There is a need then, to foster communication between those concerned with the current state of various social determinants of health and those knowledgeable about their health effects. This need is especially great in Canada as a consensus is emerging that the quality of the many social determinants of health is deteriorating as a result of policy decisions being driven by various political, economic, and social forces.

—Dennis Raphael, 2004

Social Determinants of Health: Canadian Perspectives

THE REPRESENTATION OF PRIMARY CARE AND PRIMARY HEALTH CARE IN NEW BRUNSWICK HEALTH POLICY: A CRITICAL DISCOURSE ANALYSIS

by

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ABSTRACT

In Canada, the social practice of health care is organized hierarchically, privileges some groups over others, and reinforces power relations that enforce constraints over directions in which health care as a social practice can move (Turner, Keyzer, & Rudge, 2007).

In this research, I focus specifically on the discourses of primary care (PC) and primary health care (PHC) and how these discourses are evident in health care reform and the implementation and ongoing practice of nurse practitioners (NP) in New Brunswick (NB), Canada. The distinctions between the discourses of PC and the broader PHC are not always clear or consistently represented. Based on my experience in the healthcare field, the general lack of consensus on what constitutes each discourse and differential support for each discourse creates challenges for interprofessional collaboration, health care provider role exploration, patient-centered care and health system reform and transformation (Muldoon, Hogg, & Levitt, 2006).

I use critical discourse analysis to investigate how government documents and discipline-specific documents from nursing and medicine organize and advocate for health care reform. Discourse analytic work in this research draws on the influence of Foucault (1972, 1973, 1977, 1988); Bacchi (1999, 2000, 2012 a,b,c, 2016) and Fairclough (1992, 1995, 2003, 2010) to explore overlying impacts of governmental, professional and organizational policies on individual and community health. These analyses of PC and PHC in health policy reveal consistencies, contradictions, and gaps between the meanings of these discourses and their effects.

The overall analyses of the 12 selected policy texts from government, medical and nursing professions, revealed emerging discourses, diverging discourses, and converging discourses. Converging or intersecting discourses included the use of neoliberal discourse in close relationship with PC. There was clear evidence of how these two combined discourses (PC and neoliberalism) argued for improved access to PC at a lower cost, with effects that attenuated the presence and influence of PHC. The presence of PHC diminished steadily in the government policy texts and was rarely (if ever) present in the medical text. This pattern was in contrast to the nursing texts where there was more continuity demonstrated in sustained use of PHC over the 30 years examined. Within the government texts, a hybrid neoliberal-PC discourse emerged that favored PC and included some elements of PHC. Government, texts, although advocating for reform, also subscribed to fiscal responsibility and value for money discourse. Nursing texts promoted PHC reform but also broader scopes of practice and greater responsibility for the profession of nursing. The medical text, although somewhat aligned with government reform direction around interdisciplinary PHC teams, promoted continued authority and privileged positions for physicians. The introduction of NPs in 2002 did not significantly change the complex privileging and related hierarchal power structure which remained relatively unchanged over the 30 years examined. The study points to far-reaching implications for addressing health inequities. PHC committed to social justice and health equity is critical in addressing health inequities. It requires coordinated action from a broad scope of health care professionals working together in teams rather than the narrow scope of primary medical practice, remunerated by fee-for-service payment, which remains the dominant model of community care in the province.

DEDICATION

This dissertation is dedicated to my father, Dr. J. Leslie Davies, who immigrated to Canada in 1950 as a 16 year-old orphan. His quiet knowledge acquisition and modest academic accomplishments have inspired and sustained me through my lengthy Ph.D. journey. Without his mentorship, understanding and unconditional love and support, this pinnacle of study would not have been imagined or reached completion.

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abilities and strengths with the odd tear of laughter at my foibles and faux-pas just to keep it real.

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List of Abbreviations

ADM	Assistant Deputy Minister
ANBHC/ACSNB	Association of New Brunswick Health Centres/Association des Centres de Santé
APN	advanced practice nurse
CACHC	Canadian Association of Community Health Centres
CDA	critical discourse analysis
CEO	Chief Executive Officer
CHA	Canada Health Act
CHC	community health centre
CHSRF	Canadian Health Services Research Foundation
CHT	Canada Health Transfer
CIHI	Canadian Institute for Health Information
CMA	Canadian Medical Association
COPD	chronic obstructive lung disease
COVID	coronavirus disease of 2019
CSC	Collaborative Services Committee
CST	Canada Social Transfer
DHW	Department of Health and Wellness
DP	A Discussion Paper: For the Health of our Communities
ECO	Executive Council Office
EMR	electronic medical records
EMT	emergency medical technician

FFS	fee-for-service remuneration
FHT	Family Health Teams
FMNB	Family Medicine New Brunswick
FPT	federal, provincial/territorial
GED	general educational development
GNB	Government of New Brunswick
GOBI	growth monitoring, oral rehydration techniques, breast-feeding, and immunization
HSC	Health Service Centres
IC2011	Igniting Change: Province's Summit on Primary Health Care
IG	Infographic
IUD	inter-uterine device
LGBTQ+	lesbian, gay, bisexual and transgender, questioning/queer+
ML	McKelvey Levesque (Report)
NANB	Nursing Association of New Brunswick
NB	New Brunswick
NBHC	New Brunswick Health Council
NBMS	New Brunswick Medical Association
NBNU	New Brunswick Nurses' Union
NFL	Newfoundland & Labrador
NP	nurse practitioner
NPNB	Nurse Practitioners of New Brunswick
OECD	Organization for Economic Co-operation and Development

OHSR	The Office of Health System Renewal
OSC	Operations Services Committee
PB	Policy Brief - The Future of Health Care in New Brunswick: The Nursing Contribution
PC	primary care
PCCPP	Primary Care Collaborative Practice Project
PCT	Primary Care Trusts
PHC	primary health care
PHCAC	Primary Health Care Advisory Committee
PHCCC	Primary Health Care Collaborative Committee
PHC-GS	Primary Health Care Global Strategy
PHCSC	Primary Health Care Steering Committee
PHP	Provincial Health Plan
PHP2008	Transforming New Brunswick's Health-care System: The Provincial Health Plan 2008-2012
PHP2013	Rebuilding Health Care Together – The Provincial Health Plan 2013-2018
PS	Position Statement – Primary Health Care
RHA	Regional Health Authorities
RHAA	Regional Health Authorities Act
RN	registered nurse
RT	respiratory therapist
UK	United Kingdom

UNB	University of New Brunswick
UNICEF	United Nations International Children's Emergency Fund
VP	Vice-President
WHO	World Health Organization
WRP	What the problem is represented to be

Chapter 1

Defining What the Problem is Represented to Be

In this chapter, I introduce the focus of my research, discuss the problem under investigation, and define the research questions that guide this study. The focus of my investigation is an exploration of how some specific discourses have influenced health care reform efforts in New Brunswick, Canada during the period 1989-2019. The study employs critical discourse analysis (CDA) to explore and describe the discourses present in policy formation and their relationship to disciplinary power and knowledge in the context of primary health care reform in New Brunswick.

Following a brief discussion of the problem, the chapter presents a review of theoretical literature that has been foundational in this investigation, helping to frame the focus of my research. I situate myself in this study and detail how the research questions reflect theoretical intersections that have influenced my understanding. The chapter concludes with an overview of the dissertation chapters.

Research Focus: Describing the Problem and its Significance

Under the federal-provincial funding formula in effect during the years under investigation (1989-2019), health care spending in Canada reportedly consumed 40% or more of provincial budgets (Drummond, 2011). At the rate of fiscal growth, 3-4% per annum, health care in its current state has been deemed not sustainable (Bliss, 2010; Dodge & Dion, 2011; Drummond, 2011; Picard, 2017). These economic realities (percentage and growth) of a neoliberally focused policy agenda are compelling provincial governments to not only rein in health care spending but to examine how healthcare dollars are spent and what population health outcomes are achieved. To date,

provincial policy reforms and federally targeted funding initiatives have not translated into significant change to the way health care in Canada is organized, delivered, and funded (Esmail, 2021; Lewis & Sullivan, 2013; WHO, 2018; Williamson, 2014). Since the creation of Canadian Medicare in 1966 (Medical Care Act, 1966) and the establishment of universal, publicly funded health insurance, the existing institutionalized organization and delivery of health care has remained largely intact. At the turn of the century, there had been very little innovation and transformation at the system level (Hutchinson et al., 2001; Jones, MacDougall, Monnais, Hanley, & Carstairs, 2021). Despite federal/provincial and territorial jurisdictions and healthcare providers advocating for reform and reorganization in an articulated vision for healthcare renewal, over the years addressed in this study, medical and hospital services have continued to be largely organized, managed, and delivered in the same way they were at the inception of Medicare in 1966 (Jones et al., 2021; Lazar, Lavis, Forest, & Church, 2013; Lewis & Sullivan, 2013; Medical Care Act, 1966).

Healthcare reform in Canada has been driven primarily by provincial governments, the public administrators of the system. From a provincial/territorial perspective, neoliberal-influenced reforms have been centered on economic drivers or attempts to control costs and improve access rather than focused on an approach to achieving health equity where health is conceptualized as a human right (Browne & Tarlier, 2008; Jones et al., 2021). From a federal perspective in contrast, policy reforms have been focused on improvements in health promotion, health equity, and population health, as evidenced by the targeted funding of various federal initiatives/transfers to provinces like the Health Accord (2004-2014) which was a 10-year plan to strengthen

health care and recommitted provincial and territorial leaders to the Canada Health Act, especially with regards to improving access to health services (Government of Canada, 2014).

Intersecting and often conflicting policy discourses from the federal and provincial/territorial governments highlight the significant influence of provincially focused politicians and healthcare professionals on health policy, especially regarding PHC reform (Lazar et al., 2013). Lazar and colleagues, in their analysis of the evidence around Canadian health policy reform, suggest that provincial medical associations, who negotiate master agreements for their members with provincial political leaders, "determine the nature and pace of reform" (p. 311). In exploring the origins of socialized healthcare in Canada, Jones (2019) notes "for organized medicine, control over health organization and delivery was paramount" (p. 342). This skewed influence of one group over others in determining health policy and the organization of services can lead to gaps in reforming healthcare organization and delivery (Jones et al., 2021; Lazar et al., 2013; Simpson, 2012) as evidenced by the autonomous disposition of primary care physicians and their disquiet with those professions who challenge their professional boundaries (Turner et al., 2007).

The nurse practitioner (NP) role evolved in Canada in the mid-1960s and early 1970s, in part as a response to medical specialization and family physician shortages in rural communities and northern outposts (Delvin, Braithwaite & Plazas, 2018). A salient, randomized control trial in Ontario found that "the NP provided primary care as safely, effectively and with as much satisfaction from the patient as the family physician" (Delvin et al., 2018, p. 111). Despite this evidence, widespread integration of NPs

throughout Canada was impeded in the late 20th and early 21st centuries by lack of legislation to support the role, a perceived threat of reduced physician income, and general lack of support from the medical community (Delvin et al., 2018).

In an effort to control costs but improve access to primary health care (PHC) services, NPs were introduced in New Brunswick in 2002 as part of health care reform mobilized by the Romanow (2002) report. The Romanow report spoke to the importance of the Canada Health Act's (1984) fifth principle which speaks to Access. It expanded the principle, from original access to services and facilities, to include access to primary health care services. This was a strategic decision as well as a political one aimed at diversifying the complement of primary health care providers and jurisdictions across the country (Mullally & Wright, 2020).

A precursor to the federally recommended implementation was a professional policy document presented to the New Brunswick Health Services Review Committee in 1998. The document, *The Future of Health Care in New Brunswick: The Nursing Contribution*, recounted the historical contributions of NPs and detailed future advancement of their role (NANB, 1998). During this time, there was a socio-political shift both federally and provincially away from the traditional medical model of care to a renewed emphasis on prevention, health promotion, and chronic disease management (Romanow, 2002). This shift was a catalyst for the re-introduction of and legislative framework to support the NP role.

As advanced practice nurses (APNs), NPs blend their advanced practice knowledge in clinical applications of pathophysiology, pharmacology, nursing theory, practice, and research, within their legal authority to order and interpret diagnostic tests,

perform approved procedures such as injections and IUD insertion, and prescribe pharmaceuticals, medical devices, and other therapies (Canadian Nurse Practitioner Initiative, 2006). Primary health care NPs offer patient-centered care across the lifespan, including health promotion and disease/injury prevention, curative, supportive, rehabilitative, and palliative care. They subscribe to being members of the interdisciplinary healthcare team with an APN role that is both inter-professionally oriented and autonomous (Bill 44, 2002; NANB, 2014). While there are other clinical specialties for NP practice found throughout Canada (e.g., Adult Health NPs), PHC is the only regulated clinical category for NP practice in New Brunswick. The introduction of NP practice in NB occurred in 2002; in 2017, CIHI reported that 125 NPs were practicing in NB, and in 2019, NPNB reported more than 130 practicing NPs. The majority (but not all) of NPs in NB work in Community Health Centres (CHC) within a salaried model of remuneration. Although this study focuses on the time period 1989-2019, in 2020, three NP clinics were announced for the urban areas of NB (Moncton, Fredericton, and Saint John) in an effort to provide the estimated 45,000 people on the Unattached Patient Registry with a primary care provider (GNB, 2020). It is within this policy-relevant context that my study has been conceptualized and conducted.

Theoretical Literature Relevant to Framing the Focus of the Investigation

CDA is a cluster of methodologies which might be best understood as "problem-oriented interdisciplinary research movements….[with] a shared interest in the semiotic dimensions of power, injustice, abuse and political-economic or cultural change in society" (Fairclough, Mulderrig, & Wodak, 2011, p. 357). It is an applicable methodology to examine the social practices which influence policy (Bacchi, 2016;

Evans-Agnew et al., 2016; Fairclough, 1992). CDA is a theoretical field of analysis and a sociolinguistic methodology focused on the investigation of power relationships and problems of social discrimination and marginalization (Fairclough, 1992, 2001, 2010; Hall, 1997; van Dijk, 2009; West, 1993). It is a branch of critical social theory attentive to society, social order, and the subsequent effects on individuals or groups of individuals. It takes into account historical issues of domination and social struggles (Foucault, 1973; Hall, 1997; van Dijk, 199, 1999; West, 1993). The concept of discourse has been widely theorized beginning with Foucault and taken up by a number of scholars including those that are featured more prominently in this dissertation, e.g., Bacchi (2006); Fairclough (1992, 2001); Hall (1997); van Dijk (2009); and Wodak (2006). Discourse has been defined by several theorists. Foucault (1998) believed that "discourse transmits and produces power; reinforces it, but also undermines and exposes it" (p. 100). Hall (1997) describes discourse (text, talk, and action) as "a privileged medium in which we make sense of things, in which meaning is produced and exchanged" (p. 1). McGregor (2003) defines discourses as "ubiquitous ways of knowing, valuing, and experiencing the world" (p. 2). Van Dijk (2009) described discourse as a "communicative event, including conversational interaction and written text as well as associated gestures, face work, images and any other semiotic or multimedia dimension of signification" (p. 98). Fairclough (1993), whose work takes on particular significance in this study, defines discourse as being "shaped and constrained by social structure in the widest sense and at all levels: by class and other social relations and at a societal level, by the relations specific to particular institutions" (p. 64).

