of this research, please contact Dr Denise Wilson, Chair, Massey University Human Ethics Committee: Northern, telephone 09 414 0800 x9070, email humanethicsnorth@massey.ac.nz.

Appendix Four

Primary health care nurse focus group information sheet

A single case study: an evaluation of the impact of the implementation of the Primary Health Care Strategy on the primary health care nursing workforce in Tairawhiti.

Dated 30.03.2010

My name is Heather Robertson and I am undertaking this research for my doctoral thesis through Massey University. I am employed as nurse leader-primary and community for Tairawhiti District Health. The primary purpose of this study is to evaluate the impact of the implementation of the Primary Health Care Strategy on the primary health care nursing workforce in Tairawhiti. I am seeking information on what change has occurred within the primary health care nursing workforce in Tairawhiti since the implementation of the Primary Health Care Strategy and how such change came about. I also want to find out how the Strategy implementation could be improved in Tairawhiti by the effective deployment of the primary health care nursing workforce.

Participant involvement
Along with other primary health care nurses I would like to invite you to participate in a focus group with up to ten people per focus group. It is estimated the focus group will last approximately 1-1½ hours. Others in the focus group will hear your comments but outside that group your anonymity is protected as no comments will be ascribed to any participant. The focus group will be taped by audio-tape then later transcribed onto paper. The tapes and transcripts will be stored for five years in a locked cupboard to keep the information secure. After these five years, the data will then be destroyed. This thesis will be given to the University for examination and the results published in journals.

If you have any particular cultural needs that I need to be aware of please let me know prior to the interview.

Participant rights
You are under no obligation to accept this invitation to participate. Non-participation will not affect future working relationships.
If you decide to participate you have the right to

- Be treated with respect and dignity.
- Be treated in a culturally appropriate manner.
- Decline to answer any particular question.
- Withdraw from the focus group but not withdraw the data you have contributed up to the time you withdraw.
- Ask any questions about the study at any time during participation.
- Provide information on the understanding that your name will not be used.
- Be given a summary of the project findings once it is concluded.

Contact details:

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Committee Approval Statement

This project has been reviewed and approved by the Massey University Human Ethics Committee: Northern, Application 10/020. If you have any concerns about the conduct of this research, please contact Dr Denise Wilson, Chair, Massey University Human Ethics Committee: Northern, telephone 09 414 0800 x9070, email humanethicsnorth@massey.ac.nz.

Appendix Five

Individual participant consent form

A single case study: an evaluation of the impact of the implementation of the Primary Health Care Strategy on the primary health care nursing workforce in Tairawhiti.

This consent form will be held for a period of five (5) years

I have read the Information Sheet and have had the details of the study explained to me. My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time.

I agree/do not agree to the interview being audio taped.

I agree to participate in this study under the conditions set out in the Information Sheet.

Signature:

---------- ----------

Full Name printed ----------

Appendix Six

Focus group participant consent form

A single case study: an evaluation of the impact of the implementation of the Primary Health Care Strategy on the primary health care nursing workforce in Tairawhiti.

This consent form will be held for a period of five (5) years

I have read the Information Sheet and have had the details of the study explained to me. My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time.

I agree to not disclose anything discussed in the Focus Group

I agree to participate in this study under the conditions set out in the Information Sheet.

Signature:

....

Full Name printed .....

Appendix Seven

Transcriber's confidentiality agreement

A single case study: an evaluation of the impact of the implementation of the Primary Health Care Strategy on the primary health care nursing workforce in Tairawhiti.

I ..... (Full Name - printed) agree to transcribe the tapes provided to me.

I agree to keep confidential all the information provided to me.

I will not make any copies of the transcripts or keep any record of them, other than those required for the project.

Signature:

....

Appendix Eight

Individual interview prompts– middle and senior managers

A single case study: an evaluation of the impact of the implementation of the Primary Health Care Strategy on the primary health care nursing workforce in Tairawhiti.

Aim of Study: To evaluate the impact of the implementation of the Primary Health Care Strategy on the primary health care nursing workforce in Tairawhiti.

Research Questions:

1. What change has occurred within the primary health care nursing workforce in Tairawhiti since the implementation of the Primary Health Care Strategy, how and why did this come about?
2. What factors influenced the deployment of primary health care nurses in Tairawhiti?

