HOW DISCOURSES STIFLE THE PRIMARY HEALTH CARE STRATEGY'S INTENT TO REDUCE HEALTH INEQUALITIES

by

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Abstract

New Zealand's Primary Health Care Strategy (PHCS) has a stated commitment to defined populations who suffer disproportionately from ill health. This thesis examines whether some prevailing discourses actually decrease the focus on health inequalities.

Words and ideas shared by a group can be considered a discourse when the underpinning values serve a social and political function for that group. To examine whether discourse was constraining health care I considered the nursing and medical media pertaining to both the PHCS and the primary health care nursing framework and sought their dominant discourses. I found that the nursing and medical media focused on predominantly professional and industrial issues. These were expressed very differently with the medical media reacting to the ramifications of the PHCS especially Primary Health Organisations (PHOs), while the nursing media had a visioning quality, imagining how nursing could function in primary health care (PHC). The result was that, in the media studied, the upheaval of the PHCS left professionals mainly wondering about their own professional interests, rather than considering what those who suffer from health inequalities needed.

The discourse of the PHCS may also serve political rather then altruistic purposes. I found historical examples of where discourse had underpinned health policy and I suggest that current (Ministry of Health) MOH discourse values decentralised community health decision making. The decentralised community health model of small community PHOs situates the responsibility for health locally. This health responsibility may gloss over factors in community health which are affected by Government policy such as employment policy, and thus should be dealt with centrally by legislation. These factors have been found to be the most pertinent in health inequalities. So while models of community partnerships may seem to place communities as agents in their own health, this downplays the determinants of health which are beyond their control. Moreover the multiple PHOs through the country, while costly in the repetition of bureaucracy, also make analysis of the PHCS difficult,

since there is in effect multiple Primary Health Care Strategies being played out in each area, as interventions of various qualities are implemented.

Having shown that discourse can decrease the focus on health inequalities due to other professional and political drivers. I then looked at health initiative concepts which are effective, efficient and equitable given the current set up of PHOs and nursing innovations.

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Chapter One: Introducing this research

1.0 Introduction

In 2001 New Zealand's Ministry of Health (MOH) launched the Primary Health Care Strategy (PHCS or the Strategy). The PHCS had a broad brief including focussing on the reduction of health inequalities, health promotion and population health, as well as providing first contact services for primary health care (King, 2001). The Strategy also states that primary "health care nursing will be crucial to the implementation of the strategy" as primary health care moves to a greater population focus and broader health services necessitating increased nursing knowledge and skill (King, 2001, p. 23).

By mid 2005 the PHCS had begun to be implemented. Primary Health Organisations (PHOs), which are management structures that both respond to the health needs of their local targeted populations and include community governance, are an important vehicle for delivery of the Strategy (King, 2001). According to the Ministry of Health website, as of July 1, 2006, 3.8 million New Zealanders were individually enrolled in one of 81 PHOs and were able to receive first level services (like general practice services) through them (Ministry of Health, 2006b).

Five years on from the initial announcement of the Strategy, it is too early to measure the outcomes of the PHCS changes in terms of impact on health inequalities, even though this should be critical to future health decision-making in a constrained health funding environment. Reports and assessments of aspects of the reorganisation of New Zealand health care have begun. I am, however, interested in considering whether discourse is constraining a commitment to the decrease in health inequalities, which is a primary target of the PHCS. A discourse is defined here as "a coherent set of words and ideas that is shaped according to the social functions that it serves for the community that uses it" (Salmon & Hall, 2003, p.1969). This thesis reports on an examination of the discourses in selected primary health care (PHC) nursing and medical media and considers whether these discourses are focused toward a decrease in health inequalities. I will then consider the broader context of the discourse of the PHCS. Having found

that the discourses in the nursing and medical media were largely concerned with professional issues and that the PHCS had political motivation as well, this thesis then highlights ways health resources can be focused on effective, efficient and equitable interventions in the current set up of PHOs and nursing innovations.

1.1 Chapter introduction

The purpose of this chapter is to contextualise my own views, this research and the larger picture of primary health care and health strategies in New Zealand. To this end I introduce the PHCS and Primary Health Organisations. I situate the PHCS beside other strategies that the government is working toward in health such as *The New Zealand Health Strategy* (Ministry of Health, 2000). I also consider what research has occurred in relation to the PHCS so far and show that this research does not consider the discourses of the health care professionals involved. Since my own experience has inevitably shaped this work I describe my current employment in a primary health management services organisation.

1.2 The Alma Ata declaration and primary health care

Primary health care is described by the Alma Ata declaration of 1978 as being "essential health care based on practical, scientifically sound and socially acceptable methods and technologies made universally accessible to individuals and families in the community" (Declaration of Alma Ata, 1978). The Alma Ata declaration emphasises the importance of primary health care as the first level of contact for individuals, families and communities within the national health system, and that primary health care is to be the "central function and main focus" of a countries health system. The declaration also emphasises that this essential health care, needs to be universally accessible and participatory for communities.

1.3 The Primary Health Care Strategy

The declaration of Alma Ata is echoed in the *Primary Health Care Strategy* (PHCS):

> A strong primary care system is central to improving the health of New Zealanders and, in particular, tackling inequalities in health….This vision involves a new direction for primary health care with a greater emphasis on population health and the role of the community, health promotion and preventive care, the need to involve a range of professionals, and the advantage of funding based on population needs rather than fees for service.
>
> (King, 2001, p. ii)

The PHCS has six key directions for PHC which are to "work with local communities and enrolled populations; identify and remove health inequalities; offer access to comprehensive services to improve, maintain and restore people's health; co-ordinate care across service areas; develop the primary care workforce [and] continuously improve quality using good information" (King, 2001, p. vii).

1.4 Primary Health Organisations

In order to develop the vision of the PHCS, PHOs were created to be the new organisational structure of primary health care. Key points about PHOs according to the PHCS are that:

- They will be funded by District Health Boards for the provision of a set of essential primary health care services to those people who are enrolled.
- At a minimum, these services will be directed towards improving and maintaining the health of the population, as well as first line services to restore people's health when they are unwell.
- Primary Health Organisations are expected to involve their communities in their governing processes.
- All providers and practitioners must be involved in the organisation's decision making: no one group should be dominant.

- Primary Health Organisations will be not-for-profit bodies and will be required to be fully and openly accountable for all public funds that they receive.
- While primary health care practitioners will be encouraged to join Primary Health Organisations, membership will be voluntary.

(King, 2001, p. viii)

To become a PHO, a not-for-profit organisation had to be set up as outlined above. These fledgling organisations could take a variety of legal forms as outlined by the Ministry; however they needed to show that they contained a governance structure that involved community representatives and health providers on the PHO Board (Ministry of Health, 2002a). In effect PHOs are decentralised decision making organisations, which, while offering much community input, are also costly in bureaucratic terms, since the bureaucratic structures will need to be repeated numerously around the country.

1.5 PHO funding

In keeping with the Health Ministry's commitment to reducing health inequalities, funding was made available to each PHO based on the numbers and demographic status of those enrolled. 'Access funded' general practices are where 50 percent or more of the enrolled patients are Maori, Pacific or people living in areas of high deprivation. Access practices are funded at an increased rate per registered person, compared with 'Interim practices'. Greater funding occurs in Access practices since it is assumed that high need groups will require greater general practice services, thus greater funding. The government intends that all practices will be funded under the Access formula from July 2007. However, even in Interim practices certain age groups attract greater funding, including those under 24 years old and those 65 and over (Ministry of Health, 2006d). PHO practices are also now 'capitated' where funding is worked out per head of those enrolled in the PHO. This funding replaces the General Medical Services benefit, which was a Government subsidy paid to general practitioners (GPs) to offset

appointment costs of certain individuals, and the Practice Nurse Subsidy, which had been paid to GPs since the 1970s so that they could employ nurses (Cumming et al., 2005; Ministry of Health, 2006b). Some practices were already funded by capitation and had community governance boards, so the move to PHOs was less challenging (Glensor, 2003, July 2). These practices which were often aligned with the Health Care Aotearoa network will be discussed further in Chapter Two.

Services to Improve Access funding and Health Promotion funding is also available to PHOs to develop projects to target Maori, Pacific and low income people, in keeping with the PHCS's goal of reducing inequalities. PHO proposals for these projects need to be signed off by the relevant District Health Board (DHB) to show that appropriate consultation and targeting of those in need has occurred (Ministry of Health, 2006a).

Other funding includes Care Plus funding which is worked out on the basis of five percent of the total enrolled population who are deemed to need greater access to health care services, generally because of chronic disease needs. Patients who qualify and are seen under this scheme should receive subsidised patient fees, consultations and care-plans aimed at improving the quality of life of the individual (Ministry of Health, 2006c).

Management Services funding is also calculated on a capitation basis determined by the number enrolled in a PHO. This has been increased since inception to help small PHOs remain viable (Ministry of Health 2006b; Cumming et al., 2005).

According to the MOH website (www.moh.govt.nz) PHOs and other primary care health professionals have also been able to apply for various innovation funds. These include nursing innovations, mental health initiatives, and reducing inequalities contingency funding.

The PHO Performance Management Project is a future funding stream and project for most PHOs as funding and details are worked through. The aim is to combine two

streams. One is looking at performance indicators that calculate improvements in population health of a PHO, such as the number of individuals immunised, or the number who have had cervical screening. The other is looking at the use of referred services, which focuses on prescribing appropriate medication or laboratory tests. This is seen as a quality improvement programme where baseline data is compared to annual data (Ministry of Health, 2006d).

1.6 Other MOH strategies

The PHCS is to be considered in conjunction with other MOH publications which also provide direction for health care. *The New Zealand Health Strategy* (Ministry of Health, 2000) lists 13 population health objectives, most of which will need to be realised in the community. Reducing smoking, obesity, and the incidence and impact of diabetes are example of goals which need primary care intervention. *The New Zealand Health Strategy* also signals that reducing inequalities between Maori and Pacific peoples and other New Zealanders is a key priority.

This commitment to reducing health inequalities is borne out further in *He Korowai Oranga. Maori Health Strategy* (Ministry of Health, 2001) and the *Pacific Health and Disability Action Plan* (Ministry of Health, 2002b). *He Korowai Oranga* embraces Maori models of health care by conceiving health not as the absence of disease, but as the development of Maori wellbeing through strong Maori communities. It focuses specifically on the concept of whanau ora or the family unit as a cohesive, nurturing place to foster psychosocial health and wellbeing. It also stresses the importance of Maori being involved in their own health care direction and decision making. The *Pacific Health and Disability Action Plan* also stresses that the involvement of Pacific peoples at all levels of the health and disability sector is important to ensure culturally competent health care.

Finally, the *New Zealand Disability Strategy* is also a key document underpinning the PHCS (Ministry of Health, 2001). According to the *Disability Strategy*, "the key common factor among people with impairments is that they face many lifelong barriers

to their full participation in New Zealand society" (Dalziel, 2001, p. 12). This strategy aims to ensure that people with impairment lead full lives, not impeded by discrimination in terms of education, employment, housing, ethnicity, gender, or other issues.

1.7 Research into the PHCS so far

According to the Ministry of Health the PHCS is being "comprehensively evaluated" (www.moh.govt.nz). Evaluations on specific parts of the Strategy include Care Plus evaluations and reports on reducing inequalities and contingency funding. Evaluations of the mental health projects and nursing innovation projects are awaited (see www.moh.govt.nz).

A major evaluation of the PHCS as a whole has been led by Victoria University of Wellington's Health Services Research Centre. The result was *Primary Health Organisations: The First Year (July 2002 - July 2003) from the PHO perspective* (Perera, McDonald, Cumming, & Goodhead, 2003). This research was undertaken under contract from the MOH. Data was obtained from or about PHOs through documentation from selected PHOs, DHBs and the MOH, telephone interviews with personnel from selected PHOs, a mailed questionnaire (to PHOs not interviewed) and a review of news articles about PHOs from both the *New Zealand Doctor* magazine and *GP Weekly*. The research attempted to solicit information from a wide range of types of PHOs (for example, rural, urban and Maori based PHOs). Findings that emerged from the interviews were not about health care outcomes, but about the processes and experiences of the PHCS implementation. In general, findings showed goodwill toward the Strategy. However, difficulties were found with inadequate MOH funding for initial PHO implementation. Findings also highlighted the risks and problems associated with a model that centred funding around enrolment with a general practice, which then carried the risk of a small business but not the corresponding control at governance levels. Shortcomings in this work were that nursing news articles were not reviewed as part of the article review, even though the role of nurses had been so specifically mentioned in the PHCS. Furthermore, although the information from questionnaires

and interviews was organised into themes, this data appears to be presented as varying opinions rather than being treated in a critical way by the authors, or as a tool to suggest change or improvement in the Strategy. The authors admit they were limited by the small number of PHOs that were involved in the research. Their goal was to achieve an overview and to highlight areas that could be followed up in later research.

The next commissioned report looking at the PHCS also came out of the Health Services Research Centre. This *Evaluation of the Implementation and Intermediate Outcomes of the Primary Health Care Strategy* (Cumming et al., 2005) had a broad brief which included evaluating the implementation of PHOs against the PHCS objectives. This research followed up on 20 research themes and used a combination of research methods including "key informant interviews; a postal questionnaire; quantitative analyses focusing on utilisation and intermediate health outcomes; and quantitative analyses in support of an economic analysis of the impact of the Strategy" (p. 19). This report also develops discourses; for example, the section on 'Concerns about the Strategy' focused almost exclusively on general practitioner (GP) concerns. The resultant discourse developed the idea that GPs are both major players and a negative influence on the Strategy. The competence of GPs and GP organisations to realise the PHCS is questioned by informants. However, the competence of community representatives is rarely questioned. This document then contributes to a MOH discourse, which will be discussed later, in that decentralised community decision making models are currently favoured over GP led models. While the Cumming et al. research is detailed and informative about the wide range of issues that have occurred in developing the PHCS, a shortcoming of this research is that the discourses being created are not challenged by the research. Like *The First Year* report, this research documents events and the narrative of others, rather than taking a critical stand on them. However, research into the outcomes of the PHCS will always be problematic, given that each PHO has focused on a wide number of issues and implemented differing interventions. Thorough health outcome based research would need to look at every intervention in every PHO and assess each intervention accordingly. Given that this type of research is not feasible at this late stage, it is questionable whether the

PHCS can ever be judged a success except in terms of the success of an individual PHO. As a hypothetical example, a small mid Auckland PHO may halve the number of people who say they smoke following a PHO initiative; however, this does not affect the smokers in the rest of the country who did not have a successful smoking initiative running. Therefore just because the smoking initiative in central Auckland was successful this does not mean the PHCS was a success.