Discourses are a reflection of ideology or "a general system of basic ideas shared by the members of a social group, ideas that will influence their interpretation of social events and situations and control their discourse and other social practices as group members" (van Dijk, 2011, p. 380). An analysis of discourse reveals how the social powers of certain groups or institutions operate (Freidson, 1970; West, 1984), and how this operation produces the marginalization of others (Evans-Agnew et al., 2016; Fairclough, 2000; Hall, 1997; van Dijk, 2001; Wodak, 1997). Discourses that lead to social goods like power and status in a society are defined as "dominant discourses" (Foucault, 1972, 1973; Gee, 2015; Hall, 2001). This theoretical literature, as described, influenced my thinking and assisted me in framing the questions I had around what makes the political agenda, how do agenda-making issues become policy and how do these policies eventually get implemented? The concept of dominant discourses as described by Foucault (1972, 1973, 1977, 1998), Fairclough (1993, 2000, 2008), Gee (1999, 2015) and Hall (1997, 2001) influenced my thinking about the way power relations influence the development and implementation of policy. Bacchi (1999, 2000, 2016), a feminist thought leader around defining how problems are articulated in policy formulation, helped me understand why some issues make the political agenda and others do not. Finally, the work of Wodak (1997), van Dijk (1998, 2009) and Smith (1990) assisted my understanding of why some groups have the power to influence health policy direction and others less so.

In organizing this research, I have come to realize and to emphasize the ways in which health care is comprised of discursive practices, or recurring episodes of interaction that have social and cultural significance to a community of speakers (Bacchi

& Bonham, 2014; Foucault, 1973; Hall, 1997; Mol, 2008). Discursive practices refer to the use of spoken and written language to represent the social world through rules, norms, and models of behaviour, or ways of being in the world (Fairclough, 1992; Gee, 1999; Foucault, 1973; Sims-Schouton, Riley, & Willig, 2007). In this research I focus specifically on the discourses of *primary care* (PC) and *primary health care* (PHC), exploring how these discourses are evident in public policy documents and in professional disciplinary documents related to health care reform in NB over a history of 30 years, from 1989-2019. In the course of study and experience, I have noticed how the terms primary care and primary health care have been used interchangeably in text and talk. In this dissertation, I use the acronym PC to refer to *primary care*; this includes discourses of primary care and primary care practices. I use the acronym PHC to refer to *primary health care*; similarly, this includes primary health care discourses, and primary health care practices.

The distinctions between the discourses of PC and the broader PHC are not always clear or consistently represented in discussions of health care reform (Barnes et al., 1995; Frenk, 2009; Harris, 2010; Muldoon & Levitt, 2006; Raphael, Curry-Stevens, & Bryant, 2008). In light of tendencies to obscure the difference between PC and PHC, the distinction between discourses of PC and PHC is especially relevant, as these discourses emerged during efforts to reform health care in NB between 1989 and 2019. Based on my experience as a senior government policy advisor and knowledge as a health care professional, the general lack of consensus among ordinary citizens, policy experts, and some health care professionals on what constitutes each discourse perpetuates inertia in evolving models of care. Differential support for each discourse

within these constituencies, creates challenges for reform policy directions such as interprofessional collaboration, interdisciplinary care teams, exploration, expansion and acceptance of healthcare provider roles, patient-centered care, and health transformation (Lazar et al., 2013; Lewis & Sullivan, 2013; Simpson et al., 2017).

The way health care is organized contributes to the formation of discursive practices with social and cultural significance, and described in relation to the formation of objects, subjects, concepts, and strategies (Anderson, Frederiksen, Kolbæk, & Beedholm, 2017; Bacchi, 2016; Fairclough, 1992; Foucault, 1973; Gee, 2015; Mol, 2008). When considering *health* or *healthcare* as discourses framed through discursive practice, the objects of these discourses are divided between the individual (subject to the routines and practices of disciplines and situated in institutions) and the population (subject to discourses of disease prevention/health promotion and chronic disease management, and situated in the community) (Anderson et al., 2017; Armstrong, 1983; Mol, 2008). These discursive practices provide a framework for investigating how systems, and disciplines working within these systems, organize and provide healthcare services to influence the health of populations and individuals. A discourse framework also discloses the overlying impacts of governmental and organizational policies on individual and community health (Benbow, Gorlick, Forchuk, Ward-Griffin, & Berman, 2016; Burnett, Ford-Gilboe, Berman, Ward-Griffin, & Wathen, 2015; Evans-Agnew et al., 2016; Hanlon, Reay, Snadden, & MacLeod, 2019; Hughes, 2010; Muldoon & Levitt, 2006; Raphael, Stevens, & Bryant, 2008; Raphael, 2008, 2011). In Canada, the social practice of healthcare is organized hierarchically, privileges some groups over others, and reinforces power relations that enforce constraints over directions in which healthcare as

a social practice can move (Hanlon et al., 2019; Hughes, 2010; Snadden, Reay, Hanlon, & MacLeod, 2019; Turner et al., 2007).

The terms PC and PHC are used in numerous international, national, and provincial (NB) policy and health professional documents dating back to the 1970s (Nurses Association of New Brunswick [NANB], 1998; Nursing Union of New Brunswick, 1995; Rachlis & Kushner, 1995; Romanow, 2002; World Health Organization [WHO], 1978, 1986, 1988, 2008, 2018). The terms are frequently used interchangeably and often are thought of (incorrectly) to be coterminous (Awofeso, 2004; Muldoon, Hogg, & Levitt, 2006; NANB, 2014). PC is frequently used to describe medically oriented discourses where it describes medical care or family practice, "family doctor-type" services delivered to individuals over an extended period of time (Keleher, 2001; Lewis & Edwards, 2004; Muldoon, Hogg, & Levitt, 2006; Swerissen, 2008). In this use of PC, the term encompasses mainly the treatment of illness and dysfunction. It is often described as front-line care or point of first contact and is traditionally in the form of a visit to a primary care provider like a family physician or nurse practitioner. Further, PC is typically described as care focused on a specific disease or body system; it is not commonly understood as community oriented care (Canadian Institute for Health Information [CIHI], 2009; Keleher, 2001). PC may include population health interventions like immunization, prevention advice in the way of smoking cessation and healthy living, as well as the diagnosis and treatment of illness. It stops short of a comprehensive, intersectoral approach to promoting or enhancing health (Lewis & Edwards, 2004).

In contrast, PHC is a broader term, derived from core principles described by the World Health Organization first in 1978, and in several subsequent WHO publications (1986, 1998, 2003, 2008, 2018). It refers to an approach to health and healthcare in a spectrum of services beyond those traditionally attributed to PC, such as addressing concerns about health equity and social factors that contribute to health equity, such as income, food security, housing, education, cultural identity, and the environment (Government of Canada, 2012). Discourses of PHC include notions of teamwork and interdisciplinary collaboration as well as community participation (Frenk, 2009; Muldoon et al., 2006, Raphael, 2008; Reutter & Kushner, 2010).

These differences in the two discourses are important, clarifying different emphasis in the concepts as they relate to health policy. For example, in their examination of the roles of NPs in Australia, Turner et al., (2007) highlight the disparity between the discourses of PC and PHC, drawing attention to how different emphasis on these discourses become evident in health policy and implementation. Although there was support in Australia for the implementation of the NP role from a policy perspective, "discursive practices that emphasized professional boundary issues and hierarchical models of care created barriers to full implementation" (p. 39). In a different analysis, Muldoon et al. (2006) propose that "PHC should be reserved to describe an approach to health policy derived from the core principles articulated by the WHO" (p. 411). This recommendation, to use the discourse of PHC consistent with WHO principles as an approach to health policy, has consequences for professional providers, their education, and their practices. My research focuses on the use of the discourses of PC and PHC in

both health policy development and in shaping existing social and discursive practices in clinical professions.

These discussions about the meanings of PC and PHC and how the discourses are represented in health policy reveal consistencies, contradictions, and gaps between these discourses and their effects. For example, among some policy decision makers, the meaning of PC does not align discursively with the discourse of PHC (Collins & Hayes, 2007; Muldoon et al., 2006; Reutter & Kushner, 2010). As Muldoon et al. (2006) argue, the terms are often used interchangeably by health policy decision makers. Uncertainty about the meaning and practices of PC and PHC is further reflected in discourses amongst healthcare professionals who practice in diverse settings. Among some providers whose practices are organized within the discourse of PC, it is possible for the term PC to have a specific meaning emphasizing first level of care, and not necessarily concerned with health equity or consideration of the social determinants of health. Those providers whose practices are organized within the discourse of PHC alternatively insist on the centrality of addressing social determinants of health and are concerned about taking action on health inequity.

In addition to these complexities, the relationship between the two discourses is further complicated by hierarchical power structures that privilege some health care practitioners over others. Organized medicine's privilege and power is derived from expert knowledge, specialized skill and the ability to translate this specialized knowledge into economic strength, political influence and social regard (Freidson, 1970, 1986; Tuohy, 2018). This complex privileging and related hierarchal power structures support the historical organization of healthcare delivery in the Canadian healthcare system. That

system has been the subject of critique by health policy experts, recognizing that it is primarily focused on the specialized delivery of medical and acute care received in hospitals (Hutchinson, 2008; Simpson et al., 2017). Medical dominance has strongly influenced this organizational structure and the discourse of PC (Coburn, 2006; White, 2002). Coburn (2006) notes, "the profession [of medicine] can and did, to various degrees and with various degrees of effectiveness, use its multiple forms of power, authority and influence to orient health care systems towards its own interests" (p. 435). These power relations then impact how PHC is reflected in health policy, both in its development and implementation (Turner et al., 2007).

The purpose of public policies is to reproduce and maintain certain values of a society (Anderson, Frederiksen, Kolbaek, & Beedholm, 2017). Anderson and colleagues (2017) propose that health policies represent the values of Western healthcare, often reflecting "neoliberal discourse and focusing on the values of the modern liberal state" (p. 2). *Neoliberalism* is a term that has been used since the 1980s to refer to a "new" politically conservative ideology of "free market" liberalism. The main tenets of neoliberalism include supporting the purported rule of the "free market" without any state interference; cutting or reducing government expenditure on social programs like income security, education and health care; reducing government regulation of commerce and services; privatization of state-owned and operated enterprises like banks, transportation infrastructure, schools and hospitals; and the erosion of social and political commitments to the public good in favor of individualism, individual responsibility, self reliance, and self interest (Kirkham & Browne, 2006; Martinez & Garcia, 1997; McGregor, 2001). Within neoliberalism as it relates to health care reform, there is not typically an

explicated relationship between economic growth and social equity, community engagement/participation, or sustainability—all prevailing discourses in PHC (McGregor, 2001).

In this study, I refer to the scholarly work of Foucault, Fairclough, and Bacchi, all of whom have contributed to the study of power relations within the discourses of health and health policy. Foucault's work focuses on the rules and practices of language that produce dominant meanings and "valid" knowledge. He defines discourse not just as a subset of language, but as a combination of language, action, interaction, ways of thinking, beliefs, values, and use of symbols or tools, acting, and being in the world (Foucault, 1972). According to Foucault's definition, discourse "creates a field of knowledge by defining what is possible to say and think, declaring the bases for deciding what is true and authorizing certain people to speak while making others silent or less authoritative" (p. 49). This is a key concept in examining the emerging discourses of PHC because it defines credible speakers within these discourses and the underlying power relations that privilege certain groups and contribute to their representative legitimacy. Foucault (1972) importantly described a form of power closely connected with knowledge or with the discursive practices of the power group creating the objects of knowledge. Foucauldian scholars describe this power grouping as *disciplinary power* "exercised on the body and soul of individuals" (Sawicki, 1991, p. 22). Disciplinary practices derived from disciplinary power create binaries such as: "healthy/ill, sane/mad, legal/delinquent, which, by virtue of their authoritative status, can be used as effective means of social control" (p. 22).

Fairclough, another scholar of discourse, understands language as a form of social practice that shapes the way people understand a given field. I draw on Fairclough's assumption that "people are not always aware of the ideological dimensions of their own practice and that ideological practices are most effective when they have become and achieved common-sense status" (Fairclough, 1992, p. 8). Fairclough (1992) refers to a process he calls *intertextuality*, where texts, documents, and policies are produced by referring to text from other documents within and outside the organization. Through the process of intertextuality, some discourses, promulgated by the most powerful, achieve dominant status and prominence in health policy documents (Evans-Agnew et al., 2016).

In keeping with my analysis of health policy, I also draw on Bacchi's scholarship detailing the idea that policy problems are socially constructed and require interrogation of the unexamined or taken for granted ways of thinking that are assumed in policy development (Bacchi, 2016). Her analysis does not focus exclusively on the language used in the policies being analyzed, but rather emphasizes the discourses upon which policy formulations are based and the ways problems are described and positioned within policy. These nuances of analyzing discourse in policy formulations are discussed in more detail, reviewing additional literature, in subsequent chapters.

Situating the Self

Foucault (1988) defined *identity* as historical and situationally produced. His concept of discursivity leads to a discursive positioning that is influenced by experiences, knowledge, discourses, and practices including the effect of power relations on our individuality. In *Discipling Foucault*, Sawicki (1991) discusses Foucault's relational model of identity. Rather than privileging one particular relationship as central to identity

formation, Sawicki disciplines Foucault by proposing that identity is produced through "disciplinary technologies" (p. 64). Sawicki contends that "a principal aim of feminism has been to build self-esteem--the sense of confidence and identity necessary for developing an oppositional movement" (p. 106). Situating the self can be a "strategy for getting clear about some of the conditions governing one's choices, and thereby free one up for new ways of thinking, new choices" (Sawicki, 1991, p. 107). Like Foucault, Hall (1990) proposed that when we speak of anything as subjects, we are essentially positioned in time and space and, more importantly to Hall, within a particular culture. These subject positions are what Hall referred to as "positions of enunciation" or "constructed sites" from which we speak about ourselves (p. 222).

The constructed site from which I speak has been developed through the course of advanced study and experience. I have explored gaps in health service delivery, examined various power relationships within healthcare, critically considered professional privilege and related hierarchical structures of healthcare, and critically considered how these intersect with healthcare policy. I have spent my professional career working within the healthcare system of NB. I began as a direct care provider (occupational therapist) and then was promoted to a manager/coordinator of rehabilitation services, and finally held leadership positions in both central government (Department of Health) and the regional health authority (RHA), Horizon Health Network. The latter positions have allowed me the opportunity to influence health policy related to PHC as a member of the provincial Primary Health Care Steering Committee and chairperson of the interdisciplinary provincial committee which developed the operational guidelines for family health teams in NB. The policy documents developed under my leadership include, *Improving Access*

and Delivery of Primary Health Care Services in New Brunswick (2010); *A Primary Health Care Framework for New Brunswick* (2012); and the *Operational Guidelines for Family Health Teams* (2013). *A Primary Health Care Framework for New Brunswick* (2012) is the only document from this trio that I selected as part of my analysis because of the consultative process that informed it and its current relevance in the provincial healthcare reform process.

In my roles at the NB Department of Health and Horizon Health Network I have had personal and professional commitments as an advocate of PHC, while also being an advocate of increasing access to PC. My social location(s) as a middle-class, white, cis-gender, professional woman have influenced how I act, how others treat and view me, and how I have come to understand the world. Work experiences and social location have influenced my thinking about power relations and the hierarchical health systems that I worked in and managed. I have come to understand that my world view is a feminist one. It is through this lens that I have concluded that more often than not, health services are centered on providers (i.e., physicians) rather than on the recipients of those services, who are the patients. My interest in NP practice developed during my experiences working as a senior policy advisor at the Department of Health during the time when NPs were introduced in the province. My collaborative policy development opportunities, as a member of the provincial Primary Health Care Steering Committee, during the planning of and participation in the 2011 Primary Health Care Summit, and the development of the *Primary Health Care Framework for New Brunswick* (2012), have highlighted and brought into focus for me the tensions between the discourses of PC and PHC and the health disciplines aligned with these discourses.