Individual Interviews: CEO of Tairawhiti District Health (TDH), CEO of Turanganui PHO, CEO and primary health care manager of Ngati Porou Hauora, director of nursing based at Gisborne Hospital, as well as the group manager of planning and funding at TDH, practice managers and general practitioners.

These questions may change depending on the response from the primary health care nurse focus groups

Topic Area: Primary Health Care Strategy

Purpose: To set the scene for the interview and determine informant's level of understanding about primary health care nursing.

- What do you think of the Primary Health Care Strategy?
- What is your understanding of what a primary health care nurse is?
- Where does the nursing role 'fit' within the Primary Health Care Strategy?

- What significant changes have occurred in your organisation regarding the Primary Health Care Strategy in the past eight years?
- How is information about the Strategy or its implementation communicated in your organisation?

Topic Area: Current primary health care nurse workforce

Purpose: To identify the professional working environment of primary health care nursing in Tairawhiti.

- Are nurses in your organisation involved in the writing or feedback on strategic plans, submissions etc. or involved nationally in the development of nursing? Should they be? Why?
- How do the nurses in your organisation link with other nurses within the DHB? Should they? Why?
- Does your organisation have a nursing workforce development plan? Should there be one? Why?
- Does your organisation have a designated role responsible for primary health care nursing leadership? Should they have? Why?
- If yes what does this look like (title, nursing governance, role, budget etc.)?
- If not who in your organisation does this work? Are there any issues around this?

Topic Area: Changed primary health care nursing role in Tairawhiti

Purpose: To identify what change has occurred within the primary health care nursing workforce in Tairawhiti since the implementation of the primary health care strategy eight years ago and how and why this come about?

- Has the primary health care nursing role changed in your organisation or in the wider Tairawhiti region in the last eight years? If there has been change what does this change look like? Why do you think this change occurred?
- Have any new positions been developed in your organisation or the wider Tairawhiti region specifically for primary health nurses in the past eight years? Why do you think that occurred?
- What, if any, initiatives and/or innovations have, or are being implemented for primary health care nursing both within your place of employment and the wider Tairawhiti region? Who instigated and who is leading these initiatives/innovations and why? What led to this?

- Are there any other opportunities that have occurred for primary health care nurses in Tairawhiti in the past eight years? How did those opportunities arise?
- How (if at all) are primary health care nurses in Tairawhiti involved in improving client access and reducing inequalities? Is this different from eight years ago?

Topic Area: **The future of primary health care nursing In Tairawhiti**

Purpose: To identify how the Primary Health Care Strategy implementation could be improved in Tairawhiti by the effective deployment of the primary health care nursing workforce?

- How do you see primary health care nursing developing in the current environment in Tairawhiti? Why? Is this how you would like to see it?
- What, if any, are the issues or barriers that are restricting primary health care nursing development both in Tairawhiti and nationally? Do you think issues/barriers are different from eight years ago? What do you think has brought about these issues/barriers? Why?
- What could be done to improve the effective deployment of primary health care nursing in Tairawhiti?
- Are nurses being best utilised to meet the needs of the community?
- Is there anything you would like to add about primary health care nursing in Tairawhiti that has not already been covered?

Appendix Nine

Focus group discussion prompts only

A single case study: an evaluation of the impact of the implementation of the Primary Health Care Strategy on the primary health care nursing workforce in Tairawhiti.

Aim of Study: To evaluate the impact of the implementation of the Primary Health Care Strategy on the primary health care nursing workforce in Tairawhiti.

Research Questions:

1. What change has occurred within the primary health care nursing workforce in Tairawhiti since the implementation of the Primary Health Care Strategy, how and why did this come about?
2. What factors influenced the deployment of primary health care nurses in Tairawhiti?

Focus Groups: practice nurses, district nurses, plunket nurses, tamariki ora nurses, public health nurses, rural health nurses, community mental health nurses, aged care nurses, sexual health nurses and specialty nurses working in primary health care.