1.8 Why this research is needed

The PHCS is a far reaching change to the way primary health care is conceived, delivered and organised in New Zealand. While there has been and will be research into the implementation of the Strategy, the research has not focused on the discourses involved. Asking the question of whether discourse is decreasing the focus on health inequalities leads us to focus on possible professional and political agendas which may derail the stated intent of the PHCS. Given that health care in New Zealand operates in a resource constrained environment, innovations and interventions should offer value for investment. This means that investment in new initiatives, at least in theory, should be motivated by a desire to decrease health inequalities and improve health generally, rather than new initiatives being subject to the discursive agendas of participants. I propose that a way to minimise the impact of political and professional agendas is to firstly identify and consider them critically, then ensure interventions and innovations have proven effectiveness, are efficient, and promote equity as well as operating within legal boundaries to protect both the carers and the cared for. This research initially considers the differing discourses and then uses a resource allocation framework of effectiveness, efficiency, equity and legal compliance to move beyond professional and political discourses. This research therefore offers new approaches to the discussion of the PHCS outcomes.

1.9 Location of self

I have decided to focus on the emergent discourses of the PHCS in relation to nurses and GPs since I work with the PHCS everyday. Over the last few years I have worked in various nursing and health management positions within a small Independent

Practice Association (IPA). (An IPA is an organisation that represents a local group of GPs in terms of contract negotiations and provides collective health support services for member and non member health organisations). After three restructures this organisation has become, among other things, a PHO Management Support Organisation for three PHOs. From within this organisation I have been party to, or participated in, the creation of two of these PHOs; and involved in numerous new primary care initiatives. These have included projects that the fledgling PHO boards have initiated, aimed at improving access to health care and health promotion for at risk groups such as Maori, Pacific and those on low incomes. While some of these projects may, to a nurse, lack appropriate evidence, they are the centre of tremendous community pride and goodwill between groups who may not have previously worked together.

More recently I have headed a Care Plus project. In line with the PHCS it targets Maori, Pacific, and low income people. This project has meant I have talked with harassed practice nurses (PNs) and GPs, and confronted the need for robust and easy information technology and claiming processes. I have visited local marae as part of the Care Plus training for PNs, and included Pacific Health Nurses as providers of Care Plus services. Of the PNs and GPs I have talked to, I have encountered varying degrees of understanding and satisfaction with the PHCS. There have been notable examples of stress, uncertainty, burnout and change fatigue, rather than excitement about the brave new world of PHOs.

The stated aim of the PHCS is of course an improvement in health for all with targeting of those most in need. Yet I wonder whether the increased primary health care spending and delivery reorganisation will bring about the required results.

1.10 Thesis overview

Chapter One has provided an introduction to the PHCS, to myself, to research into the PHCS and why this research is needed.

Chapter Two looks at three topics. First the events preceding the PHCS in General Practice; then health inequalities and potential reasons for them. Finally I look at the influential nursing reports that were released prior to and as a result of the PHCS.

Chapter Three discusses discourse as method. I outline how this research is situated outside the postmodern paradigm since I intend to consider and offer suggestions to improve practice. I discuss how this research was carried out using the *Kai Tiaki Nursing New Zealand* journal, the *Practice Nurse* journal and the *New Zealand Doctor* newspaper.

Chapter Four looks at the discourses revealed in the medical media surveyed. These discourses attempt to legitimate the continued control of general practice by GPs, yet they also critique the PHCS.

Chapter Five reveals the nursing discourses and finds them often led from the Minister of Health, thus constraining debate. The nursing centred discourses are more interested in how to improve nursing, than how nursing can serve those with inequalities.

Chapter Six turns to discourse and the PHCS. This chapter discusses the prevailing discourse in which the small community governed organisations are the favoured unit to achieve the PHCS aims. This is in spite of the expense of multiple bureaucracies and the evidence that wider Government policy will have a bigger effect on health care. This chapter then concludes with the development of a resource allocation framework which would channel thinking toward efficient, effective and equitable health interventions which are also cognisant of legal issues.

The conclusion finds that various discourses are, in many cases, constraining practice from focusing on how to decrease health inequalities.

1.11 Chapter conclusion

In this chapter I have introduced the context of my research, in the primary health care environment, in New Zealand. Specifically I am interested in the PHCS which has heralded a number of changes and potential changes in PHC practice. Notably, the PHCS has a focus on health inequalities. While two reports have been commissioned to look at the outcomes of the PHCS, neither report looked critically at the discourses of the doctors and nurses involved in PHC, which is what this research will do. I have also located myself in this research as someone who works in the PHO environment for a Management Services Organisation.

The PHCS was of course not developed in isolation from concerns that had existed about New Zealand primary health care prior to the Strategies implementation. The next section will focus on these concerns especially around primary health care governance, nursing issues and inequalities.

Chapter Two: Back-grounding the Strategy

2.0 Chapter introduction

This chapter focuses on background events that preceded and informed the development of the Primary Health Care Strategy (PHCS) and the nursing and medical discourses I analyse. The chapter is organised around the following three themes: general practice development and governance, inequalities in health and primary health care (PHC) nursing.

Preceding historical events to the PHCS are an important part of discourse creation. Historical events and the way they are interpreted and recorded affect the creation of the future discourse. Background information is provided on general practice governance since this issue becomes a pivotal part of the discussion in the medical discourses analysed. Governance is the directional control of an organisation. An example in general practice is the ability of general practitioners (GPs) to set their own fees. The fees issue is highlighted in the GP writings surveyed in Chapter Four, yet this issue also has a history of tension between successive Government and GP organisations.

Since health inequalities are the stated focus of the PHCS, this chapter outlines the potential reasons and solutions for these inequalities. This chapter's final section focuses on the recent nursing reports and Ministry of Health (MOH) led nursing developments which have influenced the PHCS and PHC nursing.

2.1 General practice development and governance

New Zealand has for many decades, been a country in which the public hospital services have been free and financed by taxation. Various community nursing services, like district nurses and public health nurses are also government funded. However, most GP services have remained as private businesses, outside governmental control, although being partially funded by the State. The public and private models of primary care have a long history.

In 1938 the Labour Government passed Social Security Legislation that provided for state run, free hospital services (or secondary care). However, at the time of the passing of this legislation, the primary medical sector, represented by the New Zealand Medical Association was unable to come to an agreement with the Government to provide fully subsidised primary care (Rose, 2004). “Being paid from the Social Security Fund and governed by the regulations, the profession would in effect be civil servants; but civil servants without hours of duty, leave, promotion or pension” (Medical Journal Editorial, 1941, cited in Rose, 2004, p.12). The GPs agreed to provide care subsidised by the government but maintained the right to also charge patient fees (Barnett & Barnett, 2004). This left the GPs as a largely autonomous profession, able to act as self employed business people, but also able to claim subsidies from the Government (Barnett, Barnett, & Kearns, 1998).

Health reforms of the 1980s led to the establishment of Area Health Boards. These combined public health and hospital board services. The enabling legislation was passed in 1983, and by 1989 14 Area Health Boards were in place (Laugesen & Salmon, 1994). In primary medical care there had been mounting problems, since the payment rate of the General Medical Subsidy paid to GPs had not kept pace with inflation. GPs had been passing on this cost to patients who were required to pay the difference (termed a part charge or a co-payment). Another problem was that the Government’s payment for laboratory work, pharmaceuticals and fee-for-service consultations by GPs was unlimited and kept increasing (Barnett et al., 1998). In 1989 the General Medical Subsidy was increased for all types of GP consultations. However, the greatest increases were targeted at ‘at risk’ groups such as children, the chronically ill and beneficiaries (Caygill, 1988).

In 1993, the National Government began the next substantial reorganisation of health care in New Zealand. The underpinning policy focus was on the need for strong financial management, so that Government debt and spending would decrease. Competition was seen as the way to do this. Twenty-three newly reorganised Crown Health Enterprises (these included the public hospitals) were to compete with other

health organisations to win contracts from the four new Regional Health Authorities which now distributed the health dollars throughout the country. The Regional Health Authorities capped budgets were to include funding for primary and preventative care (Barnett et al., 1998). This was seen as a way in which costs could be contained as the focus would be on keeping people well, not just providing for them when they were sick (Upton, 1991). The Crown Health Enterprises, as limited liability companies, were expected to make a profit. In order for cost containment to occur, part charges were introduced for hospital, outpatient and pharmaceuticals. However, people whose income fell below a set minimum were eligible for the newly introduced Community Services Card (CSC). The CSC meant health treatment was free (in hospital) and at reduced cost for GP consultation and pharmaceuticals. High user health cards and pharmaceutical subsidy cards were also introduced. These cards offset costs once participants had attended the GP a set number of times annually, or purchased a minimal number of prescribed pharmaceuticals. Mental health and maternity hospital services remained free. Public outcry meant that the other hospital part charges were soon dropped (Nelson, 2003).

Maori and iwi health providers, as well as other community based, non profit health organisations grew into the gap that had emerged for culturally acceptable and affordable health care (Crampton, Woodward, & Dowell, 2001). These models were bulk funded (capitated) where the Government paid a lump sum ‘per head’ for those who belonged to the practice. One of the groups that developed this model was Health Care Aotearoa, where governance of the practices was vested in a community governance board. Often these organisations served disadvantaged groups, where there was a high proportion of ethnic minorities, including Maori (Ashton et al., 2004; Crampton et al., 2001).

Another reorganisation that occurred at this time was the emergence of Independent Practice Associations (IPA). IPAs would negotiate collectively with the local Regional Health Authority, on behalf of groups of local GPs (Barnett et al., 1998). IPAs also became responsible for local budget holding for laboratory and pharmaceutical spending and would run initiatives to control inappropriate GP prescribing and test

ordering in order to achieve a budget under-spend. The contract was that the financial surplus created would be reinvested in health (Love, 2003).

These two general practice organisational changes resulted in changing autonomy for GPs. In the Health Care Aotearoa model, GPs became employees of a community board and subject to its governance; while under the IPA model, GPs had their practice evaluated and realigned with IPA incentive schemes. Both of these factors were important steps in the formulations of Primary Health Organisations (PHOs) which had both community governance boards and the control of GP practice as mandates. At the same time, new Government regulations restricted GPs in where they could practise geographically, in an attempt to control over or under-servicing by GPs (Barnett et al., 1998).

Generally, however, the health changes of the 1990s were not seen as a success, for example, some Crown Health Enterprises ran at a loss (Bowie & Shirley, 1994). Administration costs were high and efficiency gains were not shown (Ashton, Cumming, & McLean, 2004). The health sector was again restructured and by 1998 the four Regional Health Authorities became the Health Funding Authority, while the Crown Health Enterprises became Hospital and Health Services. Efficiencies and accountabilities, but not profit was expected (Ashton et al., 2004).

One of the occurrences in these health changes documented is the oscillation between regional (for example four Regional Health Authorities) and then centralised health administration (for example one Health Funding Authority). This occurs as a centralised and therefore more efficient model is favoured over localised, more community oriented, yet more expensive bureaucratic models. The PHCS can be said to be favouring the discourse of the latter community oriented model.

Internationally health sector models have not been shown to be organised rationally. This can be observed by comparing countries which share health goals, yet prioritise, resource and legitimate their health care systems very differently. “Government strategies for determining the right level [of health resources] are varied, and none particularly scientific” (Scott, 2001, p. 9). What appears to occur is that health reform is

based on the prevailing political discourse or favoured perception rather than rigorously defensible health policy. The PHCS changes can also be viewed in this light and this is discussed in Chapter Six.

At the primary care level, the CSC had only limited success in being used by those who were eligible for reduced appointment costs, due to administration, uptake and other issues (Crampton, 2001). Those who had a CSC still had to meet the GP co-payment charge and this could be prohibitive at a time when other welfare changes, like the charging of market rent for state housing and benefit reduction, was causing financial hardship (Barnett & Barnett, 2004). When an increase in the subsidy paid to GPs for children under six was instated in 1997, the GPs again lobbied successfully to continue setting their own co-payment (Crampton, 2001). This continued a trend started in 1938 where GPs would remain Government subsidised, but were also able to run as private business that could set its own fees.

The PHCS built on key elements that had occurred in the years preceding its release. These elements as discussed above include the ability to completely reorganise health contracting over short spaces of time and the development of capitated and often community governed practices. These capitated practices situated GPs as employees of community boards and were located in and worked with deprived communities. These communities were to be a focus of developing Primary Health Organisations under the PHCS. Meanwhile those GP practices organised under the IPA model had proved that local strategies could increase accountability by general practitioners. By changing GP prescribing behaviour and making savings on laboratory test and pharmaceuticals, and that these savings could be reinvested in the community health (Barnett et al., 1998).

Although over 90% of GPs were members of IPAs by 1999 (Malcolm, Wright, & Barnett, 1999), the model that the MOH backed, going into the new PHCS environment, was the community run, non profit organisations like the Health Care Aotearoa practices (Barnett & Barnett, 2004). While this was presumably due to a stated Government aim of decreasing inequalities and promoting better access to health care for those disadvantaged (Barnett & Barnett), various GPs have viewed the changes

and the loss of autonomy inherent in being governed by a community board as "nationalisation by stealth" (Fountain, 2003a, September 10, p. 1). The two types of general practice structures can be viewed as being in binary opposite positions where one is perceived as good (community governed practices) and the other bad (IPA affiliated practices). This simplistic rendering of complex situations is an example of discourse, where right and wrong has been constructed through language. These concepts of discourse will be discussed further in Chapter Three. This chapter now turns to inequalities in health care which is an underpinning factor in the PHCS.

2.2 Inequalities in health

The Primary Health Care strategy sets the focus on inequalities right from the opening statement: "A strong primary health care system is central to improving the health of New Zealanders and, in particular, tackling inequalities in health" (King, 2001, p. vii). Why has this become a focal point for the Strategy? The findings of the *Decades of Disparity. Ethnic Mortality trends in New Zealand 1980-1999* (Ajwani et al., 2003) provides some answers, given that the Maori and Pacific mortality rates have not declined at the same rate as the non Maori, non Pacific rates over the last two decades. Ajwani et al. divided the reason for these trends in mortality into three categories: epidemiological, social structural and health services.

An epidemiological focus looks at the causes of disease across a population. Diabetes, cardiovascular disease and cancer cause disparity in death rate across ethnic minorities, with Maori disproportionately affected (Ajwani et al., 2003). High risk factors which relate to these diseases, such as smoking, obesity and high blood pressure have been found to be consistent with ethnic differences in mortality. While it may seem plausible to situate the responsibility for the risk factor with the individual, risk factors should not be treated as the fault of individuals (Ajwani et al.). Risk factors and health have been shown to be linked to social determinants of health (Robinson & Blaiklock, 2003). Social determinants of health may include economic status and education level.