Research Questions

The research questions I examined in this study are:

1. How are the discourses of primary care (PC) and primary health care (PHC) reflected in New Brunswick health policy post Canada Health Act (CHA, 1984)?
2. How are the discourses of PC and PHC represented in New Brunswick health discipline documents, specifically nursing and medicine, post Canada Health Act (CHA, 1984)?
3. What are some examples of consistencies/continuities, contradictions/discontinuities, intersections, and gaps in PHC and PC discourses as reflected in the selected provincial health policy and professional discipline documents?
4. How are the discourses of PC and PHC represented in the Government of New Brunswick health policy documents and in professional discipline documents specifically in relation to the introduction of Nurse Practitioners (NPs) in New Brunswick?

In addressing my research questions, I examined the emergence of PC and PHC discourses in NB through selected government policy and disciplinary level texts. I compared and contrasted how these discourses are represented in health policy and discipline-specific documents. Specifically, I examined the emergence of these discourses in government health policy documents and how these discourses evolved and were reflected in discipline produced texts and events during the period 1989-2019 when NPs were introduced and integrated in New Brunswick. These texts and events include material related to NB nurse practitioners as well as texts and events related to the work

of the NB Medical Society. My analysis considered examples of PC and PHC discourses beginning in 1989, five years after the 1984 enactment of the CHA legislation that provided clarity surrounding the standards to which provinces must adhere to guarantee eligibility for federal contributions. The final texts analyzed appeared in 2019 under the authorship of the Nurses Association of New Brunswick (NANB) nurse practitioner group.

Theoretical Intersections in Defining the Focus of this Study

This study explores how professional discourses operate in constructing and representing health policy around primary health care reform in New Brunswick. Consistent with my literature review, the study focuses on consistencies, gaps, and contradictions in disciplinary discourses of PC and PHC, asking also how these may contribute to barriers in healthcare transformation (Lewis & Leeder, 2009). The use of CDA in this study further explicates how continuities and discontinuities in the discourses of PC and PHC reflect professional practices in diverse settings where hierarchical power structures privilege some healthcare providers over others.

I have chosen a hybrid CDA theoretical framework, addressing questions that reflect a combination of work influenced by Foucault, Fairclough, and Bacchi. This combination aims to explore the interconnectivity between discursive practices, texts, and broader social and cultural structures and processes, examining how these relationships are a factor in securing power and hegemony especially in health care (Fairclough, 1993). Institutional partitioning of knowledge, as it occurs in healthcare or professional practice, influences the social practices through which certain objects, concepts, and strategies are formed (Foucault, 1972). I have analyzed discipline-specific, historical texts from the

provincial nursing union (NBNU), and the professional associations of nursing (NANB), and medicine (New Brunswick Medical Society [NBMS]), respectively, to examine consistencies, contradictions, intersections, and gaps in the discourse of PC and PHC within these texts. I have chosen these two disciplines as representing the discourses of PC and PHC in different ways. There are instances where both advanced practice nursing (APN) and medicine take up the discourse of PC, emphasizing access to care. And there are instances in which both APN and medicine take up the discourse of PHC, emphasizing the importance of health promotion and sometimes health equity. However, my experience as a policy advisor and administrator suggests that discontinuities exist.

My research demonstrates that the discourse of PC is more strongly represented in medicine and that the discourse of PHC is more strongly represented in APN. I compare these discourses and how they are taken up in professional documents and in government policy documents used to distribute, organize, and align healthcare resources. I draw attention to a historically situated policy level priority focus in NB involving the introduction of PHC nurse practitioners as primary care providers. This focus on NPs is relevant because the discourse of PHC reform speaks to enhanced access to PC, increased emphasis on health promotion and disease prevention, attention to the social determinants of health, and use of interdisciplinary teams, all within the scope of practice of a NP and at a reduced cost than traditional models, e.g., family physicians (DiCenso et al., 2007).

Overview of the Chapters

In this Chapter, I have discussed the focus and purpose of the study, discussed theoretical literature that has influenced how I framed this research, presented specific

research questions, briefly discussed the significance of the research focus, and situated myself within the work.

In Chapter 2, I situate the study first by reviewing in more detail the historical development of healthcare in Canada and New Brunswick. In addressing this historical context, I discuss and use some specific discourse-analytic concepts that are critical to the study. This includes a discussion of the development of the discourses of PC and PHC. I provide analysis of some features of each discourse and discuss concepts that characterize these histories or trajectories, e.g., continuities, discontinuities, and divergences, in the discourses.

Chapter 3 describes the methodology and methods of CDA. This chapter includes a discussion of the hybrid method of CDA used in this study, a combination of Fairclough's (1992, 2001, 2003) analytic framework and that of Bacchi (2012a, 2016), focusing on *what the problem is represented to be* (WPR) in policy analysis.

Chapter 4, "Building PHC Momentum," presents the first section of findings or data analysis. This chapter is focused on six policy-related documents released between 1989 and 2012 and representative of a time when the discourse of PHC was building in momentum. These include one government-produced text and five health care discipline-produced documents. The documents reviewed are as follows: *Report of the Commission on Selected Health Care Programs* (McKelvey Levesque, 1989); *A Discussion Paper: For the Health of our Communities* (NBNU, 1995); *The Future of Health Care in New Brunswick: The Nursing Contribution* (NANB, 1998); *Annual Report: Primary Care Collaborative Practice Project and Promoting Primary Health Care* (NANB, 2007); *Health Centres in New Brunswick: Leaders in the Provision of Primary Health Care*

(NANB, 2011); *Igniting Change: Province's Summit on Primary Health Care* (NANB, 2011). The analysis presents details of the interdiscursivity found between the six documents as well as the emergence, continuities/convergence and discontinuities/divergence of discourses related to PC and PHC.

Chapter 5, "Attenuation of PHC," presents my analysis of six policy-related documents produced between 2012-2019. These include two government-produced and four discipline-produced documents. One of the discipline-produced documents is from NBMS, two are from the NANB and one (with an infographic) is from the Nurse Practitioners of New Brunswick (NPNB), an interest group under NANB. The documents reviewed are: *A Primary Health Care Framework for New Brunswick* (GNB, 2012); *Rebuilding Health Care Together-The Provincial Health Plan 2013-2018* (GNB, 2013); *Fixing New Brunswick's Healthcare System: New Brunswick's Doctors Have a Plan CARE FIRST* (NBMS, 2013); *Position Statement–Primary Health Care* (NANB, 2014); *Nurse Practitioners of NB- Priorities* (NPNB, 2019); *Nurse Practitioners of NB-Infographic* (NPNB, 2019).

The analysis of each document in Chapters 4 and 5 addresses four elements: i) historical significance and purpose of each document; ii) analytic framework (Fairclough, 1992, 2001, 2003); iii) problem representation (Bacchi, 2012, 2016); and iv) discourse direction (Bacchi & Bonham, 2014). I examine each document to determine where there is ambiguity between PC and PHC, and which discourses (PC, PHC, neoliberalism) emerge, converge, diverge, or disappear.

The final chapter, Chapter 6, discusses and summarizes the findings, describing patterns that arise from the document analyses of Chapters 4 and 5. This chapter also

discusses the findings in relation to the research questions and links the findings back to the theoretical underpinnings of the study. The limitations and implications of the study are discussed and areas for further research and policy development are recommended.

Chapter 2

Situating the Study

In this chapter I discuss historical and governmental contexts of healthcare in Canada, as these contexts have influenced healthcare reform. I also discuss the discourses of primary care (PC) and primary health care (PHC), by placing them in historical and political context. In situating the focus of the study contextually in this way, this chapter presents details about federal and provincial responsibilities related to funding and the role of provinces in delivering care. I rely on literature that clarifies these historical and contextual details. Additionally, I review in more detail literature that examines the discourses of PC and PHC as they have emerged in Canadian healthcare reform efforts during the last 50 plus years.

In situating the study in this way, I am paying particular attention to key elements contained in PC and PHC, the trajectories of these discourses over time, the intersections and contrasts of these discourses in recent history, and the influence of these discourses on provincial health policy and planning.

Health Care in Canada

The Canadian national identity is framed in part by the pride that is felt about Medicare, a "free" public system of healthcare, sustained through taxation. Canada's constitution sets out the powers of the federal, provincial, and territorial governments. Under the British North America (Constitution*)* Act of 1867, jurisdiction over establishing, maintaining, and managing health care services rests with provincial and territorial governments (Crichton, Hsu, & Tsang, 1990). Under this same Act, the Government of Canada is granted powers to tax and borrow, and to spend resulting

monies in ways that do not infringe on provincial powers. Canada has 13 provincial and territorial health care systems that operate within a federal legislative framework: the *Canada Health Act* (CHA) (Hutchinson, Levesque, Strumpf, & Coyle, 2011).

Before World War II, healthcare in Canada was, for the most part, privately delivered and funded. In 1957, the federal government passed the *Hospital Insurance and Diagnostic Services Act* which offered to reimburse, or cost share, one-half of provincial and territorial costs for specified hospital and diagnostic services (Crichton et al., 1990; Marchildon, 2012). In 1966, the federal *Medical Care Act* introduced a cost sharing arrangement with the provinces and territories. Under this Act, the Canadian government agreed to pay for one-half of provincial and territorial costs for medical services provided by a doctor outside hospitals (Crichton et al., 1990; Marchildon, 2012). In 1984, the CHA built on the *Medical Care Act* by providing clarity surrounding the standards to which provinces must adhere to guarantee eligibility for federal contributions. These standards or principles include universality (all citizens covered), comprehensiveness (all medically necessary hospital and physician services), portability (of services between all provinces and territories), public administration of publicly funded insurance, and the fifth principle, as referenced by the Romanow report (2002), accessibility (removal of financial or other barriers so that publically funded health services are available to all Canadians when they need them (CHA, 1984). By defining the comprehensiveness standard as coverage of hospital and physician services, the CHA privileged physicians and hospital care and had the compounding effect of minimizing care by other health care providers in spaces outside of hospitals, such as in community or homes (Hutchinson, Abelson, & Lavis, 2001). In 2003, the provincial and federal leaders (i.e., First Ministers)

agreed on the *Accord on Health Care Renewal*, which provided for structural change to the healthcare system to support access, quality, and long-term sustainability (Government of Canada, 2003). The Accord committed governments to work toward targeted reforms in areas such as accelerated PHC renewal; supporting information technology (e.g., electronic health records, telehealth); coverage for certain home care services and drugs; enhanced access to diagnostic and medical equipment; and better accountability from provincial and territorial governments. Under the Accord, federal government cash transfers in support of healthcare were increased and split into the Canada Health Transfer (CHT) for health and the Canada Social Transfer (CST) for post-secondary education, social services, and social assistance, effective April 2004 (Government of Canada, 2003). In 2004, further reforms were announced by First Ministers in *A 10-Year Plan to Strengthen Health Care*. In 2012, the federal, provincial, and territorial governments committed to a health care renewal plan that included work toward reforms in key areas such as wait times management; health human resources; Aboriginal health; home care; PHC; a national pharmaceutical strategy; healthcare services in the Canadian North; medical equipment; prevention, promotion, and public health; and enhanced reporting on progress made on these reforms (Government of Canada, 2012). It should be noted here that some health services are funded and provided directly by the federal government. These services include Indigenous health and Veteran's healthcare. This separation of services and funding has added increased complexity to the delivery of provincial health services to these populations, especially Indigenous peoples where tripartite negotiations between Indigenous communities, provincial and federal entities is required (Kirby & LeBreton, 2002).

To support the *10-Year Plan to Strengthen Health Care*, the Government of Canada increased health care cash transfers, including annual increases to the Canada Health Transfer (CHT) from 2006-07 until 2013-14. This increase was intended to provide predictable growth in federal funding (Government of Canada, 2012). In December 2011, the Government of Canada announced that the CHT would continue to grow at 6% annually until 2016-17, and starting in 2017-18, the CHT would grow in line with a three-year moving average of nominal gross domestic product (GDP) growth, with funding guaranteed to increase by at least 3% per year. The CHT and the CST will be reviewed in 2024 (Government of Canada, 2014).

As noted earlier, under the federal-provincial funding formula, healthcare spending consumes approximately 40% or more of provincial budgets (Drummond, 2011; Picard, 2017; Robson, 2019).). At the rate of fiscal growth, approximately 3-4% per annum, the sustainability of health care in its current state is a concern for economists and administrators of the system (Bliss, 2010; Dodge & Dion, 2011; Drummond, 2011; Picard, 2017; Robson, 2019). These economic realities are compelling provincial governments to not only rein in spending but to examine how healthcare dollars are spent and what population health outcomes are achieved. As highlighted in the previous chapter, provincial policy reforms and federally targeted funding initiatives have not translated into significant change to the way healthcare is organized, delivered, and funded (Lazar et al., 2013; Lewis & Sullivan, 2013; Simpson et al., 2017). Innovation and transformative change has occurred in small regional pockets, but systemic reform remains elusive (Hutchinson et al., 2001). Generally, medical and hospital services continue to be organized, managed, and delivered largely the way they were at the

inception of Medicare in 1966 when acute illness was more prevalent than chronic conditions and the mean age of populations was significantly younger (Lazar et al., 2013; Lewis & Sullivan, 2013; Medical Care Act, 1966).

The *Canadian Health Act* and the Health Accord have produced trends for health reform in Canada by focusing on accessibility through wait time management and improved PHC as examples. With the end of stable funding for healthcare in 2014, provinces have faced escalating healthcare costs. Needless to say, healthcare reform has been driven primarily by governments, the public administrators of the system. From a provincial/territorial perspective, these reforms have been centered on economic drivers or attempts to control costs while improving access. From a federal perspective, reforms have been focused more on improvements in health promotion, health equity, and population health as evidenced by the targeted funding of the Health Accord and 10-year Plan to Strengthen Health Care (Government of Canada, 2014). These intersecting and often conflicting areas of emphasis in policy discourses from the federal and provincial/territorial governments highlight the significant influence of provincially focused politicians and healthcare professionals (especially physicians) on health policy, especially with regard to PC reform (Lazar et al., 2013). Lazar and colleagues (2013), in their analysis of the evidence around Canadian health policy reform, suggested that provincial medical associations, who negotiate master agreements for their members with provincial political leaders, "determine the nature and pace of reform" (p. 311). This skewed influence of one group over others in determining health policy can lead to gaps in healthcare organization and delivery (Lazar et al., 2013; Simpson, 2012).

From an international perspective, the World Health Organization (WHO) in its report of 2008, *Primary Health Care-Now More than Ever,* also advocated for the renewed focus and investment in PHC. The WHO noted that the response of the health sector and governments to the current day challenges like globalization, aging populations, and urbanization has been "slow and inadequate" (WHO, 2008, p. 54). This 2008 document built on the earlier WHO 1986 report, the Ottawa Charter, by exemplifying how PC systems can be reformed within the context of PHC to include "health promotion and (illness) prevention, cure and care together in a socially productive way at the interface between the population and the health system" (WHO, 2008, p. 41). The document emphasized the importance of PC within a PHC context as the consistent and regular point of contact for people within the healthcare system. With this regularity comes the opportunity for comprehensive and integrated, person-centered care: a "consistent, trusting relationship between providers and receivers of care promotes continuity of care" from cradle to grave (p. 42). The most recent WHO document, *A Vision for Primary Health Care in the 21st Century* (2018), provided important background for the affirmation of PHC, articulated in the *Astana Declaration on Primary Health Care* (WHO, 2018). Within this declaration is the framework for achieving "health and well-being for all" (p. viii). The framework described the actions that health systems and governments can incorporate to achieve the goal of health for all. These include:

> empowering people to take ownership of their health and health care; making bold political choices for health; putting public health and primary care at the centre of

> universal health coverage; and aligning partner support to national policies, strategies, and plans. (p. viii)

Many countries, including Canada, have not achieved health and well-being for all (Hutchison et al., 2011; Nixon et al., 2018; Raphael, 2008; Simpson, 2012). Health equity, "avoidable inequalities in health between groups of people within and between countries" (WHO, 2005, p. 1), remains an elusive goal nationally and internationally (Pauly, Shahram, Dang, Marcellus, & MacDonald, 2017). In exploring health gaps and inequity among social groups, relationships within healthcare that involve privileging and power, as well as hierarchical structures of healthcare and healthcare policy, all influence the achievement of health for all. I believe it is a prerequisite to consider the discourses of PC and PHC in efforts to achieve health equity. The distinction between PC and the broader PHC are not always clear, and, as stated earlier, it is my contention that the general lack of consensus on what constitutes each discourse creates challenges for interprofessional collaboration, sound understanding of health provider roles, and the achievement of social justice and health equity in patient-centered care.