Topic Area: Primary Health Care Strategy

Purpose: To discuss their understanding about the Primary Health Care Strategy including:

- What is your understanding of what a primary health care nurse is?
- What do you know about the primary health care strategy?
- Given what you know, what do you think of the primary health care strategy?
- Where does the nursing role 'fit' within the Primary Health Care Strategy?
- How is information about the Strategy or its implementation communicated to you?
- What significant changes have occurred in your organisation in the past eight years?

Topic Area: The changing role of primary health care nursing in Tairawhiti

Purpose: To discuss what change if any has occurred within the primary health care nursing workforce in Tairawhiti since the implementation of the primary health care strategy eight years ago and how and why this come about e.g.

- Has the primary health care nursing role changed in your organisation or in the wider Tairawhiti region in the last eight years? If there has been change what does this change look like? Why do you think this change occurred? (New positions/contracts, responsibilities etc.)
- Does your organisation have a nursing workforce development plan? Should there be one? Why?
- Does your organisation have a designated role responsible for primary health care nursing leadership? Should they have? Why? If yes what does this look like (title, nursing governance, role, budget etc.)? If not who in your organisation does this work? Are there any issues around this?
- Are you best placed to meet the needs of your community as you see them?

Topic Area: **The future of primary health care nursing in Tairawhiti**

Purpose: To discuss how the Primary Health Care Strategy implementation could be improved in Tairawhiti by the effective deployment of the primary health care nursing workforce e.g.

- How could the Primary Health Care Strategy implementation be improved in Tairawhiti by the effective deployment of the primary health care nursing workforce? (e.g. education, access to a PDRP programme, competency based annual appraisal, nursing recruitment and retention, nursing leadership, issues or barriers and solutions to these, opportunities, nurse led clinics, client access/reduce inequalities?
- What are some of the barriers or issues for primary health care nursing that are restricting primary health care nursing in Tairawhiti and how might they be overcome?
- Is there anything you would like to add about primary health care nursing in Tairawhiti that has not already been covered?

Appendix Ten

Document Table

Type of document	Organisation type	Availability	Summary of focus/content
Board Minutes 2001-2010	DHB	Public archived	As set out in Section 25 of the New Zealand Public Health and Disability Act 2000, the Board is the governing body of a statutory entity with the authority to exercise the powers and perform the functions of the entity. The minutes must be available for inspection at a place or places within the district. Any member of the public may take notes from any minutes inspected by that member of the public. http://www.legislation.govt.nz/act/public/2000/0091/latest/ Included in the minutes were quality and risk reports, a chairs reports, TWON reports, Chief executive reports, TDH funder reports, correspondence, and decision items on funding of local services as well as information and general business.
CEPHAC Minutes 2001-2010	DHB	Public archived	There is a statuary requirement that the Board have a committee, to advise on health improvement measures, called the Community and Public Health Advisory committee under Section 34 of the New Zealand Public Health & Disability Act. http://www.legislation.govt.nz/act/public/2000/0091/latest/DLM80838.html The minutes must be available for inspection at a place or places within the district. Any member of the public may take notes from any minutes inspected by that member of the public. http://www.legislation.govt.nz/act/public/2000/0091/latest/ Included in the minutes were TDH

			provider reports (Public Health and Mental Health), information items, action items and other business. Action items included recommendations to the Board on community based services.
District Annual Plans 2001-2013	DHB	Public archived	Under Section 38 of the New Zealand Public Health & Disability Act each District Health Board (DHB) has a statutory responsibility to prepare an Annual plan for approval by the Minister of Health. This provides accountability to the Minister of Health. It must include a statement of intent (Section 139 of the Crown Entities act 2004). This provides accountability to the Parliament and the public. Every plan must address (i) local, regional, and national needs for health services (ii) how health services can be properly co-ordinated to meet those needs (iii) the optimum arrangement for the most effective and efficient delivery of health services The annual plan must also demonstrate how a DHB plan is to operate in a financially responsible manner and must reflect the overall direction set out in, and not be inconsistent with, the New Zealand health strategy and the New Zealand disability strategy. http://www.legislation.govt.nz/act/public/2000/0091/latest/DLM80844.hm1
Communication Plans 2001-2010	MoH	Official Information Act request (OIA)	The communication plans included the purpose of the Strategy, process for implementation, emphasis on importance of Strategy, as well as key messages