Social structural or social determinants of health are affected by the social and economic structure of a country. The major economic changes that occurred in New Zealand through the 1980s and 1990s form an "influential backdrop to the mortality trends" (Ajwani et al., 2003, p. 50), as New Zealand moved from a regulated to a deregulated economy. The user pays philosophy in the deregulated economy affected health, education, state housing, and the tax system (with the implementation of the goods and services tax that taxed everyone on purchase of products or services, rather than on income). During this time the inequalities between Maori and non-Maori widened across determinants such as income, education and housing (Howden-Chapman, & Tobias, 2000). Disposable income for Maori decreased as the higher unemployment rate, income gaps and benefit cuts affected Maori disproportionately (Ajwani et al.). This has meant that Maori on restricted incomes have had to make difficult health choices including forgoing or delaying seeking medical care (Barnett, 2001).

New Zealand's health system is another reason for the inequalities in mortality across ethnicities given that the health system does not offer universal free access to primary health care. As noted previously, GPs have usually operated under a system in which they charge for their services. This has been found to stop or delay the seeking of medical care. Yet it is more than just income that affects seeking medical care, since iwi-based organisations attracted more Maori than other low cost practices, reflecting the need for culturally appropriate, as well as cheaper care (Barnett & Barnett, 2004). The delay in seeking medical care may be further compounded by an inability to seek timely and expensive private medical investigations by those (often Maori) without medical insurance (Ajwani et al., 2003).

So far this section has highlighted some problems in New Zealand's health which affects some ethnicities in disproportionate ways. PHOs were set up to address this inequality with extra funding targeted to Maori, Pacific and low income people. The PHO discourse especially targets access to care for Maori, Pacific and low income people through the Services to Improve Access funding (Ministry of Health, 2006a).

However, as discussed above, social determinants of health which are most affected by government policy on employment, housing and benefits may be a greater cause of mortality and morbidity trends.

Nurses also form a key part of the primary care health system and the developments within the nursing profession are now discussed.

2.3 Primary health care nursing

That nurses have been singled out for special professional treatment under the PHCS has been apparent from the release of the strategy itself. Indeed in the Strategy's chapter on the primary health care workforce, nursing is the only health profession that gets its own heading of "Primary Health Care nursing". Under this heading we find that "Primary health care nursing will be crucial to the implementation of the Strategy, and will therefore be best addressed at the national level" (King, 2001, p. 23). The evaluation of the role of nurses who work in primary care had begun well before the PHCS was released and can be seen as informing some of the direction the PHCS has taken. This next section will discuss nursing documents that preceded or were written as a result of the PHCS.

These influential nursing documents were the *Report of the Ministerial Taskforce on Nursing: Releasing the Potential of Nursing* (Ministerial Taskforce on Nursing, 1998); the *Locating Nursing in Primary Health Care* (Carryer, Dignam, Horsburgh, Hughes, & Martin, 1999); and *A Framework for Complementary Models of Rural Nursing* (Litchfield, 2001). Once the Strategy was released *Investing in Health: Whakatohutia te Oranga Tangata* (Expert Advisory Group, 2003) was influential in the further development of primary health care nursing.

The *Report of the Ministerial Taskforce on Nursing* was the first report on New Zealand nursing services in over 15 years. The taskforce collected data by mailing one-page questionnaires to 30,000 nurses and 400 sector agencies, obtaining submissions and running focus groups and hui. The taskforce recommended progressive changes,

some of which have since come to fruition. These changes include the furthering of the Nurse Practitioner role and the Health Practitioner Competence Assurance Act, 2003.

Locating Nursing in Primary Health Care was part of a range of reports written for the National Health Committee to provide independent advice to the Ministry of Health on the development of primary health care (Carryer et al., 1999). The authors claimed the report was a "perspective on the role nursing could have in New Zealand in the provision of primary health care" (p. 1). Issues identified in the report included the constraint on practice nurse (PN) autonomy, since the PN subsidy was paid to GPs, who then employed PNs. Another issue was the distribution of nursing services across many providers leading to duplication and fragmentation of services. The report argued for a comprehensive primary health nursing role. This idea was further developed by the later PHC nursing Expert Advisory Group of which Carryer and Hughes were again members, possible testament to the role of individuals in leading discourse. The National Health Committee report also claimed that nurses were well situated to engage with communities, to set health promotion priorities and to establish community partnerships.

Litchfield's brief from the Rural Nursing Project, was to examine the scopes of practice and employment diversity in the rural sector. This project was initially funded by the Health Funding Authority and later the Ministry of Health. Litchfield's research was based mainly on interviews from nine nurses in varying rural nursing situations. This became *A Framework for Complementary Models of Rural Nursing*, (Litchfield, 2001). Litchfield found that the work of the rural nurse could be classified in terms of where they were employed. This was either: by the hospital (district or public health nursing); by general practice; or by community trust and iwi organisations. The latter groups had great scope to create their roles as their communities demanded. However, there was often still a notion of constraints placed by contracts on their work (Litchfield, 2001). In comparison to Carryer et al. (1999), Litchfield did not recommend one comprehensive primary care nursing role, but saw the furthering of each role in its own category, as funding became available. Litchfield could see nurses employed by PHOs

being able to better provide the wide ranging practice required, while those employed by DHBs would be constrained by the hospitals core services. Litchfield also found that consultative and collegial relationships existed between rural GPs and nurses (rather than power imbalances caused by the practice nurse subsidy). The rural nurses who contributed to this work conveyed the impression of the often organic or needs based development of their roles. They filled the gaps in rural community health care as best they could.

After the PHCS was launched an Expert Advisory Group of nurses was appointed to provide advice to the Ministry of Health on activating primary health care nursing in New Zealand. *Investing in Health: Whakatohutia te Oranga Tangata* (Expert Advisory Group, 2003) was the result. Research methodologies that underpinned *Investing in Health* included a literature review which looked at the health outcomes and the impact of primary health care nursing, a survey of PHC nurses which looked at their education, career structures and barriers to collaboration, analysis of previous reports on primary health care nursing and informal stakeholder discussions (Expert Advisory Group, 2003). The Expert Advisory Group provided some key advice and recommendations including a definition of a primary health care nurse and PHC nursing:

> 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. The setting and the ethnic and cultural groupings of the people determine models of practice. Partnership with people – individuals, whanau, communities and population – to achieve the shared goal of health for all, is central to primary health care nursing.
>
> (p. 9)

The Group's vision for PHC nursing 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" (sic) (2003, p. 9).

The PHC Expert Advisory Group made a large number of recommendations to the MOH, DHBs and PHOs. A selection of these recommendations were that the MOH should fund, monitor and evaluate innovative models of primary health care nursing practice, fund primary health nurses in relevant postgraduate education, and promote and identify barriers to the primary care Nurse Practitioner. DHB and PHOs were advised to facilitate nursing leadership structures in PHOs (Expert Advisory Group, 2003, p. ix-xii). The methodologies that the Advisory Group used meant a variety of opinions were canvassed from different sources. However, the varying views and voices that different nurses held are not contained in this research, as the Expert Advisory Group opted for a unified voice making recommendations for nursing.

Since the PHCS there has been a major investment in the PHC nursing workforce. In 2002, as was recommended by the Expert Advisory Group, PHC nurses were invited to apply to the Primary Health Care Nursing Innovation Fund (King, 2002). Applications needed to show that the innovation was in line with the PHC nursing framework (of the Expert Advisory Group) and involved PHC nurses reducing fragmentation of services. Many nurses applied to the fund and there were 139 entries, of which 11 were chosen as best representing nurses working collaboratively (King, 2003). The money for the nursing innovation fund came from a total allocation of $8.1 million to be used to develop primary health care nursing over five years. Most of this fund is targeted at the nursing innovations projects (up to $7 million). The remaining funds will to be used to evaluate the projects and support nurses in post graduate study (King, 2002).

In 2003, 180 nurses, again in line with the Expert Advisory Group recommendations, received scholarships to help them in their post graduate primary health care nursing study (King, 2003). Thirteen rural nurses also received year long scholarships from the

Ministry of Health (six nurses in 2003 and seven nurses in 2004), that would enable them to participate in full time study toward a nurse practitioner qualification with specific prescribing rights (O'Connor, 2004).

A further MOH nursing report was published in 2005. *Evolving Models of Primary Health Care Nursing Practice* (Ministry of Health, 2005b) showcased eight examples of primary health care nursing which had been self selected by replying to an email. As the report says this does not mean these examples are representative of all primary health care nursing. However, the report did acknowledge the changing role and potential of nurses. The report found that the title of primary health care nurse was only used by one profiled group, and that structural problems still prevented nurses from realising the potential of the primary health care nurse practitioner.

These lead nursing documents began constructing key nursing discourses that impacted on the PHCS and the development of the PHC nursing discourse. The issues discussed centre around the importance and potential of nurses, rather than the needs of primary health care. The development of a nursing centred discourse will be further discussed in Chapter Five.

2.4 Chapter conclusion

When beliefs are commonly held within a group the belief held can be understood as a discourse. Discourses were apparent prior to the release of the PHCS and the advent of PHOs. For example, GP discourse focused on the right to be autonomous in their fee setting. However, the Government discourse moving into the PHCS era, centred on the community governed organisations such as the Health Care Aotearoa model practices, rather than the GP based organisations. PHCS can therefore be conceived as favouring a discourse of decentralised decision making.

The problems and solutions for those who experience health inequalities are also discursive. Thus while it may seem logical to situate the responsibility for health individually, government policy and health access affect groups and their health

outcomes disproportionately. This debate of health responsibility is taken up in the discourses in the nursing and medical media discussed in Chapters Four and Five.

Prior to the release of the PHCS there were key nursing reports that set the agenda and discourse for later developments in PHC nursing. The need to enhance the nursing profession and the roles of nursing was a key driver in the PHC nursing discourse. In effect nursing answered the question of what can be done to improve nursing, rather than what will improve health. This discourse will also be developed in Chapter Five. The next chapter will consider the nature of discourse and how this thesis will use discourse analysis.

Chapter Three: Discourse and its analysis

3.0 Chapter introduction

I have discussed elements of the Primary Health Care Strategy (PHCS) and the discourses that were apparent prior to the PHCS in Chapters One and Two. I now discuss the method I used to consider whether discourse is decreasing the focus on health inequalities. This chapter explains discourse and how various nurses and others have applied discourse analysis. The postmodern assumptions of discourse analysis are briefly explained and challenged. Finally, how this research was conducted using discourse analysis is explained.

3.1 Definitions of discourse

Discourse according to Salmon and Hall is the use of a "coherent set of words and ideas that is shaped according to social functions that it serves for the community that uses it" (2003, p. 1969). When discourse is referred to in linguistics it refers to a single extended text which will then be analysed (Macey, 2001). Some writers, under the rubric of discourse analysis, therefore use several texts and then analyse how these texts represent an underlying social structure like racism, sexism or medical dominance (see Crowe, 2005; Phillips, 2001; Weeks, 2005); others concentrate on the meanings or double meanings in the words themselves (Macey, 2001). Other notions of discourse situate the receiver within a core group of ideas that relate to a certain way of knowing. An example is the concept of caring as part of a discourse in nursing. Foucault's analysis of discourse seeks to uncover the historical factors which have influenced the way we understand various aspects of human nature, for example, that human sciences and pathology have been dominant discourses in understanding (and controlling) the human condition (Wilkin, 1999).

In this thesis I narrow the meaning of discourse to refer to groups of written texts which do form a "coherent set of words and ideas that is shaped according to social functions that it serves for the community that uses it" (Salmon & Hall, 2003, p. 1969). That discourses serve a social function for communities is important to this thesis, since

discourse is political, in that power relations are created and recreated in language. I am most interested in discourse where the explicit or implicit function of the texts is to create, entrench, maintain or change the power structures of collective entities (Fairclough, 1992).

Discourse analysis seeks to problematise taken-for-granted aspects of text by critiquing the text and considering who gains from the worldview the text assumes. Assumed in discourse analysis according to Crowe (2005) is that language constructs our perceptions and experiences and that written text is culturally and historically situated, rather than a reflection of truth. Discourse analysis can therefore be situated in a postmodern or relativist paradigm. Postmodern ideas that may inform discourse analysis have questioned whether language is capable of representing truth, since language may reflect the bias of the writer and the paradigm the writer is writing from, therefore truth is created by those who use it (Giddings & Wood, 2002). According to Robinson and Groves (2004) Derrida showed that text revealed binary opposites in which one interpretation had supremacy, while Foucault teased out how social control has occurred through the relationship between power and knowledge. However, I find the relativist implications of postmodernism not terribly useful in the present context, given that nurses often need to 'take a stand' on issues. I discuss the issue of the short comings of postmodern relativism, in more depth, later in this chapter.

Discourse analysis is not widely used by nurse researchers. However, it is thought to be a valuable technique for getting nurses to consider the power discourses in which they are involved, for example medical, nursing and patient discourses (Powers, 1994).

3.1.1 Discourse analysis as used by nurses

Foucault's work on discourse has helped inform nursing research using discourse analysis (Crowe, 2005; Giddings & Wood, 2002; Phillips, 2001; Powers, 1996; Weeks, 2005; Winch, 2005; Zeeman et al., 2002). Powers found Foucault's discourse analysis "is useful for the examination of discourses in, or related to, nursing" (p. 207). Like others, she points a discursive lens at texts, by considering the following: What are the

‘rules’ of becoming an advocate in nursing and other disciplines, what are the power differentials, gender issues and voices heard and not heard, what outcomes are acceptable and not acceptable? In terms of nursing discourses, Powers asks: “What kind of practices or discourses had to be in place before the discourse of nursing theory could be constructed? What social practices and power arrangements are necessary for the discourse of nursing theory to continue?” (p. 209).

Crowe (2005) also defends the use of discourse analysis in nursing. Crowe contends that discourse analysis “places the social and historical context rather than either the researcher’s hypothesis or the individual’s experience as central to the enquiry process” (p. 56). Crowe analyses the American Psychiatric Associations (APA) website information on the explanation of mental illness. She then ascertains the following: the purpose and context for which the text was produced, the way the text claims authority, how the text calls upon and is linked to other discourses, the processes of naming and categorising, the construction of major concepts, subject position, reality and social relations and possible nursing repercussions. Through this approach, Crowe revealed that the APA text marginalises treatments and disciplines that are outside the medical model and positions psychiatrists as the mental health experts.