The terms PC and PHC are used in numerous policy and health professional documents dating back to the early 1970s. The terms are frequently used interchangeably and often assumed to be synonymous. Scholars have suggested that ambiguities, continuities, and discontinuities between PC and PHC (as discourses) contribute to barriers in healthcare transformation, where services are organized around the needs of patients, their families, and communities (Lewis & Leeder, 2009; Turner et al., 2007; WHO, 2008, 2018). These ambiguities arise in the continuities and discontinuities between the discourses, and their respective constructs. Continuities and discontinuities

are reflected in discourses amongst health care professionals who practice in diverse settings and are also demonstrated in the hierarchical power structures which privilege some health care providers over others (Frenk, 2009; Griscti, Aston, Warner, Martin-Misener, & McLeod, 2016; Simpson, Walker, Drummond, Sinclair, & Wilson, 2017). Additionally, privilege and power among those who emphasize one or the other discourse support the current structure, organization, and design of the Canadian healthcare system, which is primarily focused on specialized primary medical care and acute care received in hospitals (Simpson et al., 2017). Discontinuities, continuities, and dissonance between the discourses of PC and PHC are further demonstrated in health policy, organizational mandates, health professional regulations, and scopes of clinical practice (Frenk, 2009; Muldoon, Hogg, Levitt, 2006).

Discourses of Primary Health Care

The term PHC was coined in 1978 by the WHO and the United Nations International Children's Emergency Fund (UNICEF) in response to low life-expectancy and high mortality rates of children in low-income countries (WHO, 1978). Although many communicable diseases had been eradicated through advances in immunization programs, WHO (1978) noted that morbidity and mortality rates were highly responsive to local, inexpensive social initiatives such as safe water and food programs. This World Health Assembly, held in Alma-Ata, Soviet Union in 1978, called for a global health strategy labelled "Primary Health Care" (p. 8). I will refer to this as the *Primary Health Care Global Strategy* (PHC-GS) when I am referring to this WHO-enunciated philosophy of practice.

The PHC-GS developed at Alma-Ata invited all member countries to achieve "health for all" by the year 2000 (WHO, 1978). This new world goal, of health for all, is referred to as the Alma-Ata Declaration where health is considered an integral constituent of social and economic development. The definition of PHC derived from the social model of health and sustained by the Declaration of Alma Ata is as follows:

> Primary health care is essential care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work and constitutes the first element of a continuing health care process. (WHO, 1978, pp. 2-3)

The WHO embraced PHC as the model for global health policy at this 1978 meeting of health ministers and experts from around the world. The discourse introduced in this Declaration clearly emphasized PHC-GS as essential care, the first point of access that should be universally accessible, and also referred to it as being an integral part of the social and economic development of the community. Following Alma Ata, there was a push back in response to the declaration from dominant genres such as medical associations on what they interpreted as a politically motivated movement and a

philosophy underpinning service delivery, which would ultimately erode their power and control within the system (Frenk, 2009). The threat for opponents of PHC-GS was and continues to be its emphasis on the social determinants of health. PHC-GS incorporates a population health approach as its foundation. This approach is concerned with improving the health of the entire population and to reduce health inequities among population groups by examining and acting upon a broad range of factors and conditions that have a strong influence on health (Public Health Agency of Canada, 2021). These factors and conditions are often referred to as the *social determinants of health* and presently are categorized by the Public Health Agency of Canada (2021) as: "Income and Income Distribution, Education, Unemployment and Job Security, Employment and Working Conditions, Early Childhood Development, Food Insecurity, Housing, Social Exclusion, Social Safety Network, Health Services, Aboriginal Status, Gender, Race, Disability" (p. 1). The social determinants of health as articulated by the PHC-GS are relevant for PHC in Canada because they provide a policy framework for reducing health inequities. According to Raphael (2004),

> There is a need then, to foster communication between those concerned with the current state of various social determinants of health and those knowledgeable about their health effects. This need is especially great in Canada as a consensus is emerging that the quality of the many social determinants of health is deteriorating as a result of policy decisions being driven by various political, economic, and social forces. (p. 5)

Considered over decades by some as being too idealistic and expensive, the vision of PHC-GS was replaced among powerful medical associations and some medical

practitioners with a disease-focused, biomedical model for PC, heavily oriented towards treatment provided mostly by physicians (Rachlis, 2004). In this context of evading key elements of PHC-GS, that discourse was avoided by medical elites and replaced by the international use of strategically important and select elements of the discourse of PC (first point of access) or family health services (e.g., family medical doctors, opticians, dentists, pharmacists). In parallel, non-physician services were embedded in what was then coined as *secondary care,* defined as health services provided in the community, such as midwives, community health nurses, public health clinics, and allied health services provided in hospitals (Shi, 2012). This discursive substitution of "primary and secondary" care was not sanctioned by the WHO and was also not aligned with important key elements of PHC. It further entrenched the power structure between a narrow, biomedically oriented, first point of contact type of PC and other types of practice among practitioners within these medicalized hierarchically organized levels of care (Barnes et al., 1995). As Funk, Saraceno, Drew, and Faydi (2008) noted, with regards to mental health care for example, the exclusion of community care services for severe psychiatric disorders and the consistent location of these services away from regular PC services "further reinforces the hierarchy and eclipsing of the psycho-social by the biomedical, rather than a holistic integrating of both" (p. 2).

The evolution of a *selective* and partial definition of PHC, provided mostly by PC physicians, was thought by administrators of healthcare in international settings to be an affordable interim measure, employing appropriate contemporary technology, such as immunization (Walsh & Warren, 1979). These selective and partial PHC programs were usually cost effective, vertical programs focused on people and populations with specific,

single health conditions such as disease or organ-specific illnesses like diabetes or malaria, sometimes housed in local hospitals or more frequently in community-based settings, with favorable outcomes and measurable results. In international settings, these favorable results created the political will for funding similar programs that were known as GOBI—growth monitoring, oral rehydration techniques, breast-feeding, and immunization (Cueto, 2004; Newell, 1988). This temporary interim approach implemented internationally, especially in economically impoverished countries in the 1980s, was rejected by advocates of PHC, usually non-physicians, as a top down, specialist driven model that promoted medicalization and biomedical superiority overlooking social factors that contribute to health and illness (Newell, 1988). The debate between selective PHC and comprehensive PHC continued into the next decade with selective PHC characterized by its PHC opponents as a narrow, technocentric approach that diverted attention away from the social inequities that contributed to disease. For example, *growth monitoring* was challenging to implement because it required mothers, who were identified as "low literate", to read charts and record measurements. These same mothers had inadequate access to education and opportunities to improve literacy levels (Cueto, 2004).

Another later and highly significant (Raphael & Bryant, 2006) WHO (1986) document, the *Ottawa Charter for Health Promotion*, referred to hereafter as the Ottawa Charter, extended the call for achieving PHC by going beyond biomedically oriented PC as a first point of access. The Ottawa Charter specifically took up the discourse of health promotion and population health as it called for "an interdisciplinary approach that engages all of the stakeholders in the process" (p. 4), including individuals, communities,

healthcare practitioners, decision-makers, and policy makers. It emphasized a shift away from dependence on healthcare practitioners and towards personal involvement, healthy public policy, and strengthened community action. It echoed its Alma-Ata predecessor, focusing on more than improved health and medical services and emphasizing that a greater focus on medical interventions does not improve overall population health. For example, medical interventions available within the Canadian health care system contribute approximately 25% to overall health status (Keon & Pépin, 2008). The emergence of emphasis on health promotion and equity in population health has been a key element within the discourse of PHC but it has remained marginal in Canadian health policy (Raphael, 2008).

The challenge in 1986 and now is that the health status of individuals and the overall population are influenced by several variables that occur outside of the health system. Societal factors and the unequal distribution of these factors contribute equally to overall health and, conversely, to inequalities in health (Raphael, 2010). Between 1986 and 2008, emphasis in the discourse of PHC began to address these factors, emphasizing gaps, disparities, and inequities in health. It did this by incorporating emphasis on the social determinants of health. In 2005, the WHO began to address health inequity and to advocate for PHC through action on the social determinants of health (WHO, 2005). A focus on optimal population health in the discourse of PHC requires integrated attention to health disparities based on social determinants like income status, race, sexuality, gender, culture, housing security, education, and food security. It requires attention to distribution of resources that address health equity (Pauly et al., 2017). Finally, it requires

a focus on health system design or redesign and emphasis on basic health services that are sensitive to the influences of the social determinants of health (WHO, 2008).

PHC is a broader discourse than PC, encompassing a wider range of healthcare providers, services, functions, and goals (Commission on the Future of Health Care in Canada, 2002; Harris, 2010). It is both a philosophy and system response to reducing health inequities and ameliorating the effects of disadvantage (Keleher, 2001; Reutter & Kushner, 2010). Emphasis on addressing the social determinants of health and health equity has been central to the discourse of PHC. PHC requires community participation in defining and implementing the health agenda, which in turn fosters social and economic development (Lewis & Edwards, 2004; Muldoon, Hogg, & Levitt, 2006). Health Canada defines PHC as "an approach to health and a spectrum of services beyond the traditional health care system. It includes all services that play a part in health, such as income, housing, education, and environment" (Health Canada, 2015, p. 1).

The discourse of PHC differs from the discourse of PC in its recognition of those parts of the healthcare system that focus on the social determinants of health and protecting/promoting the health of all people in all communities. Health providers who work within a PHC model are usually engaged (even in PC practices) in working with issues regarding health in a preventative manner, with emphasis on addressing the social determinants of health and health disparities in preventing or treating illness, and with population health understanding as they provide individual or community-oriented care (Keleher, 2001). As Raphael (2010) points out, discourses of "individualism and personal responsibility can be a barrier for health professionals and the public to fully embrace the social determinants of health" (p. 4). It leads to placing the locus of control on the

individual and their health choices (victim blaming) rather than an understanding that health status is influenced by or directly the result of how a society organizes its distribution of resources (Raphael, 2010; Reutter & Kushner, 2010). PHC, with a philosophical underpinning of social justice, intersectoral action, and community engagement, is positioned to address health inequity (Reutter & Kushner, 2010). Marmot, Friel, Bell, Houweling, and Taylor (2008) argue that, "Health care systems have the best health outcomes when based in PHC" (p. 1665).

Another common thread entwined within the discourse of PHC is the relatively low cost of services as compared to the other more expensive parts of the present health care system (Frenk, 2009; Swerissen, 2008). The Government of Canada (2003) identified PHC as key to the sustainability of Canada's health care system because it "supports a system in which individuals, families and communities are encouraged and supported to stay as healthy as possible, thereby reducing pressure on the more expensive and resource-intensive, acute care and emergency services" (p. 153).

The WHO Astana Declaration (2018) identified PHC care as being "the most effective, efficient and equitable approach to enhance health" (p. 1). This newest contribution to the discourse of PHC continued to demonstrate familiar continuities and discontinuities in the two discourses. Significantly, it called on world leaders to address today's challenges and seize opportunities for a healthy future by making "bold political choices for health" (p. 2).

This analysis demonstrates that key elements of the discourse of PHC have evolved since 1978. While it originally included reference to being essential care, the first point of access, universally accessible, and an integral part of the social and economic

development of a community, over time the discourse shifted to make distinctions between selective and comprehensive PHC. In the new millennia, the discourse of PHC evolved to include health promotion, a focus which was quickly displaced by a related emphasis on population health (Raphael, 2008). These elements emerged in evolving ways in efforts to address the social determinants of health and health disparities. In recent years, the discourse of PHC at the international level and in Canada has demonstrated key elements of health equity: empowerment of people and communities; quality health care; evidenced-based policies and actions; and efficient, integrated public health and PC (WHO, 2018).

Discourses of Primary Care

Frenk (2009) traced the origins of the discourse of PC to a report published in the UK in 1920 that referred to three levels of care: "primary care, secondary care and teaching hospitals" (p. 170). This hierarchical, three-tiered configuration as a vision of healthcare services was circulating at the onset of PHC discourse and is still prominent in Canada today. Frenk critiqued this configuration as a flawed system that assumes a "linear progression of health (care) from simple to complex over a lifetime" (p. 170). Access to healthcare, for most Canadians, is through a PC (first point of access) provider; this is usually a family physician, but more recently may also be a nurse practitioner or in some locations a registered nurse (RN). This entry point into the system is usually the first point of contact, where diagnosis and treatment are offered and referral to other health services, often specialty physician care (secondary and/or tertiary) and other providers, is initiated. This entry level of healthcare is referred to as PC (Shi, 2012, p. 2). The challenge with this discourse is that placing it in the hierarchy of primary, secondary,

and tertiary denotes “simplicity both of difficulties and resources” (Frenk, 2009, p. 171). The other challenge is that in Canada, there are other entry points like the emergency room, an ambulance, or through Tele-Care 811 (GNB, 2010).

Thirty years post Alma-Ata, the discourse of PC is still being used in Canada and globally to describe it as basic medical care or family practice, “family doctor-type” services delivered to individuals over an extended period of time (Muldoon et al., 2006). Within Canada, family physicians have been the main source of PC delivery (Canadian Institute for Health Information [CIHI], 2020; Canadian Medical Association [CMA], 2018; Lazar et al., 2013). As PC is usually an individual’s first interaction with the healthcare system, primary caregivers, who historically have been physicians, are considered the gatekeepers of the Canadian health care system (Hutchinson et al., 2011). A model of PC has been envisioned as the place where health problems are commonly first identified, managed, or referred in the context of early intervention (Hutchinson et al., 2011; Lazar et al., 2013; Starfield, Shi, & Macinko, 2005; WHO, 2008). A common public understanding of the elements of PC encompasses mainly the treatment of illness and dysfunction. It is often described as "front-line” care and “point of first contact,” and is traditionally in the form of a visit to a primary care provider such as a family physician or nurse practitioner. In these contexts, medically oriented PC is frequently focused on a specific disease or body system, and it may or may not include community engaged care dealing with underlying and contributing social determinants of health (CIHI, 2009; Keleher, 2001; Reutter & Kushner, 2010). In some cases, nurse practitioners are viewed as agents of PC. They may or may not be functioning in a PHC model that addresses structural factors in the social determinants of health (Reutter & Kushner, 2010). The

critique of a narrowly medicalized focus on sick-care inherent in discourses of PC is that it further disenfranchises the concepts of PHC-GS in Alma-Ata (WHO, 2008).