Weeks (2005) looked at the discourses created in nurse to physician communication in the peri-operative environment and suggested there were gendered and cultural patterns which were counter to a collaborative culture. She suggested that action in the form of collaboration in research, leadership, education and clinical practice would help replace “traditional hierarchy and turf protection” with “mutual understanding” (p. 54). In this research Weeks had both taken a stand on what was wrong, and suggested change strategies. In taking a stand she had assumed that collaborative culture and mutual understanding were appropriate and worthwhile outcomes.

Phillips (2001) examined the production of discourses of masculinity and links to male violence. Her data collection included media representation and group and individual interviews with teenage boys. She describes her discourse analysis approach as post

structural, psychoanalytic and feminist, and stresses the importance of looking behind hegemonic norms of a society. She found binary opposite positions at work in the lives of those she interviewed, for example, the popular versus the outcast. Phillips had a strategy for uncovering oppressive discourses and was willing to say that these are unhealthy for society, for example:

> Not noticing gender, race, class, and other structuring mechanisms in a gendered, racialized, and classed society works against health and well-being…. Calling attention to the gendered and racialized processes by which norms are constituted helps reveal their consequences in peoples' lives and the purposes they serve in maintaining the status quo and conditions of oppression. (Phillips, 2001, p.45)

However, Phillips falls short of articulating an emancipatory strategy. Indeed Foucault was also cautious of action recommendations since they may lead to further repression (Powers, 1994). Foucault distanced himself from the intent of emancipation and focused on historically created discourses and why they are understood in a certain way (Foucault, 1980; Wilkin, 1999).

3.1.2 The postmodern or interpretive problem of truth and action

This type of deconstruction of discourse, where the reader is open to interpret the data, leads to results that are not easily generalised (Gutting, 2005; Powers, 1994, 1996). For example, Powers (1994) claims that her data could produce another interpretation given a different conceptual framework. Others state that discourse analysis can neither describe, nor explain, nor make a claim on the truth or truths. However change and progress is possible after a discourse analysis has been carried out (Zeeman et al., 2002). This statement is in itself very problematic, since one wonders why change or progress would be based on analysis that the writer admits is contextual and partial.

Nurses who have used discourse analysis are then left in a theoretical quandary. If their analysis is relative (or open to multiple interpretations) how can they possibly decide which are the correct versions of truth, or claims of right or wrong, to follow? This theoretical problem of postmodernism is generally solved by turning to another

discourse the nurse deems as a more correct theoretical position. Powers (1994) got around the problem of needing to make recommendations in her Foucault inspired discourse analysis of nursing diagnoses, by adopting arguments from feminist emancipatory research. Patterson (2002) also turned to feminism in her analysis of the discourse of a group of rural midwives, seeing feminism as a reference point to aid discussion. "For rural midwives in New Zealand, a feminist and collective voice has been seen as important in their quest for autonomy. Moreover, as an historically female profession whose work is about women, feminism contributes a social critique of gender relations, which might otherwise be lost in a sea of postmodern relativism" (p. 76). In effect, Powers and Patterson have used feminism in order to take a stand on their findings, and while this may be problematic and like any discourse marginalise others, it does provide a reference point in Patterson's "sea of post-modern relativism" (2002, p. 76).

Siedel (1993) also took a stand on what was right by using an ethical, rather than feminist standpoint. Siedel's work is on the competing discourses of HIV/Aids in sub-Saharan Africa. Siedel discusses competing discourses such as the discourse on rights and empowerment which positions people with HIV as people with rights to inclusion, treatment and self determination, while the competing discourse is around the control or exclusion of people with HIV. Siedel firmly backs the rights discourse and uses ethical arguments to do this.

I followed the lead of Siedel, Powers and Patterson and turned to other ideas to arbitrate the competing discourses in primary health care. The ideas I used for this arbitration are from the field of health resource allocation or quality frameworks, which argue for a fair allocation of resources. This will lay the groundwork for my discussion in Chapter Six, where I consider PHC nursing and the PHCS in terms of efficiency, effectiveness, equity and the legal status of interventions. These terms, I hope, will offer a more neutral ground than the politically charged discourses of nursing and medicine. For the writings on nursing, medicine and the PHCS are political. Language does not merely represent reality, but constructs and shapes what passes for normal.

3.1.3 Rigour and the interpretive paradigm

Discourse analysis is not regarded as an absolute method of research. More importantly there is a theoretical position that the discourse analyst takes, by regarding texts as being organised in a way that promotes one shared theory of truth, that is able to influence the power differentials in some way. To uncover themes that may illuminate discourses, authors will consider texts in terms of certain questions. For example, one may consider what the purpose of the text is, how the text claims authority, and how the text is connected to other texts (Crowe, 2005). Rigour then is supported by being appropriate in terms of the texts chosen, the research question, and the breadth of sampled resources. Rigour is further supported by being faithful to the interpretive paradigm and by providing detailed descriptions of the processes of data gathering and analysing (Crowe). While I will be rigorous, according to Crowe's definition, in aspects such as breadth of sampled resources and appropriate research question and texts; I disagree with aspects of the interpretive paradigm. I accept that the information conveyed by any text is partial and that it inevitably informs power relations. Yet the postmodern or interpretive position suggests an inability to make truth claims, which makes it clearly illogical to suggest change strategies, when all knowledge is understood as an interpretation. To this end even a feminist or nursing position can be discounted as merely privileging one position over others, and thus is the antithesis of a post-modern goal of unmasking power relations. Nurses and those working in health care need to both be aware of power relationships and suggest improvements. I have therefore both looked at the power relations in the texts studied and used a resource allocation framework to further discuss PHC, since this model is inclusive of nursing and medical paradigms, but does not privilege either one of these positions. While a resource framework is another discourse, a resource allocation framework argues from the point of view that ethically resources should be allocated to maximise the good they can do, rather than from an interest group perspective.

3.2 Research method

In order to evaluate the discourses of the nurses and doctors involved in the implementation of the PHCS I needed to seek the discourses of those who were involved in these changes. Interviewing would have captured the private discourses of some individuals. However, by using the public record of the time I was able to capture the 'recorded discourses' that are in circulation. Voices of assent and dissent are expressed in the professional media of those who work within the Strategy. These media discourses are important since they not only reflect opinion; they also create discourses that may be influential in defining 'truth'. This media will become the privileged voices which will be left to speak for the time and help create the future understanding of events.

3.2.1 Media choices

Prior to evaluating whether discourse is constraining a true commitment to the decrease in health inequalities, I needed to establish what the discourses in nursing and medical media are. The media I chose was the *Kai Tiaki Nursing New Zealand (Kai Tiaki)* and *Practice Nurse* journals and the *New Zealand Doctor (NZ Doctor)* newspaper. Details of these media publications follow. I did not use scholarly journals like the *Nursing Praxis in New Zealand* and the *New Zealand Medical Journal* which publish research, rather I chose to use media in which opinions on a subject are offered so I could establish themes at the 'ground level'. However, I did refer to a wider range of journals in my analysis.

I chose to use *Kai Tiaki Nursing New Zealand* (*Kai Tiaki)* in my discourse analysis since it is widely available to primary health care nurses. *Kai Tiaki* is the official journal of the New Zealand Nurses Organisation (NZNO), a nursing organisation which provides industrial and professional nursing support and boasts nearly 40,000 members (International Nurses Day, 2005). Included in membership to NZNO is a free subscription to the *Kai Tiaki* journal. Of the co-editors, who are employed journalists, one has a comprehensive nursing qualification (Introducing the Editorial Team, 2006). The co-editors generally write the 'news focus' and 'profile' articles, while the

‘editorial’ and ‘viewpoint’ sections may be written by guest writers who are usually nurses.

I chose to use the *Practice Nurse* journal in my discourse analysis because, currently, practice nurses are the nurses most involved in PHOs. The *Practice Nurse* journal is written by practice nurses for practice nurses. It is the journal of the Practice Nurse Section which is affiliated with NZNO and comes out four times per year. The journal also features articles by practice nursing opinion leaders. These opinion leaders are in prominent positions, for example as chair people of the NZNO Practice Nurse Section.

The journal I chose to obtain a medical perspective from was the *NZ Doctor*. This is a newspaper style publication and is independent of a medical practice organisation. The original intended audience was GPs and the subheading of the newspaper in 2003 read “real news for Doctors”. However, the subheading on the newspaper’s website says the newspaper now serves the “primary health sector” with “relevant health news” (http://www.nzdoctor.co.nz/HOTP/07-06/19Jul.htm). The website is linked to practice nurse, practice manager, IT, PHO, patient resource and GP information. The newspaper and website can therefore appeal to a wide audience, while promoting the GP view. The action of integration rather than domination of subordinate groups, is to Fairclough (1992), one of the ways a powerful group may dominate others. The *NZ Doctor*’s appeal to the wider PHC sector rather than just GPs, can then be understood as an example of medical domination.

The editor and staff writers of *NZ Doctor* are employed journalists. Articles written by these people, generally feature interviews with staff working in, or commenting on general practice. While GP articles predominate, other health professionals also provide articles and interviews, for example Nursing Professor Carryer (13 July, 2005) provides an article on Nurse Practitioners. Literature surveys from the *NZ Doctor* have already been used to establish themes by other writers (See Barnett, Barnett, & Kearns, 1998; Perera, McDonald, Cumming, & Goodhead, 2003).

3.2.2 Limitations

One of the problems with choosing these particular publications was that, even though there were two nursing journal, compared to the one medical newspaper, there was far more published material from the medical side. This is because the *NZ Doctor* publishes fortnightly, compared to the monthly *Kai Tiaki* format and the three monthly *Practice Nurse*. In terms of amount of literature therefore the PN voice is then not a dominant one in primary care.

A lesser PN voice is compounded by the *NZ Doctor* and the generalist *Kai Tiaki* journal both employing staff, while the *Practice Nurse* journal generally relies on PNs submitting articles. None the less, I still looked for the dominant themes in the nursing and medical media, irrespective of the number of articles involved in each group. Another potential problem with choosing these journals was the number of articles that were written by journalists, including the editor, as opposed to health professionals. The journalists get around this by quoting the health professionals they interview. However the journalists' work is also important because it both reflects and informs the primary health discourses. Furthermore, having journalists and editors who are not part of the profession may free these people to write in more outspoken ways, immune to employer or professional backlash. The editor of the *NZ Doctor* is a good example of this, as her work is often thought provoking and controversial. As editor she oscillates between talking in support of GPs, and challenging their thinking on issues.

It must be also acknowledged that *Kai Tiaki* and the *Practice Nurse* journals both are affiliated with NZNO. This poses two problems. Firstly this may mean that NZNO, which has a trade union role, promotes an industrial centred nursing approach. This approach was found in the discourse analysis. Secondly, given that not all nurses are members of NZNO, other discourses in other nursing media were excluded. An example is the primary care web discussion through the College of Nurses Aotearoa (NZ) Inc (see http://www.nurse.org.nz/). I did not include this material since, as a non member of the College of Nurses, I do not have access to this discussion; nor does this

web log form a historical paper based record that will contribute to the historical record of the time.

3.3.3 Time span

The material surveyed for this discourse analysis, to establish dominant themes, was between January 2002 and July 2005 of the above journals. The start date meant the PHCS had begun to be implemented (since its release was in 2001) so implications of the PHCS were being written about. The mid 2005 end date was chosen because this was when the general election campaigning began so agendas were more political. This date was also chosen to ensure the timely completion of this thesis.

3.3.4 Discourse survey

In order to establish what the discourses were in nursing and medical media a page-by-page search of the journals/ newspaper was undertaken to find articles which concerned the PHCS, PHOs or the PHC nursing framework. From this search I was able to assemble key themes about the primary health care strategy and PHC nursing framework into thematic groupings. I colour coded and grouped according to themes that emerged after reading through the material frequently. The decision to establish themes was made in the same way Powers does, namely by achieving an "overall impression" through reading and rereading all the relevant articles numerous times (1994, p. 94), and grouping articles accordingly.

To ensure I was cognisant of the dominant themes, I looked for (and found) agreement in other articles outside the primary survey that acknowledged the dominant theme found in the primary survey. Common themes across one data set (for example nursing) were then considered to be a discourse in nursing since, by definition, I will have found a "coherent set of words and ideas that is shaped according to social functions that it serves for the community that uses it" (Salmon & Hall, 2003, p. 1969). Having located the dominant themes I then unpacked these themes and looked at the discourses created in terms of power relationships or other phenomena. This I do in Chapter Four for the GP media and Chapter Five for the nursing media. In order to analyse the discourses I

was cognisant of the suggestions from Terre Blanche and Durrheim (2002) and Crowe (2005) on how to uncover a discourse by considering certain questions in relation to the themes. For example, who does the discourse serve? And who are the voices not represented in this discourse? The discussion of binary opposite and invisible positions was an important aspect of considering the position of the dominant viewpoint which was recorded and naturalised. Critiquing the discursive binary opposite position enables one to imagine how the discourse would be, if the opposite viewpoint was promoted. For example, by considering that nurses, rather than being integral to the PHCS, were irrelevant, there is scope to reveal that discourse is very influential in shaping our perception of reality. Similarly, by bearing in mind invisible positions one can be reminded of those who are not represented in the dialogues, for example the Maori perspectives. Another important concept used is that of intertextuality. Intertextuality occurs as texts converse and interact with the concepts and discourses in previous and future texts (Fairclough, 1992). Further, intertextuality also serves to strengthen the existence of a discourse when discourse is observed in one media and then referred to in another.

Only part of my aim in this thesis was to reveal discourses in the mentioned media. In order to assess whether discourse is decreasing the focus on health inequalities, I needed to critique the discourses. Therefore I needed to decide what the best or most appropriate discourses and actions in a constrained health environment were. As mentioned earlier in this chapter, this means that I diverge from a postmodern approach, since I am not proposing that all the information has relative merit given different perspectives. Therefore in Chapter Six, I consider the discourses of the PHCS. In this sixth chapter I propose that health professionals can mitigate some of the effects of discourse by considering health care in terms of effectiveness, efficiency and equity-tenets of ethical resource allocation. I also suggest some ways that resource allocation can be implemented to focus the energy of those who work within the PHCS.

3.4 Chapter conclusion

Discourse analysis serves as a way of elucidating the power relationships that are implicit in text and considering the wider implications of these. In this chapter I have discussed discourse analysis and my method for applying this to the texts of nursing and medical journals with regard to the PHCS. This method involves finding the dominant themes across the nursing and medical journals, then discussing the power relations involved. I have also discussed a conceptual shortcoming in the post-modern perspective where all information is given relative merit, and then one perspective is privileged over another, for example the feminist or nursing perspective. Therefore I will not be using these perspectives and will use a more neutral resource allocation framework to move the discussion beyond power relations. The next two chapters will show my findings in terms of the nursing and medical media.

Chapter Four: Medical media discussion

4.0 Chapter introduction

Chapter Four is concerned with revealing the discourses in the medical media regarding the Primary Health Care Strategy (PHCS) and then offering critique on whether discourse is decreasing the focus on health inequalities. These findings are based on a discourse analysis of the *New Zealand Doctor* (*NZ Doctor).* I summarise the findings from *NZ Doctor* first (in this chapter) because the general practitioner (GP) discourse concerns the PHCS as well as their industrial concerns. This provides a backdrop to the nursing discursive findings which are discussed in Chapter Five. In Chapter Six I consider primary health care (PHC) discourses and suggest an alternative approach using a resource allocation framework.

Discourse analysis aims to reveal the power of groups (such as nursing or medicine) and structures (such as a medical hierarchy) that the texts maintain or challenge. The 'discourse of dissatisfaction' in the *NZ Doctor* maintains a medically dominant position in a number of ways. This medically dominant position is maintained, for example, by claiming that the PHCS was unsatisfactory, by naturalising the position of the Independent Practice Association (IPA) run primary health organisations (PHOs) over the Health Care Aotearoa type organisations, and by keeping relatively silent on both the needs of people to affordable health care and the Maori and Pacific people who are the stated focus of the PHCS.

4.0.1 Primary health care governance structures

Prior to the PHCS the majority of GP practices were self-employed businesses, in which the GPs claimed the General Medical Subsidy to subsidise patient costs. A minority of GPs and practice nurses (PNs) were employed by community boards in non profit, non Government organisations like capitated Health Care Aotearoa Practices (Ashton, Cumming, & McLean, 2004; Crampton, 2005). GPs who were business owners, were in many respects autonomous in their practice (Crampton), although,

those GPs who joined IPAs were offered incentives or advice to practice in certain ways, for example with respect to prescribing certain medications (Ashton et al.).

Becoming part of a PHO fundamentally challenged the autonomy of GPs who ran their own practice business. For in return for funding based on the number of patients that were enrolled with the practice, GP practices, on becoming part of the PHO, were subject to PHO governance.

4.1 Recurrent themes

The *NZ Doctor* newspaper tracked many issues pertinent to the primary health care sector after the PHCS was instated. Many of these issues can be captured under the umbrella theme of dissatisfaction with the PHCS. Although there were some positive aspects of the PHCS that were written about, there were many more examples of dissatisfaction expressed toward a variety of aspects of the Strategy. Samples of areas of dissatisfaction follow.

Dissatisfaction was levelled at PHO boards where problems with board members or policy had led to PHO boards being unable to form or being forced to fold as an organisation (Fountain, 2003b, September 10; Guthrie, 2005, May 4; Meylan, 2003, October 22; Meylan 2004, February 23; Meylan, 2004, November 17; Meylan, 2005, February 9; Meylan, 2005, March 10; Meylan, 2005, April 6). In regard to the Middlemore PHO Dr Sturm was reported to say that the PHO board's "philosophical differences were brought about by people bringing different expectations about what the PHO was about, and their inflexibility in this regard brought about complete inertia" (Meylan, 2005, March 10, p. 3). In regard to the struggling North Harbour PHO, Cooke, the General Manager of Planning and Funding Waitemata DHB, was reported saying that "there should be benefit from getting general practice together with Maori health providers but actually delivering the value for the two is tricky" (Meylan, 2005, April 6, p. 3).

Conversely, dissatisfaction was also felt by Maori health providers who had existed before the PHCS and had to negotiate new relationships with sometimes 'mainstream' (often IPA affiliated) GP providers. In a feature article about Maori providers, Meylan sought opinion from various Maori providers throughout the country. Two Maori board members interviewed claimed Maori struggle when they are not the dominant player in governance of a PHO (Meylan, 2004, April 7).

In another *NZ Doctor* story, Meylan discusses the estimated "millions of [Service to Improve Access] SIA dollars [that] remained unspent in PHO bank accounts" (Meylan, 2004, December 15). The reasons offered for this under-spend were that PHOs were busy building relationships, that practices had been too busy with the Meningococcal B vaccination campaign, and that there was difficulty implementing projects for reasons such as workforce issues.

There was also dissatisfaction over the contracts that GPs needed to sign to become a PHO, especially with regard to the Ministry of Health's authority to set patient subsidy and fees policies (A sample of these articles are: Fountain, 2005, June 29; Hill, 2003, January 29; Hill, 2003a, March 12; Hill, 2003, September 24; Hill, 2004, May 7; Hill, 2004, June 30; Meylan, 2003, September 24; Topham-Kindley, 2005, June 29). In regard to GPs autonomy in fee setting, IPAC spokesperson, Dr McCormack, described the GPs right to set fees as "unalienable" (Hill, 2003, February 26, p. 1). A few months later IPAC warned GPs that "Agreeing to a contract that doesn't support the maintenance of clinical autonomy, retention of a GP's right to set fees and assurance that general practice remains viable, will have long term consequences for the quality of primary care in New Zealand" (Hill, 2003a, March, 12, p. 1). Negotiations involving the Western Bay of Plenty PHO also mentioned the "right to have a non capped fee" (Hill, 2003, September 24, p. 2). Prior to this Fountain (2003a, September 10, p. 1) was musing over whether these policies were an example of "nationalisation by stealth" suggesting that the PHCS was a screen for bringing general practice into the public health system.

Negative language is apparent in the articles surrounding contracts and fees policies, especially with regard to Ministry of Health (MOH) management. For example "PHO contracts look to founder by July if IPAC cannot renegotiate crucial aspects with the health ministry. This latest bad news [Emphasis is my own] comes after concerns in December that PHOs agreeing to maximum copayments could be in breach of the Commerce Act" (Hill, 2003, January 29, p. 1). Also "GPs should get ready to break some bad news to their over 65-year-old patients. On Tuesday last week as PHOs scrambled to reset fees in line with a shift in Ministry of Health policy, it looks like a number of practices would not be receiving new funds for this age group until as late as October" (Hill, 2004, June 30, p. 3). And "with almost as many flip flops as a jandal factory the previously delayed over 65 funding is being brought forward a year at the same time $3 prescriptions are being pushed back six months" (Meylan, 2003, 24 September, p. 3).

Another source of discontent was the capitation, enrolment, and funding formula (St John, 2003, December 2). Individual cases of dissatisfaction were documented; for example, the Rotorua GP group found PHO funding rules would mean that in their area, 62% of the increase in funding would go to higher income patients anyway (St John, 2003, December 2). Other reports on the PHCS furthered the effect of finding fault with the PHCS. For example in regard to the PHO Management Service Fees report, *NZ Doctor* found that the report "highlights a stream of problems around a lack of processes, planning and logic in the implementation of the Primary Health Care Strategy" (Meylan, 2005, March 23).

While each area of dissatisfaction could be discussed separately, it is not my intention to tease out each aspect, since it is the underpinning discourse that is most pertinent to this thesis. Cumulatively, however, each aspect of dissatisfaction adds to the creation of the discourse of dissatisfaction with the PHCS. Generally, the GPs involved were quoted or wrote articles that built up this discourse of dissatisfaction. However this was by no means exclusive, as PHO managers and Maori providers were also quoted in their dissatisfaction at aspects of the PHCS. That this phenomenon of dissatisfaction

was not unique to the *NZ Doctor* can be seen through the intertextual agreement that will be discussed below. Importantly, also, is that while aspects of the implementation of the PHCS were found to be at fault (Fountain, December 17, 2003; Perera et al., 2003; New Zealand Doctor, 2003, September 24), there was broad agreement with respect to the underpinning philosophy of decreasing health inequalities, increasing community participation, and increasing health sector collaboration for personal and population health. A simplistic assumption would be that the biggest problem to GPs was their lack of autonomy with regard to the new PHO board structure, to which GPs were subject at the time. However, aspects of the PHCS that did not affect GP autonomy were also discussed. The dissatisfaction discourse can then be understood on a number of levels. We will now turn to some discursive intentions of these texts.

4.2 A discourse of dissatisfaction

These texts discuss and critique the PHCS as it affects privately owned general practices. This results in the legitimating of the current or previous model of general practice as normal, and changes to this as abnormal and a threat to GPs rights. The texts therefore form a discourse that supports the institutions of general practice as a privately owned business model.

One of the way that texts claim authority to support the status quo in general practice is by quoting opinion leaders in the medical field, for example Victor Klap (Hill, 2003, February 26); Dr McCormack (Hill, 2003a, March, 12); GP leaders group spokesperson Peter Foley (Topham-Kindley, 2005, June 29); and Royal New Zealand College of GPs chief executive Claire Austin (Hill, 2003b, July 16). All of these authorities speak out about negative aspects of the PHO reality under the PHCS.

Use of phrases such as the 'GPs right to set fees' shapes the justice discourse on what is considered right and normal. According to Marxist historical materialism, since the dominant powerful group have economic control (which is true of the majority of GP practices) they will inform the discourse on justice and so legitimate the dominant group's continued economic control (Pogge, 2002). The business model is also

legitimated by claiming the authority of the scientific method to 'prove' patients will be worse off under the new model, as happened in Rotorua (St John, 2003, December 2).

The texts also reveal situations where an assault on general practice has resulted in a combined response from the GP sector groups, which has led to a compromise being negotiated with the Ministry (Meylan, 2003, October 8). This is an interesting situational response akin to the response by general practice in 1991. In 1991 health reforms required GPs to contract regionally with Regional Health Authorities, which resulted in IPA organisations being formed to represent GPs in local groupings (Barnett et al., 1998). After the implementation of the PHCS, the autonomy of GPs to set fees was again threatened by the requirements of PHO contracts. A combined contract negotiating GP group called IFC (representing IPAC, First Health and CareNet) was formed to lobby the MOH on GPs behalf (Meylan, 2003, October 8). At both times, in 1991 and 2003, the GPs maintained a more powerful position by forming umbrella organisations which could represent them, thus limiting the Governments ability to dictate GP fees.

4.3 Binary opposites

One aspect of discourse is the development of binary opposite positions where one position is taken for granted, or naturalised as the right position (Fairclough, 1992). The binary opposite position to the large, IPA affiliated practice PHOs are the small non-Government, non- profit model practice. This dichotomous position is directly referred to by the *NZ Doctor* editor, based on her experience at a Ministry of Health run Primary Focus conference. She reports that the conference perception was that:

> The good guys are the small, struggling, access PHOs who are loved and beloved of their communities. The bad guys are the large, interim, mostly urban PHOs run by the apparently cold-hearted, distant IPAs, their biggest crimes being well resourced in IT and having GP members who run small businesses.
>
> (Fountain, 2005, March 23)

The development of binary positions was also noted by Barnett and Barnett (2004): "The government's policy discourse appeared to downplay IPAs, instead endorsing a community-orientated model along the lines of third sector organisations [Health Care Aotearoa model] as the preferred vehicle to achieve its policy aims" (p. 56).

The dichotomous positions can be summarised by generalising that PHOs that were affiliated with IPA linked management services agencies would find it difficult to make community links, while small PHOs, although integrated into the community (Glensor, 2003), would find it difficult to fulfil requirements such as the performance management programme, due to lack of economies of scale and low management fees (Kumar, 2004, August, 25; Hill, 2005, February 23). Over time there were actions that modified both positions. There were calls for the MOH to assist in community participation (Hill, 2003, May 21), and a project in which a community participation tool kit was trialled (Neuwelt et al., 2005). With regard to the financial difficulties of smaller PHOs the MOH eventually increased the management fee for smaller PHOs (Meylan, 2005, March 23; Kumar, 2004, August, 25). Thus the MOH continued to support the small, decentralised community model of PHOs. Historically, in New Zealand local and more expensive bureaucratic models of health care have oscillated with centralised health care models. Currently the Government discourse supports the local model.

4.4 Invisibility

With the *NZ Doctor's* viewpoint that GPs have a right to set fees, there is little discussion of the opposition discourse that people have a right to affordable health care. Moreover, there is disagreement about who should be responsible for this affordable health care. The MOH (in the form of the PHCS) states that communities and their PHO are responsible for the health of local communities (King, 2001), while various GPs have stated that the real issues in health care are decided by policies beyond their control like taxation, employment and education (Kumar, 2004, July 14; Hill, 2003, June 18; Meylan, 2004, April 7; Robinson & Blaiklock, 2003).

While Maori, Pacific and low income people are a focal point of the strategy, their needs, while referred to and occasionally focused on in articles on inequality (Meylan, 2003, July 16) and Maori and Pacific PHOs (Meylan, 2004, April 7; Hill, 2003b, March 12), do not make up the major part of *NZ Doctor* discourse, since *NZ Doctor* concerns itself primarily with GP autonomy and income structures. As yet, the successes of Maori and Pacific providers will not dominate history from the perspective of this newspaper. History will also judge whether the PHCS policy focus on Maori and Pacific groups and importantly their ill health, leads to health gain or stigmatisation, as discourse may serve to preserve the perception, rather than eliminate the problem (Powers, 1996). This ethnic-centred discourse may affix a stereotype of racial inferiority (Powers). In this way the concept that Maori and Pacific people are linked to ill health becomes naturalised. Minority ill health is a complex worldwide phenomenon, where the interplay of social structures (employment and housing) have also been found to be important (Robinson & Blaiklock, 2003). However, the PHO discourse seeks to apportion the responsibility for Maori and Pacific ill health on local communities, rather than Governmental policies. Maori and Pacific people have also become depersonalised economic objects who are talked of in terms of 'pepper potting' when practices strive to increase their ethnic mix for financial reasons (Busy PHO timeline, 2003, September 24).

4.5 Intertextuality

Intertextuality, as explained by Fairclough (1992), constantly occurs in texts as texts converse with previous and future texts, and interact with their concepts and discourses. While this may be implicit generally in literature, this is made explicit in *NZ Doctor* articles which highlight PHCS reports. Almost without exception the reviewed reports are critical of aspects of the PHCS also, which further legitimises the *NZ Doctor* stance of an unsatisfactory PHCS. Reports reviewed include *PHOs and Maori Health* (Meylan, 2004, April 7); the report on the demise of Middlemore PHO (Meylan, 2004, November 17); papers released by the RNZCGPs on the vulnerability of primary care and the concerns with inadequate PHO infrastructure and infrastructure funding (Hill,

2003b, July 16); and a MOH report which found the management service fee formula illogical (Meylan, 2005, 23 March).