Although the discourse of PC has evolved from sick care to include population health and health promotion interventions such as immunization and prevention advice in the way of smoking cessation, addressing obesity, or adopting healthy lifestyle practices, these discourses still converge with biomedical discourses related to the diagnosis and treatment of illness (Raphael, 2008). In these elements or approaches to health promotion, the discourse of PC can stop short of a comprehensive, health equity oriented, intersectoral approach to promoting or enhancing health through policy and program redesign in practices that include a focus on the social determinants of health (Lewis & Edwards, 2004).

Some forms of PC discourse can be consistent with PHC discourse if the first points of contact are anchored in a PHC philosophy and are less exclusively or narrowly medically or disease focused. These points of convergence emphasize the continuities that can exist between discourses of PC and PHC. Raphael (2008) for example, points to community health centres (CHCs) as an example of a kind of PC, or first level of care, embedded in the "principles of Alma Ata" (p. 489). PC discourse can include health promotion and illness prevention as well as diagnosis and treatment. However, when PC discourse focuses solely and in decontextualized ways on individual engagement in actions (such as smoking cessation, physical activity, and healthy eating) in the absence of engaging action on relevant social determinants of health, it evades important root causes of illness and disease. When these social determinants are neglected, individual

strategies promoted within PC are less impactful, can convey unintended messages of victim blaming, and may even contribute to health disparity (Raphael, 2010).

Other key elements of the discourse of PC include: an a-historical and decontextualized focus on individual health promotion; individually focused prevention and early medical intervention strategies; and recent hyper-attention to what is termed *evidence-based intervention*, using scientific approaches to investigate effectiveness of treatments at the level of populations and treat chronic disease at the level of the individual. However, within this individualistic and medically oriented perspective, the coordination and integration of patient care, sometimes referred to as the "bread and butter" of PC, has become more complex with increased specialty care and sub-specialization (Starfield, Shi, & Macinko, 2005). The increased time and effort that is required to coordinate and integrate care for individuals has contributed, in part, to over saturation of PC practices where fewer patients can be accepted and more citizens are being left without a PC provider (Simpson et al, 2017). This trend in the delivery of PC demonstrates one example of how the discourse of PC overshadowed other discourses and contributed to unanticipated negative effects in the delivery of healthcare since the mid-1970s (Hutchinson, 2008).

An example of PC contributing to unanticipated negative effects includes the recent proliferation of information management systems associated with PC. Beginning in the early-mid 1990s, the introduction of widespread electronic clinical information management systems have become more readily integrated into practice, enabling PC providers to focus on quality and evidence-based practices with greater ease and accuracy (Hutchinson, 2008). The functionalities of these electronic systems have supported

enhancements such as: decision support at point of care; population management tools, i.e., registries for groups of similar patients (for example people with diabetes); and performance measurement tools like wait times and team functioning. However, as an element of *quality of care* and a recently introduced discourse of PC (Hutchinson et al., 2011; Islam, Poly, & Li, 2018), these performance measurement tools, although effective in improving efficiency, have not translated into improved access to or quality of PC (O'Donnell, Kaner, Shaw & Haighton, 2018).

Another emerging element in the discourse of PC evolved in the early 2000s, related to increased emphasis on partnerships, teams working together, and including patients/clients and their families as part of the care team (Hutchinson, 2008). There was an "emerging recognition that there must be a greater emphasis on partnerships with consumers and support for self-management of chronic disease" (Swerissen, 2008, p. 55). This is an example of converging continuity in the two discourses of PC and PHC. These examples demonstrate that over time, PC has shifted to appropriate some of the discursive elements of PHC—though the extent to which these elements have made a difference in "health for all" (health equity) is not clear.

There is evidence that some important key elements of the discourse of PC have evolved since 1978. Although they originally included reference to point of first contact with the healthcare system and front-line care, over time, the discourse has shifted to include health promotion/disease prevention and continuous, patient-centered care (Shi, 2012; Starfield, Shi, & Macinko, 2005). This inclusion of attention to health promotion and illness prevention mirrors similar developments in the discourse of PHC, although this emphasis has been focused on individuals in PC and has not included as much

attention in addressing health inequity, acting on the social determinants of health and community empowerment. Presently, the discourse of PC at the international level and in Canada demonstrates key elements of quality care, partnership, teamwork, and self-management support involving patients and their families (OECD, 2019).

Differentiation between Discourses of Primary Care and Primary Health Care

Does differentiation between the discourses of PC and PHC matter? In examining the influence of these discourses on provincial health policy and planning, because of the comprehensive and interdisciplinary[1] nature of PHC, it is important that PHC not be confused with PC or medically oriented primary care. There have been several attempts nationally to articulate the difference between the two discourses.

In 2005, the Health Council of Canada attempted a convergence of the two constructs of PHC and PC by defining PHC as something that:

> not only provides the entry point of contact for individuals with the health care system, but also serves as the vehicle for ensuring continuity of care across the system. Most definitions of primary health care also recognize health promotion, disease and injury prevention and the importance of placing stronger emphasis on the determinants of health and strategies to advance individual and population health. Through primary health care, short-term health issues are resolved, and most chronic conditions are managed. (p. 5)

[1] In this dissertation, the terms *multidisciplinary* and *interdisciplinary* are used in relation to the periods of time examined. Multidisciplinary is used primarily in the earlier documents during the time period between 1989–1995. Within this context multidisciplinary is understood as "disciplines working alongside or parallel, in a silo format without much interaction" (Angelini, 2011, p. 176). The discourse changed roughly around 1998 with the gradual replacement of multidisciplinary by the term interdisciplinary. In this dissertation, interdisciplinary is used (in the context of health care) as involving interprofessional collaboration where professions work "together in collaboration by integrating services and utilizing teamwork concepts" (Angelini, 2011, p. 176). Interdisciplinarity within a health care setting then is understood to mean "coming together around patient care issues, allowing decision making to occur within the group and allowing for transformation to occur" (Angelini, 2011, p. 176).

Subsuming these two constructs into one definition clearly highlights the intersections between the two discourses of PC and PHC that have contributed to confusion and perpetuated power struggles between primary care and primary health care providers. A comprehensive PHC approach addresses a range of social and environmental factors that cause ill-health as well as those that sustain and create good health.

In 2012, Health Canada defined PHC as:

> An approach to health and a spectrum of services beyond the traditional health care system. It includes all services that play a part in health, such as income, housing, education, and environment. Primary care is the element within primary health care that focuses on health care services, including health promotion, illness and injury prevention, and the diagnosis and treatment of illness and injury. (p. 1)

In contrast to the Health Council of Canada definition, Health Canada spoke to the uniqueness of PC and PHC and positioned PC as an element within the broader PHC. Clearly this broader definition of PHC encompasses more than primary medical care. It includes community health services, Indigenous health services, and broader preventative programs that span health, social, economic, educational, and other services. It emphasizes a philosophy of prevention and health promotion that addresses structural inequities that cause and sustain illness. Recognizing this wider scope of focus matters for several reasons. At a socio-political level of understanding, using the discourses of PC and PHC interchangeably may suggest that those components of PHC other than primary bio-medically oriented care are less important (or that they are addressed by "non-medical" practitioners). This reflects and further contributes to the privileging of

physicians over other health care providers. For advocates of PHC, PC refers partially to only one aspect of PHC—the first level of predominately curative bio-medical care—and does not reflect the need for intersectoral and health promoting elements of PHC, both of which are necessary to achieve health equity (Canadian Nurses Association, 2010).

Another element of PC discourse that matters has been the emergence of the strand of evidence-based discourse in the 1980s, which helped to bring the power and discipline of scientific evidence to health care decision-making (WHO, 2008). An exclusively biomedical approach to the health sciences typically reflects what has been termed positivist science (Raphael et al., 2008). Raphael and colleagues examined the problems of applying an exclusively positivist approach to health sciences and other areas of social inquiry: "When applied to the health and social sciences, positivist science generally avoids dealing with aspects of the broader environments" (p. 4). According to Raphael et al., the focus of this positivist scientific approach in medical practice is on cells, physiological systems, and organs. In a broader perspective found in community health, public health, qualitative health research, and related health sciences, the focus includes a broader appreciation for behavioral risk factors, focusing carefully on achieving contextually sensitive scientific explanations. In contrast, an important aspect of positivist biomedically oriented science is its professed commitment to objectivity derived from decontextualized evidence. In the critique of such an exclusively positivist approach to health care research, PHC advocates argue that this kind of science leads some researchers and healthcare providers to be unwilling or unprepared to make what are termed "informed normative" judgments based on qualitative research about what

"should be" … rather than limiting their investigation to the positivist description of "what is" (p. 4).

The WHO's Alma-Ata and Ottawa Charter are foundational to the discourse of PHC characterized by the integration of the concepts of empowerment, community-action, and transformative learning. The underpinnings of the discourse of PHC emphasize health equity, community participation, and empowerment; a grass roots approach to planning, implementation, and monitoring; health promotion and disease prevention; interdisciplinary practice; intersectoral action; access to PC that is consistent with the philosophy of PHC; and political advocacy focused on the social determinants of health (WHO, 2008, 2018).

Because most of the evidence supporting the benefits of PC is derived from general practice and family medicine rather than other health professionals or from PHC teams, that evidence cannot simply be extrapolated to guide the more expansive paradigm of PHC. This is especially relevant regarding the efficacy of team approaches to care in PHC involving other healthcare providers such as nurses, social workers, occupational therapists, and dieticians (Keleher, 2001). One of the most significant differences between the discourses of PC and PHC is that PHC is fully participatory and as such involves the community in all aspects of health throughout the life cycle (Anderson & McFarlane, 2008; Wass, 2000; WHO, 1999). Hutchinson (2008) articulated some arguments that have been expressed by primary care providers. Although consistent with the discourse of PC the social determinants are challenging to address within the *practice* of PC, "the social determinants of health lie primarily in the domain of public policy and are largely beyond the reach of primary health care" (p. 65). Hutchinson's work

highlights the ambiguity of PC and PHC in that he was describing the work of PC (family) physicians but referred to this work as PHC.

In comparison, practitioners working within PHC who are oriented by its philosophy of practice believe that they can learn how best to transform the present arrangement of "sick-care" (versus health care), which is a medicalized system of PC, through the philosophical underpinnings of empowerment, social justice, democratic engagement, and community action. Their aspirations are to re-model PC into a model of PHC through action on the social determinants of health—action which reflects broader values of health equity, is embedded in the community, and focused on opportunities for change (Ramsden & Integrated Primary Health Care Research Team, 2003). The PHC discourses of *team-based care*, *community-focused*, and *client-centeredness* reflect this philosophical position (Frenk, 2009; Hutchinson, 2008).

Although not a dominant entity of PC in Canada, community health centers are a delivery model that embodies the principles of team-based, community focused care and offers primary care providers an opportunity to practice within the principles and philosophy of PHC. Historically, in Saskatchewan, the birthplace of Medicare, community health centres were considered "a backbone of health care reform, and rural health in particular" and were part of the Co-operative Commonwealth Federation (CCF) election platform in 1944 (Jones, 2019, p. 340). Although the model provided an opportunity to those who wanted to provide health services in a more altruistic, community-focused way, the community health centre model was criticized by organized medicine as "socialistic" during a time when socialism was likened to communism and deemed an undesirable societal ideology (Jones, 2019, p. 342).

Another early example of PC embedded within the principles and philosophy of PHC was the Group Health Centre in Sault Ste Marie, established under the stewardship of the United Steelworkers of America in 1963 (Lomas, 1985). This model again attracted physicians and care providers who wanted to practice in ways consistent with PHC and receive commensurate salaried remuneration. The Group Health Centre model involved "patients in organizing their own care" (Lomas, 1985, p. 62). Again, it was not without its critics. According to Lomas, "one of the most striking aspects of the development of alternative health care structures is the degree of opposition they experience from within the medical profession itself" (p. 127). According to Lomas, organized medicine's three main concerns with the model were that there existed a "restrictions on free choice of physician, the threat to an encumbered doctor-patient relationship and (perceived) absence of evaluative procedures to judge efficacy" (p. 127).

In summary, the discourse of PC describes the organization of healthcare as focused on the individual's first point of access to the healthcare system through treatment organized principally by a biomedically oriented epistemology. Within this discourse, care has been described as episodic and organized significantly by a medicalized approach, although with increasing emphasis on patient or person centeredness (Frenk, 2009). PHC discourse provides a broader social view of health focused on communities and has a wider range of intervention strategies focused on achieving health equity through action on the social determinants of health. PHC practices can include PC and illness management, plus illness prevention, health promotion, education, community engagement to act on the social determinants of health, and capacity building. PC often consists of vertical programs, i.e., health programs

focused on people and populations with specific, single episodic or chronic health conditions (WHO, 2018). Examples of this vertical programming include disease or organ-specific programs like diabetes education or cardiac rehabilitation programs. These have been described as usually located in local hospitals or related facilities and critically described as *silos* lacking the sort of horizontal, inter-professional community-based integration that characterizes PHC (Charles-Jones, Latimer, & May, 2003). As has been established, PC is synonymous with primary medical care and usually refers to the first level of contact with predominantly curative care. This PC discourse has been disciplined for over 40 years by the WHO, including in its statement of 2008, which advocated that: "people-centered care focused on health needs, ensures an enduring personal relationship throughout the life cycle, is comprehensive, continuous and tackles determinants of ill-health where people are partners in managing their own health and that of their community" (p. 43).

Although PC is a vital element of PHC, unless it is reorganized to be consistent with the principles of PHC, it does not reflect the important social justice, political, intersectoral, health equity and health-promoting elements of the discourse of PHC. Childhood poverty is a classic example of a population health challenge where interventions exist outside of a primary care provider's office. Solutions are multi-faceted, requiring political, social, and economic actions that address the social determinants of health and health equity (Russell, Rubin, & Leeder, 2008). The following quotation from family physician, Gottlieb (2010), exemplifies the importance of addressing the social determinants of health:

> I had diagnosed "abdominal pain" when the real problem was hunger; I confused social issues with medical problems. I mislabeled the hopelessness of long-term unemployment as depression and the poverty that causes patients to miss pills or appointments as noncompliance. In one older patient, I mistook the inability to read for dementia. My medical training had not prepared me for this ambush of social circumstance. Real-life obstacles had an enormous impact on my patients' lives but because I had neither the skills nor the resources for treating them, I ignored the social context of disease altogether. (Section A-8)

In summary, the key elements of the discourses of PC and PHC have evolved since 1978. PC discourse was originally centered on point of first contact medical care, subsumed in the broader, more expansive discourse of PHC that included community-based health promotion and illness prevention, as well as social justice and health equity. Over time, the lines blurred with intersecting discourses of person-centered, continuous care throughout the lifecycle that is comprehensive and team oriented. Presently, the discourses of both PC and PHC frequently continue to demonstrate this ongoing blurring of distinctions, for example when they both include attention to quality, collaboration, and community focused care.

Continuities/Discontinuities of Primary Health Care and Primary Care Discourses

In this section I draw on select theoretical literature to discuss continuities and discontinuities in the discourses of PC and PHC over time. I rely on Foucault's 1972 work focused on methodologies of historical archaeology and genealogy where he examined and analyzed the text, talk, and actions of a culture to construct the *episteme*, or knowledge and social practices of that culture. He noticed that some of the cultural

discourse in a given historical context was linear and continuous over time and, conversely, there were overlaps, breaks, and discontinuity in the discourse as knowledge was accumulated and society reconfigured itself. For Foucault (1972), discontinuity and continuity reflect the flow of history and the circumstance that some "things are no longer perceived, described, expressed, characterized, classified and known in the same way" (p. 217) from one historical period to the next. These insights are relevant in that the discourses of PC and PHC differ, but over time have intersected. The WHO (2008) publication, *Primary Health Care-Now More Than Ever*, illustrates their intersections and provides an important example of continuity and discontinuities between the two discourses.