4.6 Critiquing the discourses

The second intent of this chapter was to critique the discourses found in the medical media reviewed, to decide whether discourse is decreasing the focus on health inequalities. As discussed, the medical media has focused on problems and dissatisfaction with the PHCS. Specifically, the GP rights discourse has focused on defending the position of GPs. Admittedly professional advocacy is a valid activity the medical and nursing groups are expected to perform given threats to their members' employment conditions. However, a large amount of time and resource has been spent on implementing, negotiating and critiquing the new order under the PHCS. What is disturbing about this input of resource, is that no one in need of health care, has directly benefited from the protracted discussions on the fee policies. New Zealand health workers should be accustomed to resources spent on restructure, since this has been a common occurrence in the last few decades. However, the diverting of resources to restructures which are based on the latest government discourse does not benefit communities in the short term and may indeed not benefit them in the longer term if changes are not given the time to 'bed in'. This discourse survey was undertaken at a time of change so a settling in period can be expected.

Critique of the PHCS in the *NZ Doctor* also focused on relevant issues in terms of decreasing health inequalities and health generally. This included discussion about the PHO funding formula that would not help targeted populations who did not attend an Access funded practice, the slow creation of outcome measures for PHOs and under-spend of funds as PHOs created their own bureaucracies. In the long term the discourse of dissatisfaction could develop a stronger PHCS as ideas are modified by real world experiences and critique.

While I am unable to judge whether it is more efficient, cost effective and beneficial to health care for GPs to be employed by PHOs or running their own small businesses, the

fact remains that this questions has rarely been raised. The dominant discourse from the MOH backs the community run PHO model. While there are well documented reasons to back this community run model in the areas of demographically at risk populations, I am unsure why this model needed to be adopted in non high risk areas, and therefore why the funds spent rearranging non high risk areas wouldn't have been better spend channelled into other targeted health programmes. Possible reasons for the Government backed discourse of the community run PHO model are that the discourse has become all pervasive so as not to be treated critically, or that the GPs who think PHOs are "nationalisation by stealth" (Fountain, 2003a, September 10, p. 1), are right.

So is discourse as documented in the *NZ Doctor* decreasing the focus on health inequalities? In the short term the answer is yes. The set up and negotiation of PHOs are a huge channelling of public money away from direct care. However in the long term this negotiation may enable more robust decentralised community health decision-making organisations which indeed fulfil the mandate of the PHCS. This is of course assuming that the PHCS, in itself, does achieve suitable outcomes.

4.7 Chapter conclusion

The PHCS discourse of dissatisfaction has been developed through the medical media surveyed and this has served to legitimate the continued control of general practice by GPs. The resulting struggle with GP groups and the MOH has meant resources are tied up sorting out this primary care restructure, rather than creatively attending to health inequalities.

Over time some aspects of the discourse of dissatisfaction should lead to a more robust PHCS as GPs query aspects of the PHCS. Nurses, also, have developed discourses in relation to PHC. These are the subject of the following chapter.

Chapter Five: Nursing media discussion

5.0 Chapter introduction

In the last chapter I looked at the 'discourse of dissatisfaction' that is developed in the *NZ Doctor*. This discourse I found reinforced the model of general practitioners (GPs) remaining dominant in general practice, and their supposed 'right' to be in that position regarding fee setting. I concluded that the predominately GP-centred discourse of dissatisfaction was decreasing the focus on inequalities at this stage. I also situated the GP discourse in the wider discourse of the Primary Health Care Strategy (PHCS). For in the PHCS discourse the Ministry of Health (MOH), currently, backs a model which focuses on decentralised community health decision-making.

The nursing discourse is very different in form to the GP discourse, since the nursing discourse is visionary (in terms of nursing potential) rather than a reaction to events (like the GPs to the PHCS). I have discussed the medical discourse first since the nursing discourse benefits from being situated in the wider PHCS. Generally I find the nursing discourse to focus on the needs of nursing, so the discourse is in effect, a nursing-centred discourse, rather than being focused on health inequalities. As I elaborate further in Chapter Six, a nursing-centred discourse advocates primarily for nurses, rather than considering ways nurses can best meet the needs and advocate for those disadvantaged in health care. Decreasing health inequalities is, after all the primary focus of the PHCS. A nursing discourse which centres on nursing opportunities also fails to mention that nurses are still very constrained by legal factors in the new primary health care (PHC) arrangements.

Lead nursing documents, for example *Locating Nursing in Primary Health Care* (Carryer et al., 1999), informed the development of the later PHC nursing opportunities discourse. The PHC nursing opportunities discourse was then led from the MOH. This nursing discourse overtly aims to promote nursing, nursing opportunities and collaborative approaches to health care, while situating the problems of nursing in the fragmentation of nurses across different employment arrangements. A linked discourse

is the PHC nurse concept which was launched by the PHC nursing Expert Advisory Group. I track the development of these two nursing discourses (of fragmentation and collaboration, and nursing opportunities and the PHC nurse concept) in this chapter.

As I did with the previous medical media section, I found all relevant articles in the targeted nursing journals, and then looked for themes in and between articles. However a feature of the articles that quickly became apparent was the dominance of the MOH in shaping the nursing discourses.

5.0.1 Primary health care nursing changes

Under the heading 'Primary Health Care Nursing' the PHCS stated that:

> The move towards greater population focus and emphasis on a wider range of services will increase the need for well-trained primary health care nurses…The primary health care nurse needs further development with clarification of the appropriate capabilities, responsibilities, areas of practices, education and career frameworks and suitable employment arrangements. Primary health care nursing will be crucial to the implementation of the Strategy, and will therefore be best addressed at the national level.
>
> (King, 2001, p. 23)

Subsequent to the release of the PHCS, the MOH moved to advance nursing as outlined in the PHCS. This included developing the concept of the PHC nurse, developing the skills and knowledge of PHC nurses (through nursing scholarships), exploring employment arrangements (through the Nursing Innovations project), and acting to bridge gaps in rural care through sponsored study toward nurse practitioner status. The Ministry had also clarified regulations for standing orders under the Medicines Act (O'Connor, 2002, p. 1). The practice nurse subsidy also became part of the capitation money paid to the general practice. In order to enact the PHC nursing changes the MOH needed to get nurses 'on board' with the PHC nursing messages. This was done, in part, by nursing media.

5.1 Recurrent themes

The recurrence of nursing importance, opportunities, fragmentation, and the need to collaborate were dominant ideas in the PHC nursing media. I have chosen to focus on these four elements due to the consistency and frequency of their occurrence in the *Kai Tiaki* and *Practice Nurse* journals. I have also chosen to track the development of the PHC nurse concept as a discourse, since this has been an overt discursive construction by lead nurses.

As early as 2001, King, the then Minister of Health, was quoted in the *Practice Nurse* in regard to positive opportunities and collaboration through the PHCS. She stated that "there will be more emphasis on developing workable models of teamwork, and recognising the complementary skills of others, as well as sharing power in order to achieve group goals. Nurses will play a crucial role" (Newsroom, 2001, p. 8). *Kai Tiaki* also featured King, stressing the nursing importance angle, telling district nurses that "district nurses were in a significant position to make the Government's recently released primary health care strategy work" (South, 2001, p. 29).

The next year a Ministerial press release from King restated the themes of fragmentation and collaboration:

> There are more than 7500 Registered Nurses working in primary health care, many of them isolated from each other. Primary health care nursing services are fragmented through various contracts and service providers. We have Plunket Nurses, District Nurses, Public Health Nurses, Practice Nurses, Maori Nurses and specialist nurses such as diabetes and asthma nurses. I want to encourage as many as appropriate to start working together. (2002, p. 1)

A year later, King (2003, p. 1) had the following to say "We have an amazing resource of primary health care nursing in this country, but it's a fragmented sector and at times that has made it difficult for nurses to deliver direct care to the community".

Hughes, the then MOH Chief Nursing Advisor, also supported these themes of collaboration, importance, fragmentation and opportunities:

> The potential for primary health care nurses to develop integrated and collaborative models of care that really meet the needs of individuals and groups has never been greater. Nurses will have roles within primary health organisations or may be contracted to PHOs through other services. Arrangements for primary health nursing services are currently fragmented, with contracting at national, regional and local levels. District Health Boards now have the opportunity to better align their primary health care nursing services to address the needs of their population.
>
> (Reported by Manchester, 2003b, p. 10)

A number of nurses have noted that the PHCS offered opportunity for innovative nursing practice (Guy, 2001; Henty, 2005). Jamieson (2002) highlighted the work that the PHC nurse strategy group had achieved in terms of the definition of PHC nurse and the nursing opportunities through the nursing innovation pilot schemes. While to Richardson, "The advent of the Primary Health Care Strategy and He Korowai Oranga bodes well for the future of nursing in Aotearoa/ New Zealand" (2003, p. 2) . "A springtime for primary health care nurses," said nurse consultant Jones with regard to the 2003 primary health care nursing innovations (Conference Report, 2003a, p. 16). Hill, the *NZ Doctor* editor, had also noticed the positioning of nurses by the Health Minister: "First she reassures GPs they are the key to primary care, then she launches into a homily depicting the role nurses will play, emphasising their worth and wide-ranging capabilities, including leadership" (Hill, 18 May, 2005, p. 1).

5.2 Developing the nursing discourse: The fragmentation and opportunities discourse

5.2.1 Intertextuality

What I call the 'discourse of fragmentation and opportunities' also refers to the linked concepts of the need for collaboration and the importance of nursing. This fragmentation and opportunities discourse did not begin with the PHCS. Fragmentation of the PHC nursing workforce was noted by the Ministerial Taskforce on Nursing in the 1998 report. A subsequent report by Carryer et al. noted that

> Primary health care nursing is established in communities at a number of levels and through various contracts, such as the well child services, home health, domiciliary nursing, health promotion, communicable disease screening and management. Not only has this led to fragmentation of service delivery but also there are gaps and duplication of services and confusion surrounding the roles of the various nurses. (1999. p. 2)

Litchfield (2001) also recognised fragmentation of nursing roles in rural health nursing. As shown above the Minister of Health was frequently to mention these themes in speeches; and the Nursing Innovation Awards encouraged nursing projects to focus on nursing leadership, collaboration and the reduction of fragmentation and duplication (King, 2002).

Fragmentation of nursing was now 'The Problem' in nursing. Fairclough (1992) describes intertextual 'conversations' in which different texts serve to enhance and validate each other. This can be seen with the development of the fragmentation and opportunities discourse. There is also an ability of discourse not to represent reality but to construct it. The MOH-led or nurse leader-led PHC texts were a site of discursive struggle as the texts attempted to both raise the consciousness of nurses about their situation and attempted to modify this situation. This was achieved through the MOH/ nursing leader insistence that nurses were valuable, that they had real opportunities, and that they needed to collaborate.

5.2.2 Counter discourse of fragmentation and opportunities

However, in spite of leading officials and nurses insisting that there were opportunities to be had in PHC, individuals questioned this as reality and a counter-discourse began to appear. In 2003, Manchester prefaced positive PHC nursing comments with "Like most Ministry of Health officials, chief nursing advisor Frances Hughes is convinced recent primary health care changes offer new and exciting opportunities for nurses", (2003, p. 10). The use of the words 'is convinced' casts doubt on the existence of new and exciting opportunities. Hill, the *NZ Doctor* Editor, had also noticed the positioning of nurses by the Health Minister who she describes as "salivating" each time she mentions a pro nurse scenario.

Harre's address at the NZNO 2005 conference spoke of the "guiding principles" or "clichés" that had become necessary in every ministerial health utterance (2005, p. 2). This included the importance of collaborative professional teams. Harre, too, had noted the repetitive rhetoric and she questioned the ability of PNs to achieve their potential given their status as poorly paid employees of GPs.

The opposite discourse for nursing, from one where nurses are highly valued and integral to the PHCS, is one in which nurses are not valued, nor integral to the PHCS. Arguably the latter discourse may have been closer to the truth. So that the fragmentation and opportunities discourse, far from reflecting or informing reality, may have hidden reality. For example, in PHOs nurses had not been legally cast as integral players, in spite of the pro-nurse PHCS rhetoric. Indeed while nursing sector change had been invited, GPs sector change was organised 'from above' by the legislative change to form of PHOs. Mackey (2002) wondered how nursing could be empowered in primary care, if structures supported GPs as the 'leaders' and authority to change was not led from the top. Even so leadership may not be enough if associated legal change does not take place. In short, nurses, although integral in the PHCS discourse, had no acknowledged role in the way PHOs were set up. Aspects of the lack of nursing input were noted by various nurses in *Kai Tiaki* and *Practice Nurse*. For example, Hansen

(2004) was disappointed that not all PHOs had a nursing voice on the governance board and worried that further fragmentation of services may occur without PHO awareness of current nursing services. O'Connor (2003) talked of an undercurrent of disquiet among nurses at the 2003 PHC conference, and wondered if nurses would achieve a voice in PHC and PHOs.

Generally, power structures within GP-owned practices remained the same, since practice nurses (PNs) were still employed by GP business owners. However, a range of people called for PNs to be employed by the PHOs, rather than by individual GP practices (Hill, 2005, May 18; Manchester, 2003b; Minto, 2004). While the PHO employment of PNs is fundamentally a sound idea, PHOs generally complained they did not have the money to set up their own infrastructure (Perera et al., 2003), so a small PHO would not be able to afford the nursing leadership positions as asked for by the Expert Advisory Group (2003), or provide the support needed for PN positions as this stage.

PNs too, found themselves to be no better off in terms of pay or conditions once PHOs were in place, in contrast to GPs who, in spite of the complaints with the PHCS, were apparently slightly better off financially after PHO implementation (Fountain, 2005, June 29). Minto (Chair of the New Zealand College of Practice Nurses [NZNO]), when considering life for PNs once their funding was part of capitation, said that "capitation as it is, is still as it was, i.e. the subsidy that pays for GPs to see patients….Being paid through the PHO has not in any way changed where it goes- to the GP with an enrolled population. PNs see no more opportunity from capitation funding now, than they did prior to the PHOs particularly those who have already been capitated" (Minto, 2004, p. 16).

PN articles also showed alignment with general practices, rather than with other PHC nurses. Both Jamieson and Minto interpreted collaboration primarily to be with GP colleagues, rather than with other PHC nurses. Jamieson hoped to "share care that had traditionally been given to doctors" (2002, p. 22). Minto (2004) envisaged PNs as

employed by PHOs so that PNs' collaborative relationship with GPs would be maintained and "fragmentation of care created by separate nursing services outside general practice" would be minimised (p. 17).

In short, since the release of the PHCS which specifically mentioned the special role nurses would play in the new PHC, there had been little change for many nurses. Undoubtedly some nurses have benefited from MOH nursing scholarships or as part of nursing innovation projects, yet it may well be that the circumstances of the majority of PHC nurses have not improved.

5.3 Nursing discourse on the PHC nurse concept

5.3.1 Intertextualtiy of the PHC nurse concept

Another associated discourse that was begun before the PHCS was the concept of the PHC nurse. A prior nursing report had found that the disease or age specialisation of PHC nursing, while leading to the development of nursing expertise, had led to a reductionist model which prevented holistic care. "Nurses" according to Carryer et al. (1999) "must cease clinging to their traditional roles and titles and instead, develop the primary health care roles that directly meet the needs of the community they serve" (p.10). Litchfield's (2001) rural report, on the other hand, had envisaged that existing and emergent nursing roles were complementary and had the potential to work more collaboratively. However the idea of a generalist PHC nurse was proposed by the Expert Advisory Group, which went on to develop an umbrella definition of a primary health care nurse.

5.3.2 Counter-discourse to the PHC nurse concept

Although nurses were encouraged to expand their ways of working and embrace the new concept of the PHC nurse, PNs in the surveyed literature, appeared to value the practice nursing role and not the Expert Advisory Group's version of a PHC nurse. For example, PN Jamieson supported practice nurses doing practice nursing in general practice and not being "morphed into some other animal", she argued PNs needed to support the working environment of their GP colleagues "in a pitched battle for PHO

'turf' with the funder and other health providers" (2002, p. 23). PN Porteous (Manchester, 2003a, p. 14) and Beckinsale (O'Connor, 2001, p. 15) both celebrated their "womb to tomb" practice nursing roles. And Beatson found, in her round up of several PHC nursing initiatives, only one primary care nursing group actually used the term PHC nurse (Ministry of Health, 2005b).

5.4 Binary opposites and invisibility: Health inequalities

Improving the general conditions of nurses was the subject of the nursing discourse discussed above. However, the object of nursing as directed by the PHCS is to redress ethnicity-based inequalities in health outcomes. Various GPs had queried underpinning assumptions of the PHCS and wondered why health inequalities, which have a social basis and are mediated by social policy can be altered by PHOs (Kumar, 2004, July 14; Hill, 2003, June 18; Meylan, 2004, April 7; Robinson & Blaiklock, 2003). While the nursing media, under review, had little debate around health inequalities as the focus of PHOs, both Penney (in O'Connor, 2003) and Richardson (2003) acknowledged the possible negative discursive effects of an ethnicity focused health discourse. Penney and Richardson stressed that a focus on those ethnicities who suffered inequalities of health, should not lead to these injustices being "normalised" (O'Connor, 2003, p. 15) or "perpetuating racist and discriminatory practices" (Richardson, 2003, p. 2). Penney also stressed that many solutions to health inequalities lay outside the health sector, and that health care that valued cultural identity was important. Retiring PN Porteous also wished that nurses would lobby government "to address the huge gap between those who can access health services and those without the resources to do so" (Manchester, 2003a, p. 15).

While there were the above comments around inequality and health outcome, this was not the dominant aspect of the PHC nursing discourse. The needs of nurses dominated. An example of this is the 2003 NZNO primary care conference, where participants decided upon five key factors that would be needed by nurses in the new primary care arena. These were nursing leadership and governance, clinical practice development and innovation, professional and career development, maximising the collective voice

of nursing, and creating strategic alliances with other disciplines and providers (Conference Report, 2003b). In short, the nursing discourse focused on the needs of nursing, rather than, for example, what Maori and Pacific people thought would assist their own health outcomes. Maori and Pacific peoples' needs were thus marginalised. A nursing-centred discourse is also in tension with the sort of partnership that is central to the definition of a PHC nurse. "Partnership "with people – individuals, whanau, communities and population- to achieve the shared goal of health for all, is central to primary health care nursing (Expert Advisory Group, 2003, p. 9). This partnership model is essential since nurses have no mandate to represent the views of other groups, as evidenced by the *He Korowai Oranga. Maori Health Strategy* (Ministry of Health, 2001) and *Pacific Health and Disability Action Plan* (Ministry of Health, 2002b), which both stress that Maori and Pacific peoples want to be consulted and involved in their own health decision making. While there was evidence of partnerships in nursing anecdote stories there was little evidence of the systematic advancement of this partnership concept at a leadership level.

5.5 Critiquing the discourses

So far I have discussed the discourses (and counter discourses) apparent in the *Kai Tiaki* and *Practice Nurse* journals. Both the 'fragmentation and opportunities' and the 'PHC nurse concept' discourses are nursing-centred. I now show how a nursing-centred discourse can both disadvantage nursing and decrease the focus on health inequalities.

Nurses have a tendency to characterise themselves as a profession which is dominated by medicine and, because the profession is composed mainly of women, to have gender as well as professional discrimination working against them (Powers, 1994). However, the nursing fragmentation and opportunity discourse was created, not by medicine, but by the MOH and nursing leaders. Because the origin of this discourse was from nursing leaders and the Minister of Health, the ideas of the discourse claim authority and an importance that might otherwise not be possible. These discourses were also able to maximize their exposure due to the prominence of people in leadership positions, such as the Minister of Health, who promoted the discourse.

As noted, the nursing-centred discourses of fragmentation and opportunities, and the PHC nurse concept appeared to highly value and support the institution of nursing. However, the cheerleading and repetitious nature of the fragmentation and opportunities discourse led some to interpret the message sarcastically. Moreover since the fragmentation problem of PHC nursing was never queried, nurses may have been constrained by a discourse which had prescribed both the problem (fragmentation) and the solution (collaboration).

The focus on issues such as fragmentation and collaboration may have also meant that there was little focus on the ways that nurses have been systematically legally disadvantaged. Collaboration will not overcome the 63 pieces of legislation which would prevent Nurse Practitioners, PNs, and occupational health nurses functioning to their potential (Ministry of Health, 2005c; College of Nurses Aotearoa (NZ), 2005). These legal impediments to nursing practice are being worked on at the MOH and through senior nurse lobby. But for PNs whose practice participates in incentive schemes such as the national 'Get Checked' diabetes scheme, and smear and immunisation schemes, their work will continue to be invisible since the service is recorded and billed to the GP's name (Minto, 2004).

The fragmentation and opportunities discourse and its collaboration focus will also not further the cause of establishing Nurse Practitioners in PHC. This is because, in the current PHC set up, Nurse Practitioners don't attract any funding. The PHO formula in capitation disadvantages Nurse Practitioners. Capitation funding, which is predicated on patient enrolment with GPs, excludes Nurse Practitioners from this funding. And while the use of Service to Improve Access and Health Promotion funding is suggested for Nurse Practitioners, Whittaker, nursing services manager at Health-WEST PHO, argues that the target for Service to Improve Access projects (Maori, Pacific and people on low incomes) doesn't fit with the expertise of many Nurse Practitioners whose scope may be child health or another subspecialty, which cuts across ethnicity boundaries (Kumar, 2005, March 9). So while the nursing fragmentation and collaboration

discourse may appear to promote nursing, it may actually disguise the ways nursing development is constrained.

As there is with the medical discourses there are also multiple discourses at work in PHC nursing. So that while the nursing and collaboration appears to promote the role of nursing and situate the potential for nursing advancement within the grasp of nurses, there are powerful legal constraints placed on nurses which are outside their direct control.

However while the discourses at work in nursing can be shown to have constrained nurses, these discourses are none the less focused on nursing issues and can be considered nursing centred discourses. As with primary care doctors, PHC nurses are grappling with their own industrial issues at a time of upheaval, and industrial issues has been a leadership focus. There are of course individuals and projects focused on ethnic diversity and the decrease of health inequalities (Manchester, 2003c); however this was not the main discursive lead that nurses were given, as reported in the media analysed. Suffice to say the nursing discourse was not focussed on the decrease in health inequalities, but on nursing issues.

5.7 Chapter conclusion

Since the creation of the PHCS, the cards have been dealt out differently between primary care doctors and nurses. GPs have, through funding incentives, been encouraged to join PHOs which involves being part of community governance structures. Meanwhile nurses have been encouraged to be innovative and apply for funding for Nursing Innovations and Scholarships. This initial configuration has meant GPs are integral to PHOs, while nurses have been asked to forge links with them.

The GP discourse while expressing dissatisfaction with the PHCS has also fought to legitimate the continued rights of GPs, especially with regard to fee setting. The GPs have sought to control their involvement by forming umbrella groups to lobby on their behalf. The discourse as reported in the *NZ Doctor,* has focused on issues as they affect

GPs, yet GPS have also discussed and evaluated the underpinning discourses of the PHCS. For example, by querying the funding formula, and the lack of outcome measures.

During the same time the nursing texts have been captured by the need to collaborate with other nurses (and health professionals) and this has become a focus. The fragmentation and opportunity discourse may marginalise nurses by focusing energy away from changing the real legislative boundaries around nursing practice. The nursing discourse is nursing-centred and this discourse has decreased the focus on the needs of others like Maori and Pacific people who are meant to be partners in PHC. The next chapter discusses the wider context of the discourses of PHC and suggests how the industrial focus of health professional can be realigned.

Chapter Six: Primary health care and a resource allocation framework

6.0 Chapter introduction

The aim of this thesis has been to look critically at the discourses in the nursing and medical media and decide if discourse was constraining a focus on decreasing health inequalities. In the short timeframe considered by this thesis I believe there is evidence of a lack of focus on health inequalities as medical and nursing professionals cope with the changing health environment and focus on their own professional needs. In this thesis I have also wanted to suggest an alternative approach using a resource allocation framework. It is not my aim to be faithful to the post-modern endeavour which, by seeing all discourse as relative, suggests a theoretical impasse to suggesting solutions. Therefore this chapter offers an alternative solutions approach.

My aims for this chapter are two fold: firstly, to situate the PHCS as a discourse, so as to widen the context of the discussion beyond the nursing and medical media; and secondly, to use a resource allocation framework to move discussion from political or professional discourse. This resource allocation framework holds that in a constrained health environment health resources should be allocated in an effective and efficient manner, while being cognisant of issues of equity and legal factors.

6.1 Adopting a critical stance to PHC discourse

Discourses underpin PHC. Therefore there are power relationships in PHC discourses that should be highlighted and debated. Crampton, Woodward and Dowell (2001), using Salamon's 'Four Failures of the Third Sector', noted that amateur interventions by non-Government, non-profit organisations (which could now include PHOs), could lead to ineffective, non professional services being given to marginalised groups. Dawbin (2004) also cautioned nurses to be aware of their legal boundaries as they were pushed by employing organisations into new PHC roles, without the necessary competence or clinical management. A scenario in PHC is then an ill-prepared health

worker delivering untried screening or other interventions to a marginalised individual or group.

Amateur interventions, however, are not just a problem in the non profit, non-government sector. Welham (June 24, 2006) describes the separation of the Child, Youth and Family Service from the then Social Welfare Department as a "failed experiment" which cost the lives of children as re-branding, restructure and "political point-scoring" became more important than the children served (p. E1). Likewise Devlin, Maynard and Mays (2001) warn that the current health restructure may mark political, rather than health change.

To this end some researchers have looked at underpinning PHC values. For example, Lewis, Eskeland and Traa-Valerezo (2004) researched primary health care amongst poor villagers in El Salvador and found that low cost community health workers were not the preferred option. Higher cost hospital appointments were sought because of the increased probability of cure for their conditions. Similarly, the wellness aspect of PHOs may be irrelevant to patients who just want to see a doctor (Perera et al., 2003).

The value of patient participation has also been questioned. A 2005 *British Medical Journal* article reported on a qualitative review of papers in which patients were involved in planning and developing health care. It noted that while patient participation contributed to changes in provision of services, there was no evidence that patient participation in health planning led to improvement "in use of services, quality of care, satisfaction, or health of patients" (Crawford et al., 2005, p. 1).

As with any discourse, a patient or community participation or empowerment discourse may not just serve the patient or community. In this way, one of the questions that may be raised from a community participation discourse is 'who gains' from this discourse. Salmon and Hall (2003) argue that the patient empowerment discourse serves medicine by transferring responsibility for health to the individual, especially in circumstances where medicine has little to offer, for example, in chronic disease management. The

situation of a patient as agent in this discourse may overstate how much the patient can and/or wants to control their situation. Similarly, it can be asked: 'Are communities agents in their own health?' Much research would suggest that populations that suffer from health disadvantage are victims, not agents, in situations beyond their control such as economic circumstances. Further the 'community as agent' discourse serves to distance the government from responsibility and to position local communities as responsible.

Although many health screening practices have been found not to be beneficial, cost effective, or evidence based (Gigerenzer, 2002), screening is one of the personal health strategies suggested, without debate, by the Ministry of Health (Robinson & Blaiklock, 2003). Screening initiatives are part of the anecdotal report by the MOH: *A Difference in Communities: What's Happening in Primary Health Organisations* (2005a). While some initiatives featured in *A Difference in Communities* do have outcome measures and are evidenced based, this was not a requirement for spending PHO money through the Services to Improve Access fund (Ministry of Health, 2006a).

Arguably much of health care is unproven, sometimes because trials in certain situations are unethical. Nurses and other health practitioners will inevitably be involved in a learning curve while practitioners improve their care, and in this time patients may suffer (Gawande, 2002). However, while it is agreed that interventions such as the National Women's Hospital clandestine 'wait and see' approach to cervical cancer, is unethical (Campbell, Gillett, & Jones, 1992), other untried and non-research based PHO and nursing initiatives are seen as innovative. There is obviously a grey area here. While full research trials seem unnecessary for health innovations, currently there are no national expectations or guidelines for the measurements of the impact of PHO health interventions (health outcome or cost-effectiveness) through Services to Improve Access (SIA) funding. Interestingly, the Ministry of Health claims that research "creates new knowledge about what works and what doesn't" and always requires both ethical approval and patient consent (Ministry of Health, 2002c 63). However, the new knowledge created under the auspices of the PHCS seems to fall

outside the research category. In spite of the unknowns surrounding the efficacy of primary care strategies, several million dollars have been spent on New Zealand primary care in the last four years. So should the discourses and strategies of PHC be treated critically by nurses? Does it matter if professional and industrial issue-led discourse dominates health care discussion? Should we care?

6.2 Resource accountability and nursing excellence

There are two reasons why we should care about the value of the interventions in the PHCS. Firstly as nurses, we are accountable for the public money we spend. Kind, Hardman and Leese (2005) note the use of scarce health financial resources in English Primary Care Trusts carries with it an obligation to prioritise and efficiently use this money. If spending taxpayer money in New Zealand carries with it an obligation to use the money wisely, then nurses should be considering health interventions in terms of efficiency and effectiveness. Nurses should also acknowledge that while money is spent in one area of health care (like primary health care) another sector may suffer (like elder care).