The intersections between the discourses of PHC and PC have occurred with continuities of "person-centered care, a central role for communities in health action and health systems as a key element of the social contract" (WHO, 2008, C. 1, p. 2). Points where discontinuities have occurred between the discourses include the concept of *curative* care. With life expectancy significantly extended, people are experiencing chronic illness versus infectious disease and death from related acute illness. Curative PC discourse focused on curing these types of acute illness has been replaced with discourses of preventing and managing chronic disease and co-morbid conditions. But the PC system has not fully adjusted to this change. For example, remuneration models, like *fee-for-service*, pay providers per patient visit rather than for a comprehensive care plan for preventing or managing illness (Morgan, Zamora, & Hindmarsh, 2007). Discontinuities in PC and PHC discourse have also occurred with respect to universally accessible care to individuals and families in the community. Health care continues to be "hospital-centric,

built around hospitals and specialists" (WHO, 2008, C. 1, p. 11). This disproportionate focus on hospitals and sub-specialty care has led to inefficiency and inequality, drawing human and financial resources from community-based PHC (WHO, 2008). Continuities in PHC discourse on the other hand have continued around equity, community participation, and self-determination. These have been embedded as "social expectations for health that increasingly pervade many other worlds' societies" (WHO, 2008, C. 1, p. 18).

With this background from the WHO of discourse continuities and discontinuities, I consider in this dissertation how discourses of PC and PHC are involved in PHC reform in New Brunswick. Because discourses are a combination of text, talk, action, interaction, ways of thinking, beliefs, values, use of symbols or tools, acting, and being in the world (Gee, 2015), it is appropriate to use discourse analysis to explore these activities (text, talk, action) involved in PHC reform in NB. This dissertation uses discourse analysis to explore discursive activity in a period when PHC reform emerged (1989-2019).

Social Practices of Healthcare

This chapter suggests that the organization of health care is a discursive practice with social, cultural, and economic significance, described in relation to the formation of objects, subjects, concepts, and strategies (Fairclough, 1992; Foucault, 1973). As previously stated, the objects of health are divided between the individual (subject to the routines and practices of disciplines and situated in institutions) and the population (subject to discourses of disease prevention/health promotion and situated in the community) (Armstrong, 1983). These constructs provide a framework for investigating

how systems that promote health and well-being in populations and society function with the overlying impacts of governmental and organizational policies on individual and community health (Evans-Agnew et al., 2016).

In Canada, the social practice of healthcare is organized hierarchically, privileges some groups over others, and supports the use of power to impose and enforce constraints over directions in which health as a social practice can move (Turner et al., 2007). More locally, the dominant discourses that are promulgated within the PHC reform space of New Brunswick are taken up by three distinct groups: (a) decision-makers, legislators, politicians; (b) healthcare professionals with a subdivision and hierarchical configuration elevating physicians above most other professions; and (c) patients/consumers of health care (Green & Thorogood, 2016). The intersection of healthcare discourses is realized in health policy and health system planning. Here, I briefly explore continuities and discontinuities of the discourses of PC and PHC in New Brunswick through the lens of these three groups of actors in the PC/PHC space.

Decision-makers and legislators are those actors that enact policy and/or determine how health systems will be organized and designed. They respond to public discourse and are driven by achieving satisfied patients at the lowest cost (Anderson, Frederiksen, Kolbæk, & Beedholm, 2017). Dominant discourses related to health care reform from legislators/decision-makers in New Brunswick include commitments to improving access to care, better coordination and integration of care, expansion of team-based approaches to care, and a commitment to patient-centered care (GNB, 2010). Policies enacted to achieve these aspirations must be negotiated with the most powerful

actors in the system, physicians or organizations representing physicians, e.g., provincial medical associations.

Healthcare professional discourse is dominated by the most powerful actors in this space, physicians. Historically, health care professions have not always worked collaboratively; in practice, hierarchical dominance and elitism have prevailed (Coburn & Willis, 2000; Freidson, 1986). In Canada, physicians were brought into Medicare on terms that included fee-for-service remuneration, clinical autonomy, and control over the organization of their medical practice (Hutchinson et al., 2011). Fee-for-service is a provincial, government-negotiated model of remuneration that essentially compensates for piecework. The publicly financed but privately delivered aspect of Canadian healthcare supports the social practice of physicians as private entrepreneurs. This founding bargain, between the medical profession and the state, "placed physicians at the heart of the decision-making system at all levels" (Tuohy, 1999, p. 56).

Medical knowledge is socially created, and the power of the professions is inextricably linked to claims of expert knowledge (Nettleton, 2006). According to Foucault (1973), the *medical gaze* implies a way of seeing or knowing and, in the context of medically controlled systems, it is restricted exclusively to the medical practitioner. A strong reinforcement for the discourses prevalent in PC is the method of remuneration for medical practitioners. According to the 2010 Canadian National Physician survey, roughly half of Canada's family physicians received more than 90% of their income from fee-for-service (p. 3). According to CIHI (2019), "since 2012-2013, the proportion of clinical payments paid through fee-for-service has gradually increased from 70.6% to 72.6% of total clinical payments" (p. 7). Included in this fee is a consideration for

overhead costs, which can vary from 30-50% of the fee. Within the publicly funded system, there has been encouragement of for-profit healthcare (i.e., the more patients a physician sees, the more money they make) through the predominant payment model of fee-for-service to family physicians and some specialists. In this model, there is a pressure to see and treat each patient quickly in order to move on to the next one. The prevalent discourses from primary care physicians working within this type of a practice include a portrayal of themselves as independent practitioners, entrepreneurs, employers, and small business owners (CBC, 2018; Lazar et al., 2013; Lewis & Sullivan, 2013). This has been a continuous discourse in PC and continues today.

Discourses of team-based, person-centered care and community participation can be represented in the discourses of PC, but in PHC they are dominant discourses. The discourse from medical practitioners around inclusion of other healthcare professionals or team members in this cultural model is articulated as an employer-employee relationship by most physicians, with the power remaining with the physician, who is perceived as the team lead (Lewis & Sullivan, 2013). Team-based care is challenging for physicians who are socialized and accustomed to being the undisputed team leader (Hutchison et al., 2011). The discourses of PC and PHC are often contradictory or discontinuous because of their differences, i.e., the democratizing inclusiveness of PHC and the exclusionary solidarity of medical control in PC. It was noted during a Canadian national PHC conference in 2004 that, "even though individual practitioners prefer to work in teams, their professional organizations strive to preserve independent practice" (Lewis & Edwards, 2004, p. 1). An example of this professional discourse can be found in a 2004 publication of the College of Family Physicians of Canada, *Family Medicine in Canada-*

Vision for the Future, which stated that medical students often feel "confused by the terminology and objectives of some primary care reform and renewal models" (p. 24). The document also expressed concern about the potential diminished role of physicians in models of PC reform:

> The role of family physicians as skilled practitioners playing a critical role in the delivery of medical care could be greatly diminished in some of these primary care reform models, with family physicians' responsibilities becoming blended with, even replaced by, those of other primary care providers. (p. 24)

What is being articulated in this text is not confusion but concern about the eroding power of physicians. Organized medicine plays an intermediary role through medical dominance in healthcare, as demonstrated in situations where medicine assumes a mediating role between state interventions and other health occupations (Coburn & Willis, 2000). In many Canadian provinces, including New Brunswick, the medical profession mediates relationships between non-physician health disciplines and the provincial government through its involvement in health care policy reforms (Coburn, 1993). In New Brunswick, mediation occurred with the introduction of NPs (2002), midwives (2010; first Midwives began practicing in 2017), and the extended services for pharmacists (2014). Lewis (2010), in his essay "So Many Voices, So Little Voices," underlined the significance of the nursing voice in Canada—a collective voice that mirrors the values of Canadian Medicare as distributive justice. He reflected on reasons why the healthcare debate "is largely framed by organized medicine" (p. 117) and argued that NPs are a "threat to the medical monopoly, and medical power has been dispatched to keep them off doctors' sacred territory" (p. 117). He urged Nursing, as a profession

that has always supported the ideals and principles of Medicare (unlike physicians), to "take centre stage" (p. 117) in debates involving healthy public policy and PHC reform.

Patients/consumers of healthcare (arguably) have the least powerful voice in influencing health policy. Although decision makers/legislators and healthcare professionals talk and write about "patient-centered care," the patients or consumers of healthcare services are often the least involved in policy decisions and organization of care (Williamson, 2014). In the dominant spaces of political advocacy, the WHO (2008) argued that prevailing discourses of patients/consumers are more aligned with decision-makers and legislators calling for better access to care and improved involvement in the organization and delivery of care than the powerful voices of "particular interest groups" (p. 18). Jeffery Turnbull, former president of the CMA, spent much of his tenure promoting the Canadian publicly funded healthcare system. He was the architect of the 2010 CMA document *Health Care Transformation in Canada,* which boldly proclaimed that, "Canadians are not receiving the value they deserve from the healthcare system" and "unwillingness to confront the challenges is not an option" (CMA, 2010, p. 3). Social theorists have noted the ways in which the institution of medicine functions to maintain the dominance and influence of medical and scientific discourses as mechanisms of social control (Fairclough, 1992; Foucault, 1973). This conflicting discourse within the field of PC, calling for transformation but also insisting on adherence to medical hegemony, epitomizes the challenges in PHC reform.

In PHC discourse, health equity, action on the social determinants of health, community participation, and self-determination have remained dominant and continuous elements. Discourses of health promotion, population health, and community-focused

interventions involving team-based interventions, accessibility, and comprehensiveness have intersected throughout both PC and PHC discourses over time with less uptake and conviction in PC (Lewis & Sullivan, 2013; WHO, 2008). This complexity, overlap, inconsistency, and interchangeability in PC and PHC has impacted healthcare transformation by impeding multi-faceted approaches to care and supporting medical hegemony.

Intersection of Discourses in Health Policy and Planning

Policies are negotiated texts (Fairclough, 2001), representing the values of a state and are used to establish order in that society (Anderson et al., 2017). WHO (2008) stressed the foundational importance of effective public policy for health and the positioning of PHC, and government system policies that need to be in place to ensure that PC is well-positioned within a PHC policy framework. These policy requirements include:

> systems policies – the arrangements that are needed across health systems' building blocks to support universal coverage and effective service delivery; public health policies – the specific actions needed to address priority health problems through cross-cutting prevention and health promotion and policies in other sectors – contributions to health that can be made through intersectoral collaboration. (p. 64)

The WHO (2018) Astana declaration spoke to "making bold political choices for health" (p. 2), where the social determinants of health are considered in all sectors of government and participatory governance is incorporated including the engagement and regulation of the private sector.

Irrespective of its publicly funded healthcare system, in capitalist societies such as Canada, there is a view that governments enact policies that serve the interests of economic elites (Brooks & Miljan, 2003). Moffatt, Martin, and Timmons (2014) identified that government policy discourse was constructed on assumptions that "command/control principles failed to engage (medical) professionals or were actively obstructed by them" (p. 686). Policy development is driven primarily by powerful interests who assure that their concerns receive more attention than those not so situated (Raphael et al., 2008). These interests are also likely to lobby for minimal government intervention in business practices and to resist government oversight and regulation (Currie & Suhomlinova, 2006). Consequently, it is unclear how willing the power structures such as medical societies are to transform healthcare in Canada and/or New Brunswick.

From a policy perspective, there has been an awakening, federally, to the value of a more socially oriented healthcare system (Health Canada, 2012; Keon & Pépin, 2008; OECD, 2020). A cultural change in PHC has been gathering force in Canada and New Brunswick (GNB, 2010). For example, the addition of chronic care management to the definition of PHC by the Health Council of Canada is a crucial strategic enhancement of the vision of PHC from a policy perspective (Health Council of Canada, 2005; Hutchinson, 2008; Simpson et al., 2017).

Internationally, health care systems throughout the economically developing world are also largely designed around the acute care setting that focuses on the delivery of episodic care. Many of these healthcare systems emerged from colonial medical services that emphasized physician-driven technology, were urban-based, and provided

curative care (Aschenbrener, 2010). This emphasis on primary episodic care practiced in PC is further reflected in the structure of the Canadian health system, which is supported by a predominance of investment in hospitals and remuneration for physicians. It is a system that critics believe overcompensates for service delivered and undercompensates for performance and improved outcomes (Dodge & Dion, 2011; Drummond, 2011; Lazar et al., 2013; OECD, 2020; Simpson, 2012; Simpson et al., 2017). To be effective, chronic care management may require more monitoring and counseling from nurses, pharmacists, and/or teams of other health providers working closer to where people live and work. This would require a different configuration of resources than seen in the traditional fee-for-service, biomedically driven PC model. These financial disincentives to team-based care, i.e., fee-for-service remuneration and lack of foundational support for interdisciplinary collaborative teams, highlight the shortcomings with PC as it has been traditionally organized within New Brunswick and other Canadian provinces (Hutchinson, 2008; Lazar et al., 2013).

There is a growing consensus generally in Canada and more specifically in New Brunswick that family physicians, nurses, and other professionals working as partners will result in better health, improved access to services, more efficient use of resources, and better satisfaction for both patients and providers (Hutchinson, 2008; Hutchison et al., 2011; New Brunswick Health Council, 2018). Such team-based models of care, working in a PHC model, are thought to be well positioned to focus on health promotion and improving the management of chronic disease (Barr et al., 2003). The need for change is also driven by perceived weaknesses in the present PC system (Starfield & Shi, 2002; Starfield, Shi, & Macinko, 2005). These weaknesses include the omission of

income, housing and food security, and the fragmentation of care and services. The lack of emphasis on health is problematic when the primary focus is on illness. Barriers to access the PC system, lack of overall accountability, and unequal distribution of resources are perennial challenges. There is an overall need for public education and awareness about poor information sharing between primary care providers and other parts of the system, as well as the collection and management of personal health information. Finally, methods of remuneration that do not support multidisciplinary team-based care results in unmet needs, lack of consumer involvement, poor focus on patient needs, power imbalances, and inconsistent quality, resulting in inappropriate care (Frankish, Moulton, & Gray, 2000).

Jeffery Simpson (2012) in his book *Chronic Condition,* noted that, "Doctors and nurses, hospitals and drugs are the heart of the healthcare system. They are its three costliest parts. Any hope of easing future cost pressures and getting better patient outcomes depends on changing each" (p. 313). Lewis and Sullivan (2013) pointed to fee-for-service remuneration as "perverse incentives that privilege piecemeal problem-solving over holistic care, prescriptions over conversations and a mechanism that gets in the way of efficient division of labour between doctors and other providers" (p. 2). Canada's 91,375 doctors are amongst the highest paid in the world (CIHI, 2019; Simpson, 2012). The average gross billing for all Canadian medical specialists in 2019 was $347,000; for family physicians, it was $280,000 (National Physician Survey, 2019). Canada has as many specialists as family doctors, reflecting the appeal of specialization over PC or generalist practice (Simpson, 2012). Lewis and Sullivan (2013) claim that, "physicians are bankrupting healthcare" (p. 1). As healthcare costs grow and transfer

payments decline, provinces are implementing policies to control costs and improve access to the healthcare system. Since physician remuneration has been identified as one of the costliest components of the Canadian provincial system, several provinces have expanded the role for non-physician PC providers who would improve access to PC at a reduced cost. These providers included midwives and nurse practitioners. The presence of primary health care NPs has illustrated how access to PC is framed within the philosophy and practice of PHC. Primary health care NPs in New Brunswick are registered to practice primary health care APN, and by so doing improve access to PC. This again exemplifies the intersection between the two discourses of PC and PHC. The introduction of these primary health care providers has created tension in a system dominated by hospital care and those privileged to work there (Hutchinson et al., 2001).

Despite long-term and focused negotiation with the NBMS, there has been little support or uptake from physicians for team-based models of care. Under their own jurisdiction and control, Family Medicine New Brunswick (FMNB) was formed as a separate entity under the NBMS to create teams of physicians working together. There are currently 1153 family physicians in NB (Michas, 2020) and 51 work in the FMNB model (NBMS, 2021). With the exception of nursing, a profession originally dominated by medical practitioners, there are no other team members included. This is an unfortunate diversion from the Family Health Team model articulated in the PHC Policy Framework (GNB, 2012). The WHO (2008) acknowledges that "professionals play a major role in how health is governed" (p. 85). Indeed, this is how governance played out in New Brunswick, with the NBMS negotiating the type of PC model that would evolve.

Consequently, the two discourses of medically focused PC and PHC remain in contested tension, while also firmly embedded within the healthcare landscape of the province.

The WHO (2008) conceded that "equity, whether in health, wealth or power is rarely, if ever, fully achieved" (p. 15). Nevertheless, the struggle for health equity has remained as a continuous element in the ongoing discourse of PHC, whether at a policy level in international landscapes or at a policy level in national and provincial settings in Canada. As an example, in NB, the policy direction set in the Primary Health Care Framework for New Brunswick (GNB, 2012), analyzed in detail in Chapter 5, directly addressed and influenced health equity through community health needs assessments (CHNA). According to the Horizon Health Network (2017) publication, *Broadening Our Focus: Identifying Regional Priorities From the Needs of our Communities*, CHNAs have occurred in all of the 22 communities represented in the Horizon Health Network. These CHNAs explicitly addressed the social determinants of health and health equity, providing a clear example of the discourse of PHC in health policy. The assessments involved "374 Community Advisory Committee members and 1,200 New Brunswickers" (p. 2). The assessments have translated into community health priorities in each community as well as 20 regional health priorities that mirror the social determinants of health inherent in PHC. Some of these regional priorities included: "housing, food security, access to PHC services, focus on chronic disease, social supports to help individuals move out of poverty and collaboration with First Nations" (p. 16). These priorities clearly reflected and continue to reflect the elements of PHC. They have informed concrete implementation of a new community health centre (CHC) in two

communities as well as a dedicated PHC team for three First Nations communities populated by Indigenous providers.

In this chapter I have explored the historical development, fundamental differences, and key elements of the discourses of PC and PHC from 1989-2019. Drawing on the literature, I have examined the contributing continuities and discontinuities of PC and PHC as these have evolved over time. I have studied how these continuities have intersected and ultimately influenced health policy and planning in Canada and New Brunswick. This situates the study and provides a foundation for examining health professional and government policy discourse during a period when healthcare policy reform efforts in New Brunswick were influenced by the discourses PC and PHC. This period, 1989-2019, included years leading up to the introduction and integration of NPs as primary health care providers in New Brunswick.

Chapter 3

Methodology and Methods

The research questions I am investigating in this study explore the discourses of primary care (PC) and primary health care (PHC), examining how these discourses are reflected in New Brunswick healthcare reform and related policy post Canada Health Act (CHA, 1984). In Foucauldian terms, I am excavating how the discourses of PC and PHC are represented in health discipline-specific documents, uncovering continuities, discontinuities, intersections, and gaps in PHC and PC discourses as reflected in government-authored health policy and professional discipline documents. I am also examining the emergence of PC and PHC discourses in NB through selected government policy and disciplinary level texts and how they are represented specifically in relation to the introduction of Nurse Practitioners in New Brunswick.

Methodology

In this chapter I briefly examine the concept of discourse as developed by Habermas and Halliday, noting also the relationship between discourse, knowledge, and power as described by theorists Foucault, Hall, West, and van Dijk. Foucault's genealogical and archaeological methodologies are included as they provide the epistemological frame of reference to examine and analyze health policy documents for the emergence, continuity, discontinuity, and gaps of the discourses of PC and PHC in health care reform efforts. Disciplinary power, poststructural feminism, and governmentality are salient constructs that are also relevant in the emergence of PHC discourse. They are also relevant in the subsequent introduction of nurse practitioners (NPs), a newly regulated nursing provider, an advanced practice nurse, within the PHC

milieu in New Brunswick. I also highlight the CDA methodology of Fairclough and Bacchi and provide details of the hybrid methodology, influenced by Fairclough, Bacchi and Foucault, foundational to this study.

Discourse

CDA has its roots in a number of disciplines but more proximately in sociolinguistics, psychology, and the social sciences. It is heavily influenced by the work of social philosophers Michel Foucault, Jürgen Habermas, and sociolinguist M. A. K. Halliday. Foucault is considered to have forged the way for CDA through his identification of dominant and hierarchical power structures, not just within society and political structures but within knowledge itself. I consider his work in a subsequent section of this chapter.

In researching CDA, I was intrigued by Jürgen Habermas' work on the *public sphere*. As a member of the Frankfurt School of Social Research, he advanced a neo-Marxist critique of Western capitalism and its pitfalls. He explored questions about the public sphere and how communicative processes influence, and are influenced by, power relations in a representative democracy. In *The Structural Transformation of the Public Sphere*, one of Habermas's earliest works, he carefully examined the ways in which communicative processes, including the pragmatics of spoken language or speech acts, operate as a medium of domination, authority, and social force in the public sphere (Habermas, 1991). Habermas's conceptualization of the public sphere was based on his own critical theoretical and historical analyses of shifts in social and political expressions of power and authority since the ancient Greek state. Like many other political theorists, Habermas viewed the public sphere in contemporary democracies as an important space

with social practices that are crucial to democratization. His analysis presented the public sphere as distinct from the state, and located in places, where citizens, like those of the eighteenth century bourgeoisie class, could discuss issues of general interests of the day, constellating elite power among "private people, gathered together as a public and articulating the needs of society with the state" (p. 176). These places existed alongside as well as outside of and beyond official or formal contexts for state related political activity (Habermas, 1991). As Habermas considered 18th century bourgeois society, he noted that the public sphere included contexts known as "salons"—like cafes, restaurants, public meeting halls, and parks, where citizens gathered and articulated and debated the needs of society and the state. What attracted Habermas to the idea of the public sphere was its foundational potential for a democratic society (Johnson, 2006). The Habermasian public sphere was conceptualized as effectively organized and maintained through dialogue, acts of speech, through debate and discussion, this public debate also enhanced by opinion-forming social organizations, grass roots movements, unions and professional associations for example (Habermas, 1991).

Habermas proposed the public sphere as a source of knowledge production arising from discourse between citizens who gathered in these public spaces. Habermas speaks of discourse as a reflective form of communicative action (Forchtner, 2011). His ideal speech situation consists of: "the absence of coercion, sincerity on the part of the participants, inclusivity and the same rights for all participants" (p. 7). The knowledge developed through this public discourse had the potential to identify power relations and empower citizens to reject hegemonic societal influence (McGregor, 2018). Although some critics point to what they take as a naïve conception of power and counterfactual

limitations of this theory, Habermas's work has been relevant for the understanding of how democratic public opinion could be shaped by and shapes political power, authority, and policy.

At the outset of my studies, this analysis of power, the shaping of political power and its transaction in speech acts in the public sphere initially brought into view the public policy debates that had been relevant to a progressive agenda for PHC. These debates were happening across Canada in public spaces like conferences and federal, provincial/territorial (FPT) meetings organized to move the agenda of health care reform forward. During this time frame (2004-2012), in my position with the NB government, I attended many of these national meetings, with my counterparts from across the country. This was an exciting time to be working and learning about healthcare reform efforts across Canada. Academics, policy experts, politicians, and civil servants (federal and provincial) assembled to debate "the art of the possible" around healthcare reform. An example of one of these conferences, the National Primary Health Care Conference held in Winnipeg in 2004, was a gathering of over 900 participants where the principles of PHC were passionately debated and new ideas about PHC were promoted.

In reflecting on these experiences in light of Habermas's work concerning public debate and policy development, I was alerted to the importance of inclusive public discourse in identifying power relations and knowledge development. In Habermas's emphasis on the pragmatics of speech acts, I found relevance for how the micro-politics of the public sphere influence policy development and existing public policies. That relevance included noticing how these speech acts convey power and authority as needed reforms are discussed, developed and implemented in health care. Studying Habermas's

work led me to the work of Halliday, Hall, West and Foucault and then more recently to Fairclough and Bacchi who influenced my decision regarding the selection of CDA as a methodology to investigate public policy discourse and associated power relations.

As early as 1970, M. A. K. Halliday was exploring the link between grammatical structure and the social system or order that language is required to serve. Halliday (1975) focuses on human meaning-making as a social practice with language serving three functions: (a) representing ideas about the world ("ideation"); (b) facilitating interpersonal and social interactions ("interpersonal"); and (c) integrating these ideas and interactions into meaningful texts, which must be relevant to their context ("textual") (p. 23). According to Wodak and Meyer (2001), Halliday argues that language—in its grammatical rules—has the potential for not only transmitting this social order, but also simultaneously maintaining it and possibly modifying it (p. 8).

These theoretical insights are important in understanding how grammatical structure influences social and political interaction. While I will be conscious of Halliday's approach, my research methodology is oriented more strongly by other social philosophers who have theorized the relationship between discourse, knowledge, and power.

Theories of Discourse, Knowledge, and Power

In this section I discuss the work of Foucault, Hall, West, and van Dijk. I have selected these theorists because of their foundational work in developing CDA and exploring connections about the discourses of knowledge, power, culture, and inequity.

Michel Foucault saw language as tied to social and political realities. Unlike Halliday, Foucault treated language conceptually as involving more than a narrowly

linguistic range of rules for grammar, syntax, semantics, phonetics, etc. Accordingly, he viewed language as linked to the production of knowledge and the perpetuation of power relations. Foucault (1998) believed that "discourse transmits and produces power; reinforces it, but also undermines and exposes it, renders it fragile and makes it possible to thwart" (p. 100). His attention focused on the rules and practices of language that produced dominant meanings and "valid" knowledge. He defined discourse not just as a subset of language, but as a combination of language, action, interaction, ways of thinking, beliefs, values, and use of symbols or tools, acting, and being in the world (Foucault, 1972).

According to Foucault's (1972) definition, discourse "creates a field of knowledge by defining what is possible to say and think, declaring the bases for deciding what is true and authorizing certain people to speak while making others silent or less authoritative" (p. 49). Foucault argues that discourses do not operate in isolation but occur in formations and are to be treated as practices that share the same object, style and often support a common institutional or administrative pattern. He referred to these practices as "discursive formations" (p. 74). Foucault understood these formations as a systematic maneuvering of several discourses or statements that constitute a body of knowledge, often describing an object or topic in a particular way and limiting other ways the object or topic may be constituted (p. 74). Foucault described a specific form of power closely connected with knowledge or with the discursive practices of the power group creating the objects of knowledge. For Foucault, disciplinary power does not only refer to specific academic disciplines such as law, medicine, biochemistry, history, political science, etc., rather it refers to the discursive practices of any power group

creating knowledge and objects of knowledge. Foucault (1977) thought that the relationship between knowledge and power was so inter-related that he typically used the expression *knowledge/power* to express this connectivity. He suggested that:

> We should admit rather that power produces knowledge…that power and knowledge directly imply one another; that there is no power relation without the correlative constitution of a field of knowledge, nor any knowledge that does not presuppose and constitute at the same time power relations. These 'power knowledge relations' are to be analyzed, therefore, not on the basis of a subject of knowledge who is or is not free in relation to the power system, but on the contrary, the subject who knows, the objects to be known and the modalities of the knowledge must be regarded as so many effects of these fundamental implications of power knowledge and their historical transformations. (pp. 27-28)

Foucault refers to power relations within a society, where the relationship is created by asserting power through the use of language embedded in speech styles, vernacular, pronunciation, vocabulary, syntax, intonation, etc., as discursive practices. In these and other pragmatic aspects of speech acts, discursive practices often denote the social status of the speaker and contribute to the power relationship.

According to Foucault (1973), who studied the discursive practices of 18th century medicine in Paris, our current notions of medical knowledge are influenced by what he labelled as the *medical gaze*, which implies a way of seeing or knowing and is restricted exclusively to the medical practitioner. The historical consequences of domination from the exclusive and exclusionary uses of knowledge-power in medicine are an important area of critique in discourse analytic research. Although important

consciousness-raising has occurred from Foucault's critiques of the medical gaze, critics of Foucault's theory of power point to its lack of capacity to define precisely who has used power to oppress others (West, 1982). Foucault (1977) did not see power only as negative, coercive, or repressive. He determined it is also productive, and a positive, force in society: "power produces; it produces reality; it produces domains of objects and rituals of truth" (p. 194). He saw power as an "every day, socialized and embodied phenomenon" (p. 167). For Foucault, power was not only hierarchical but circular and power relations were endemic through all relational structures of society.

Foucault's methodologies examine historical power relations and knowledge development and include archaeology and genealogy. Foucauldian scholars have discerned that these two methodologies also correlate with shifts in Foucault's philosophical thinking (Hall, 2001; Scheurich & McKenzie, 2005). Foucault's archaeologies include *The Birth of the Clinic*; *The Order of Things*; and *The Archaeology of Knowledge*, written in his early period and the genealogies, *Discipline and Punish* and the *History of Sexuality*, developed in his later years.

To develop his archaeologies Foucault (1972) interrogated historical texts and archival information searching for complex sets of concepts including savoir (implicit knowledge specific to a society), connaissance (formal bodies of learning), discursive formation, discontinuity, and discursive practices (p. 261). He saw archaeologies as focused on patterns operating beneath consciousness, yielding a historiography of statements contained in discourse, and an intellectual excavation of systems of thought (Scheurich & McKenzie, 2005).

Foucault's genealogy is a progression from his archaeological examination. The point of a Foucauldian genealogical analysis is to demonstrate that a given system of thought, perhaps uncovered in an archaeological excavation, is further understood by examining institutions of social practices and technologies of power (Scheurich & McKenzie, 2005). Foucault was strongly influenced by German philosopher Frederich Nietzsche's. Nietzsche's critical theory of slave morality and of power as diffusive rather than one dimensional were formative in the development of Foucault's genealogy, leading him to focus differently on moral and political dimensions of knowledge-power (Sawicki, 1991, p. 55).

In the first of his genealogies focused on the penal system, *Discipline and Punish*, Foucault (1977) outlined four general rules for his genealogical methodology. The first rule states:

> Do not concentrate the study of the punitive mechanisms on their repressive effects alone, on their punishment aspects alone, but situate them in a whole series of their possible positive effects, even if these seem marginal at first sight. As a consequence, regard punishment as a complex social function. (p. 23)

Foucault's second rule is to analyze methods "not simply as consequences of legislation or indicators of social structures, but as techniques possessing their own specificity in the more general field of other ways of exercising power" (p. 23). Foucault's third rule addresses comparative analysis in search of common patterns:

> See whether there is not some common matrix or whether they do not both derive from a single process of epistemologicao-juridical formation; in short, make the

> technology of power the very principle both of humanization of the penal system and of the knowledge of man [sic]. (p. 23)

Foucault's fourth rule states,

> Thus by an analysis…as a technique of power, one might understand both how man [*sic*], the soul, the normal or abnormal individual have come to duplicate crime as objects of penal intervention and in what way a specific mode of subjection was able to give birth to man as an object of knowledge for a discourse with a scientific status. (p. 24)

While all four of these rules would be relevant to a genealogy of health care reform, this fourth Foucauldian rule has particular significance in my area of investigation. The extent to which health discipline discourses operate as pluralities of power and medicine emerges as a discursive formation that subjugates and self-regulates through disciplinary power and legislative authority is a question relevant for genealogical study. Although methodologically, I am not carrying out a genealogy, the aspects of archaeology and genealogy that have influenced my thinking are their intertextuality with Bacchi's methodology, a "Foucault-influenced poststructuralism perspective" (Bacchi, 2016, p. 8).