Secondly, nurses should be concerned with providing excellent care, especially to those who cannot assert themselves in a partnership. This means providing care that both protects the rights of patients; and the responsibility of nurses to provide evidence-based, ethical care. Nurses, at least traditionally, have been committed to alleviating suffering and caring for (and about) marginalised individuals and groups. According to the International Council of Nurses (2006) “The nurses’ primary professional responsibility is to the person requiring nursing care” (p. 1). This should be central to our philosophy as nurses. However, the primary care nursing discourse, at least as surveyed here, has at its focus the development of nursing, and not the alleviation of suffering and caring for and about marginalised individuals and groups. Indeed, the concept of relieving suffering is not to be found in the new definition of the Primary Health Care Nurse (See Expert Advisory Group, 2003). At the highest levels the question posed was not what can nursing do for primary care, but what can nursing do to further the nursing agenda.

Before developing my ideas about how the PHCS could be developed more usefully, three further issues need clarifying. Firstly, I accept that the professional development, pay, and conditions of PHC nurses are integral to a healthy nursing workforce. However, I believe that these goals can be pursued alongside the goals of PHC initiatives. Secondly, I understand that innovations by nature may have little evidence to support their efficacy, and I am not advocating stagnation, just a healthy and safe "balance between control and autonomy" (Ministry of Health, 2003, p. 4). Thirdly, I accept that the nature of evidence is difficult in primary care, given that timeframes are excessively long and evidence may be difficult to obtain. While accepting these three factors I still support practice where the discourse looks at health needs, not just nursing needs.

6.3 Resource Allocation in PHC

According to the MOH (2003) resource: *Improving Quality (IQ): A Systems Approach for the New Zealand Health and Disability Sector,* as well as the principles of the Treaty of Waitangi, there are several key dimensions of quality in the health and disability system. These dimensions are that systems must be people-centred; promote access and equity; be safe; be effective (in that an expected and measurable benefit is achieved); and be efficient (in that greatest possible benefit is achieved for the resources used). Campbell et al. (1992) also used the quality concepts of efficiency, effectiveness and equity to help evaluate the ethical allocation of scarce health resources. In this next section I have termed these concepts part of a resource allocation framework. This framework also needs to include legal considerations.

These three principles of Campbell et al. (1992) provide another platform from which policies and projects can be evaluated. Problems under the three quality topics of efficiency, effectiveness and equity were raised in the *NZ Doctor* discourse of dissatisfaction. For example, questions about effectiveness were raised with regard to the lack of outcome measures in the PHCS. Indeed the Performance Management project was developed after the Strategy had been in place at least two years

(Performance goals for PHOs finalised, 2003). Efficiency questions were raised in the debate of the size of PHOs, where it was argued that larger PHOs would have the infrastructure to better support PHO projects such as Performance Management. Equity questions were raised over the fairness of the funding formula, since the status of others enrolled at your GP practice –and not your individual circumstances– will affect how much you then pay at the GPs.

Given that up to $7 million of funding was allocated to primary health care nursing for the nursing innovation projects, it is interesting to see whether effectiveness, efficiency or equity considerations shaped the project discourse. Ministry information about the Nursing Innovation projects considers effectiveness by asking for the "anticipated changes or benefits" from the proposal; efficiency by having innovations reduce fragmentation and duplication and equity by having innovations adhere to the PHCS focus on those who have greatest health inequalities (King, 2002). Yet with the nursing discourse focused on the problem of solving fragmentation, some opportunities to maximise the ethical allocation of health resources were probably lost. So how would nursing and PHC projects be modelled if questions of efficiency, effectiveness and equity were paramount?

6.4 Consideration of efficiency, effectiveness and equity

6.4.1 Effectiveness

An effective intervention occurs when an expected and measurable benefit is achieved (Joanna Briggs Institute, 2006; Minister of Health, 2003). For an intervention to have an expected benefit there must be some form of evidence to support the intended intervention. Although the Ministry of Health (2002c) and the Joanna Briggs Institute both consider using processes such as clinical audit as a way to improve practice, there is little evidence for this rhetoric being put into practice in other MOH initiatives. For example, there is currently no call for evidence of effectiveness in the design of SIA projects (See Ministry of Health, 2006). To consider the measurable effectiveness of nursing and other interventions, benchmarking data is needed on the effectiveness of similar interventions, and tools are needed that will provide measures of changing

health outcomes in terms of patients or communities. Kind et al. (2005) successfully trialled a quick patient survey that identified self reported health status in general practice clients; this was repeated a year later to track changes. The tools included information on mobility, self care, pain, and anxiety – information that may be useful for nurses to plan and evaluate interventions.

6.4.2 Efficiency

Efficiency is achieved when the "greatest possible benefit is achieved for the resources used" (Minister of Health, 2003). The learning from projects and innovations needs to be transferable between PHOs and DHBs. Efficiencies are gained when areas focus on the development of tools and processes that can be shared. Examples include the patient survey above and the WellChild service, in which a standard of care is delivered nationally to children following the protocols in the WellChild book (Ministry of Health, 2005d). However, different nurses may deliver this service, depending on local contracts (Royal New Zealand Plunket Society & Bounty Service Ltd, 2005). This means that nationally the same standardised advice and protocols for care are used, and protocols such as the immunisation schedule are updated as evidence changes. This is an effective and efficient way for nurses to work, since they do not have to design their own programmes around the country. However, they can adapt the way they deliver the WellChild contract to their client group.

Currently there is a counter-incentive for PHOs' management agencies to share the tools, programmes and projects they have developed, since they compete for business in terms of GP practices and high needs clients, in many areas. This means that nationally, all the PHO management agencies or PHOs must employ similar staff to create and run the same programmes. These programmes include, for example, the Care Plus and Performance Management projects. These projects require top-level clinical, information technology, and accounting staff. Data base management systems, patient information pamphlets, and accounting systems must all be created all over the country at great expense, all doing much the same thing. The down side of localised structures

is that a greater number of bureaucracies will be needed, which is obviously very costly for the country.

Collaboration also enhances efficiency. However, focusing on the tools of nursing rather than just the professional boundaries may be useful in enhancing collaboration in nursing. In this way the use of the same nursing assessment tool for complementary nursing groups may increase efficiency and enhance a common language.

The use of remote access computers will also increase nursing efficiency and ensure nurses can send and receive patient information to the PHO. This requires that nurses continue to seek integration into the PHO system.

Nelson (2003), in discussing sustainable health innovations, found they would need to be "assessable, acceptable, coordinated, complementary, efficient and effective", and that "this requires time" (p. 253). I would add that these initiatives also require financial investment. While some parts of an innovation need to be done at a local level (for example the assessable, acceptable, coordinated and complementary parts), other areas of an initiative can be done to a standard that can then be shared. In a targeted health intervention this would include the assessment forms, entry criteria, data management processes and consent forms.

6.4.3 Equity

The equity of an intervention is more difficult to assess. Simplistically, equity can be judged on the basis of relative need for an intervention: those with a greater need for health care should get a larger slice of the intervention. This approach has been adopted by the PHCS, which has indicated that those most in need for health interventions are Maori, Pacific or persons with a low income. However, there are other ways to assess equity. For instance, we can judge equity on the opportunity to participate in an intervention, or, alternatively, on the outcome of the intervention (Campbell et al. 1992). Again, this has been simplified by the Service to Improve Access project which asked applicants for funding to "describe the service and how it will reduce barriers to

access for the target group/s" (Ministry of Health, 2006a, p. 2). This affirms a focus on entry into the intervention, rather than outcome.

Putting aside the question of whether the opportunity to participate in an intervention is really an outcome measure, the entry into an intervention still requires tracking. This reinforces the need for shareable systems as outlined under the headings effectiveness and efficiency above.

The ideas of equity also bring to light problems of the underpinning philosophies of the PHCS. The idea that communities, in concert with local health professionals, decide some aspects of local care on local need, presupposes that needs are very different. The opposite discourse to this is that needs, in health, are actually quite similar. Important equity issues are raised by the fact that, in NZ, care options for a certain conditions are enormously different depending on where you live, what PHO you belong to, and the resources- financial and intellectual, of your PHO. Another approach would be to have national standards of care which can then be 'localised' to meet local resource issues. This gets around problems of differing regional standards of care and the need for local input to galvanise community participation.

6.4.4 Legal considerations

Nursing and other primary health developments need to be compliant with existing legal and ethical frameworks. While the SIA Funding Form (2006) is silent on initiatives being legal; discussion should occur about whether initiatives do respect clients' rights as prescribed in the Health and Disability Commissioners' Regulations, 1996, and Health Information Privacy Code, 1994 (Minister of Health, 2003). Health workers also need to have their legal rights respected in terms of Health and Safety Legislation. So while it may be efficient to transfer patient data electronically and have it available to multiple health professionals, this may not be acceptable to the patient in terms of confidentiality, or legal in terms of the Health Information Privacy Code. The PHCS is in its infancy, yet this should not excuse projects that put workers or patients at risk. There is great scope to create and share policy resources which address these

concerns which would help obviate the need for each PHO to create their own policies and necessary infrastructure.

6.5 Chapter Conclusion

PHC nursing operated within the discourses of PHC and the PHCS. It is therefore beholden upon nurses not to take for granted the concepts and discourses which influence their practice. In order to use valuable tax dollars efficiently, effectively, and with respect to issues of equity and legality, new nursing projects need to focus on the development of tools and skills that are transferable, teachable and measurable. This will enable nursing to create and share a discourse where credible results of nursing interventions and the effectiveness of nursing care is expressed. This should also help nurses to develop national discourses that look beyond the parochial needs of nursing.

Conclusion

When groups of people subscribe to the same belief on a subject they can be said to be following the same discourse. When this discourse becomes naturalised or becomes such common sense that it is no longer questioned, this has ramifications in that alternative discourses and the power relationships maintained are no longer noticed. This thesis aimed to look at the discourses surrounding the Primary Health Care Strategy (PHCS) to see if they were decreasing the focus on health inequalities.

In order to do this I needed to situate primary health care, and nursing and medical developments historically. Therefore in Chapters One and Two I have discussed the PHCS, the primary health care nursing framework, and the possible reasons for health inequalities.

Through the articles in the *New Zealand Doctor* newspaper, highlighted in Chapter Four, I was able to discern a 'discourse of dissatisfaction' with the PHCS. A general trend in articles that I reviewed was that the PHCS was poorly thought through. GP complaints were particularly loud whenever the GP's right to set their own fees was threatened. Through the GP 'discourse of dissatisfaction' the GPs attempted to legitimate the continued control of their practice, claiming a 'right' to do so. During the timeframe studied, the power struggle between GP groups and the MOH has tied up resources that may otherwise have helped combat health inequalities. However, the GP discourse of dissatisfaction did focus on issues that were not GP centred, for example, the problems with the population funding formula, which does not target those in need who live in a low deprivation area. This may ensure a more equitable primary health care scheme in the future.

I then discussed the nursing discourses in Chapter Five. The nursing discourses that emerged from the *Kai Tiaki* and *Practice Nurse* journals were very different in form from the GP discourses. The nursing discourse was influenced by key nursing reports. In particular, subsequent to these reports the Minister of Health was frequently quoted as saying that nurses were valued; were fragmented across differing employment

arrangements; needed to collaborate; and were faced with substantial opportunities in PHC. I called this discourse the 'fragmentation and opportunities discourse'. While an outwardly positive discourse, critics mocked its repetitive nature. The discourse may have also constrained nurses by providing a problem (in nursing fragmentation) and a solution (in collaboration). This succeeded in setting a nursing-centred agenda to the exclusion of other important nursing aims. Further, the emphasis on nursing opportunities may have taken the focus away from the ways that nursing practice was legally constrained. The nursing-centred discourse also marginalised the needs of others by focusing on the needs of nursing as paramount. The nursing media did not generally seek out the views of others like the 'objects' of the PHC discourse, including the Maori and Pacific people and their needs in PHC.

The nursing discourse behind the PHC nurse concept was also discussed in Chapter Five. The PHC nurse as a concept in itself has not been taken up fully by nurses. Practice nurses, for example, value the role they have already. A striking feature of the nursing discourse is that the discourses are oriented toward the goals of nursing as paramount. The nursing discourse answers the question "what does nursing need?" where an alternative and more resource-oriented question would ask, "what does PHC need from nursing?" More specifically, what do people who are currently disadvantaged need from nursing/ health care? Working out the gaps and opportunities in PHC (rather than nursing) would then provide a worthy platform from which to look at training, career structures, and leadership in nursing. This would preclude the need to train persons for new roles, like the Nurse Practitioner role, that in the short term will struggle to find a niche in the PHO environment.

Both nurses and doctors were also subject to a wider discourse developed by the MOH whose rhetoric claimed to value decentralised community health decision making. The decentralised community health model of small community PHOs situates the responsibility for health locally. This local situation of health responsibility may gloss over factors in community health which are affected by the government's policies on housing, education, and employment, and thus should be dealt with centrally by

legislation. Both nursing and medical commentators pointed out the importance of government policy in health care. Decentralised models are also more expensive because they must replicate bureaucracies in each PHO. The decentralised focus on local initiatives orientates health away from national standards of care. So an individual's primary health options will vary widely depending on which PHO he or she belongs to. However, these last two complaints (of bureaucracy and the lack of national standards) can be modified within the current structures with standardised systems and protocols for some care, which can then be modified for particular local environments. An example of this is the WellChild framework in which a national standard of care may be delivered by a range of nurses (and GPs in certain areas).

In Chapter Six, I developed an ethical resource allocation framework which considers health resource allocation in terms of effectiveness, efficiency, equity, and legal factors as a way of focusing aspects of resource allocation to community and nursing interventions. Given that health delivery in a constrained environment should offer quality for investment, I maintain that nurses and others working in health should adopt a trial, rather than an innovation approach. This focuses on interventions that have a research framework, where the effectiveness of an intervention can be quantified. Interventions should also be efficient, which is most easily achieved when interventions are transferable, so that tools and learnable skills are trialled and then made available for use elsewhere. Equity of an intervention will be apparent when interventions are oriented toward entry and outcome criteria of an intervention. Therefore interventions will need to appeal to the ethnic or other group they are targeting. Interventions should also take into account the legal and ethical accountabilities of the health professional.

Finally, we can ask whether the current discourses are holding back a primary health care commitment of inequalities. This thesis can only reply to that question with a strong yes. Primary health care is full of discourses, competing discourses and counter-discourses. This is the reality in a culture that understands itself through language. Yet rather than surrendering to the postmodern conundrum of relativism, I suggest we orientate health care innovation and interventions toward a health resource allocation

framework which considers health resource allocation in terms of effectiveness, efficiency, equity and legal considerations. This will help our health system focus on improving the health of New Zealanders and removing inequalities in health.

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