Foucault's genealogies trace the development of people and society through history and accounts for the constitution of knowledges, discourses, and domains of objects. In the Nietzschean tradition, Foucault investigates those elements that are without history, i.e., sexuality (Scheurich & McKenzie, 2005). A Foucauldian genealogy is not a search for origins or construction of a linear development, rather it often shows plural, competing, and contradictory pasts (Springer & Clinton, 2015). The relationship

between power and knowledge in genealogies is commonly focused on disciplinary power, revealed in three distinct functions: (a) hierarchical observation in prisons, health care settings such as institutions, medical clinics and interprofessional work; (b) normalizing judgement, where the actions or attributes of each subject are compared against norms such as legislation, policies, procedures, professional regulations and other social normative judgments; and (c) examination, where individuals can be assessed and corrected (Foucault, 1977; Nettleton, 2006). Foucault's archeological and genealogical work is relevant in this study for its applicability to a study of disciplinary power and hierarchical structure in health care as well as the emergence and continuity of the discourses of PC and PHC.

Poststructural feminist scholar, Sawicki (1991), in *Disciplining Foucault*, describes disciplinary power as "exercised on the body and soul of individuals" (p. 22). According to Sawicki, disciplinary practices derived from disciplinary power create binaries such as: "healthy/ill, sane/mad, civilized/uncivilized, legal/delinquent, which, by virtue of their authoritative status, can be used as effective means of social control" (p. 22). Foucault was critical of the model of power called "juridico-discursive," which is based on power being possessed by individuals or classes, flowing from a centralized source or hierarchically, top to bottom; and being mostly repressive in nature. In her disciplining of Foucault, Sawicki summarizes that "ways of knowing are equated with ways of exercising power over individuals" (p. 22). Where Foucault conceived power as being exercised versus possessed and productive rather than repressive, Sawicki argued that the power of sexism is embodied and repressive (Sawicki, 1991).

Stuart Hall, a leading scholar in cultural studies and critical race theory, expanded Foucault's work to include race and cultural systems of representation. Hall (1997) describes discourse (text, talk, and action) as "a privileged medium in which we make sense of things, in which meaning is produced and exchanged" (p. 1). He contends that discourse is used to construct cultural meaning because it operates as a representational system. Representation through discourse is central to the processes by which meaning is produced. Hall asserts that meanings can only be shared through common access to language and that culture is about shared meanings. Therefore, a common language is related to possibilities for shared cultural identity. Individuals can share similar or common meanings when they interpret the world in roughly similar ways and can express themselves, their thoughts, and feelings about the world in ways that will be understood by each other (Hall, Morley, & Chen, 1996). According to Hall (1997), power consistently strives to fix meaning to support its agenda but meaning is constantly changing and cannot be kept static. Hall's argument that identity is always changing and cannot be fixed matters in democratic societies and is an important element in interrupting distorted power relations that are based on cultural stereotypes. Hall et al. (1996) asserts that to "sustain democratic societies, it is imperative to critically interrogate the meanings of socially transmitted representations, including media representations" (p. 50). Many systems of meaning are based on binary structures (male/female; young/old; black/white). In challenging these binaries, Hall et al. (1996) promote semiotic interpretation, which involves exposing the culturally arbitrary nature of this binary opposition and describing the deeper significance of structures of representation operating throughout a culture.

Hall's approach is heavily influenced by neo-Marxist thinking, which critiques how power operates in capitalist societies. For Hall (1997), political, economic and/or military dominance involves the social-economic processes for maintaining the existing class structure among subordinate classes who buy into the dominant view promoted by the ownership classes (p. 48). Among neo-Marxist thinkers, these processes for constellating social, political, and economic dominance have been referred to as "hegemony." Hall was interested in understanding how hegemony (as the dominant perspective) requires the influences of political, economic, and social forces that converge in various media. In his view of representation, mass media and communications encode a dominant ideology that finds acceptance among the masses. In Hall's theory, media is perfectly positioned to maximize the willing consent and participation of the consumer to maintain and perpetuate the existing relations of power and wealth distribution (Hall, 1997).

Hegemony of ideologies that protect the governing class is not accomplished through force, compulsion, intimidation, or manipulation but through willing consent of those with less power and wealth to accept a dominant ideology, to see the world and act according to the views of the more powerful. Groups have this social power if they are able to control the acts and thought processes of members of other groups (Hall, 1997). This ability to control presupposes a privilege or access to scarce social resources such as power, control, money, status, fame, knowledge, information, and culture. The power of dominant groups may be integrated in laws, rules, customs, habits, knowledge, and general consensus, as embodied in class domination, sexism, and racism (Hall, 1997, Smith, 1990; van Dijk, 1991; West, 1984, 1993). A current day example of this cultural

representation in the field of health care is an image that I encountered frequently as an occupational therapist: women were thought to be nurses and men were thought to be physicians.

Stuart Hall had a major influence on media studies with his encoding/decoding model of communication. Hall's (1997) model of interpretive positions, hegemonic, negotiated and oppositional is relevant to my study and the way that discourse is understood and interpreted according to discursive positioning. Hall theorized that audiences are presented with messages that are interpreted (decoded) in ways that reflect an individual's cultural background, socio-economic position, and experiential learning. Decoding involves both verbal and non-verbal forms of communication, semiotics, or cultural signs. Decoding is about positioning information, by the recipient, into categories that they have already formulated themselves. It is the process of obtaining, absorbing, understanding, and occasionally using the information that was received through a verbal or non-verbal message. Hall (1997) claims that the recipient of these messages (the decoding subject) can adopt three interpretive positions:

- The *dominant/hegemonic position* involves interpreting the meaning of the message in the exact way that the sender intended the message to be interpreted (decoded); it is "an attempt by the dominant social group to win consent of other groups to achieve a kind of superiority in both thought and practice over them" (p. 166).
- The *negotiated position* involves accepting and rejecting the elements of a message. The recipient shares the texts code and generally accepts the encoded

meaning, but concurrently resists parts of the message or modifies it in a way which reflects their own world view and/or lived experience (p. 348).

- The *oppositional position*, in which a recipient recognizes that their meaning is not the dominant meaning or what was intended. They do not share the text's code and end up rejecting it (pp. 363-364).

Although Hall's model has been criticized because it assumes that the text is encoded in the dominant code and that individual decodings of a text cannot be reduced to a direct consequence of socio-economic positioning (Chandler, 2017), it will be considered in this study for the value it brings to the *hegemonic and negotiated* positions.

The work of Cornel West, an American scholar who influenced critical race theories, is also relevant for my study. In his book *Race Matters* (1993) West used Foucauldian philosophy to trace the cultural dynamics of race, racialization, and racialized stereotyping in the United States. He shares the common concern and central theme of Foucauldian power/knowledge and uses the term "genealogy" to name his analysis of racist ideology. Also, in *Prophesy Deliverance!* West (1982) provides a genealogical account of white supremacist ideology utilizing a Foucault's genealogical methodology to examine the level of discourse and the discursive conditions present for the legitimacy of white supremacy. Although influenced by Foucault, West's conception of human agency does not allow him to accept Foucault's description of modern power completely. Foucault rejects ideologies like Marxism that deal with power only in hierarchically ordered structures to construct subjects in terms of class (Gilyard, 2008). For West, the downfall of the Foucauldian method is its deflection of focus away from the importance of class relations intersecting with other power relations and its devaluing

of moral discourse as a formation that supports widespread resistance. According to West (1993), Foucault is reluctant to support mass political action. In *Race Matters,* West invites Foucault to sing the "insurrection of subjugated knowledges in the black revolutionary choir" (Dyson, 2015, para. 12). West (1993) proclaims that his purpose is to "speak the truth to power with love so that the quality of everyday life for ordinary people is enhanced and white supremacy is stripped of its authority and legitimacy" (p. xxiv). According to an essay by B.E. Stone (2011), West's main criticism of Foucault is that his methodologies of archaeology and genealogy do not lay out paths for liberation, and West was frustrated by what he perceived as Foucault's lack of interest in polemics and his entrenchment in academia (p. 97). I have included West's work and continue to draw on it because of its relevance for addressing intersections in the discourses of neoliberalism and cultural identity, including gender, race and class. His work speaks to me in his efforts to speak truth to power and dismantle long standing supremacy and improve everyday life for ordinary people.

The work of social theorist Teun van Dijk was also helpful for my study. Van Dijk (2001) takes up the discussion of discourse, language, and power by arguing that it is important to theorize discourse as being concerned with both micro and macro notions of power and domination. Van Dijk proposes that it is important to study discourse as it occurs at the micro level of social practices. He acknowledges that discourse is not only found in speech acts, but also in texts and in actions, interactions, and social practices that are enabled by discourse or that form conditions or consequences of text and talk. He distinguishes between various kinds of knowledge, discourse, and power: personal knowledge, group knowledge, and cultural knowledge. Personal knowledge is

represented in cognitive models about specific lived experience. Group knowledge is shared by specific social groups such as professionals, social movements, and corporate entities, and that it may be "biased and ideological" (p. 114) and not recognized as knowledge by other groups. Cultural knowledge is shared more widely by members of a society and forms the foundation of what is perceived to be common or shared social practices and discourses. In pointing to the analysis of discourse, van Dijk (2001) proposes that critical discourse analysis is a:

> cognitive, social and political analysis of the role that discourse plays in local, microstructures as well as global, macrostructures of society, that a bottom-up and top-down analysis of text, talk and action within societal structures is a foundational element for uncovering dominance and abuse of power. (p. 119)

This description by van Dijk, of an approach for analyzing discourse, draws on strands of Foucauldian thought and other critical theory to suggest a methodological orientation for my study and to point toward specific methods of critical discourse analysis (CDA). His work is relevant to this study in the differentiation between personal knowledge and group knowledge and the consideration of lived experience in reinforcing beliefs and practices.

In Foucauldian and post-Foucauldian analysis, a more subtle use of power operates through discourse (text, talk, and action), takes for granted the power-knowledge understandings of dominant players, and creates labels that reinforce dominant beliefs and practices. Those groups who control the most influential discourse also have more opportunities to control the thinking and actions of others. The less powerful people are,

the less they have access to various forms of text or talk (van Dijk, 2001). In this frame of reference, power operates at the level of the individual and the institution.

The relevance of van Dijk's work in this inquiry is what van Dijk refers to as the "institution" or the social practice of health—the discourses of health disciplines, the subjects and objects of these discourses, the relationships operating in these discourses, and the way power is expressed and transacted. As noted by Turner et al., (2007), "Discourses of health are directed by those who use power to impose and enforce constraints over directions in which health as a social practice can move" (p. 41). Of specific concern are ways that medical knowledge is socially created and the power of medical and other health professions to inextricably link their privilege to claims of expert knowledge (Nettleton, 2006). Social and political theorists have noted the ways in which the institution of medicine functions to maintain the dominance and influence of medical and scientific discourses as mechanisms of social control (Foucault, 1973). The objects of health-related discourses are divided between the individual (subject to the routines and practices of disciplines and situated in institutions) and the population (subject to discourses of disease prevention/health promotion, and situated in the community) (Armstrong, 1983). These constructs provide a framework for investigating how systems that promote particular understandings of health in populations and society function with the overlying impacts of governmental and organizational policies on individual and community health to maintain existing structures and discourses (Evans-Agnew et al., 2016).

Governmentality. Governmentality is a Foucauldian concept that is relevant to this study. Simply explained, governmentality is about relationships, policies, and

practices that result in particular ways of governing from afar and particular ways of seeking to shape the conduct of individuals and groups (Foucault, 1996; Miller & Rose, 2008). It refers to "a form of thinking about and exercising power that has emerged in recent decades in modern Western liberal societies as an element in the development of welfare states" (Ravn, Frederiksen, & Beedholm, 2016, p. 548).

Foucault (1977, 1998) was concerned with how governing took place and therefore studied the practices of governing, such as the governing of *madness* and *sexuality*. In his studies of governing practices, Foucault detected styles of problematization that he described as *govern-mentalities* or *political rationalities* that provided the rationales for rule (Bacchi, 2012c).

Drawing on Foucault, Bacchi (2012c) states "govern-mentalities, then, are the ways in which rule is rationalized and rendered *effective*" (p. 5). She underscores that these "rationalities (or rationales) are not restricted to conventional governmental institutions; rather the role of professionals and professional knowledges in governing processes is emphasized" (p. 5). Bacchi (2016) speaks specifically to governmentality in policy analysis: "the political focus becomes how we influence people to behave in desired/desirable ways instead of how we can produce a just society" (p. 8). Bacchi's analysis is, therefore, particularly relevant to my critical analysis of professional and government health policy documents.

Poststructuralist feminism. Feminist poststructuralism is another philosophical perspective that is relevant to this CDA of power and control in health care reform. According to Lazar (2007), much of feminist scholarship is "motivated by goals of social emancipation and transformation, the critique of grossly unequal social orders and in

regard to discursive dimensions of social (in) justice" (p. 141). Feminist poststructuralism speaks to social realities constructed and modified discursively depending on time, context, experience, and power. A feminist poststructuralist view is focused on how discourses are socially, historically, and institutionally created and maintained, and how gender, power, and language are used to position discourses marginally or hegemonically (MacDonald, 2019; Sawicki, 1991; Weedon, 1997). Weedon (1997) held that "language is the place where actual and possible forms of social organization and their likely social and political consequences are defined and contested yet it is also the place where our sense of selves, our subjectivity is constructed" (p. 21). Feminist poststructuralism then provides a perspective that focuses on the critique and transformation of patriarchal power relations, in ways that are more sensitive to gender than early Foucauldian analysis (Sawicki, 1991). According to Sawicki (1991), "Freedom lies in our capacity to discover the historical links between certain modes of self-understanding and modes of domination, and to resist the ways in which we have already been classified and identified by dominant discourses" (p. 43). Feminist poststructuralism is relevant in arguing that gender intersects with other forms of inequality, thus patriarchal power matters.

Patriarchal ideology is a factor to be considered in this critical discourse analysis because nursing as well as other health professions have predominantly been practiced by women, while medicine, traditionally, has been a profession practiced by and dominated by men. There exists a hierarchy in the health care system with the knowledge and authority of (male) physicians positioned at the apex of the hierarchy and (female) nurses located lower in that hierarchy (Adams & Bourgeault, 2004). As an example of

poststructural feminism in health care, Turner et al., (2007) found that with the introduction of nurse practitioners in Australia, as new and autonomous providers, policy, text and talk still reinforced subservient, traditional roles for nurses within the hierarchical structure of the health care system. From a Canadian perspective, Jefferies, Goldberg, Aston, & Tomblin (2018) used a poststructural feminist framework to uncover generational oppression and discrimination of Black nurse leaders through systemic, institutional, and historical discourses.

CDA Methodology

Connected to the exploration of theories of discourse, knowledge, and power explored in the previous section, CDA is a well-established methodology and method of research and inquiry that has been influenced by its critical discourse theoretical roots. It is a branch of critical social theory attentive to society, social order, and the subsequent effects on individuals or groups of individuals. It takes into account historical issues of domination and social struggles. CDA inquiry is a sociolinguistic methodology focused on the investigation of power relationships and problems of social discrimination and marginalization (van Dijk, 2009). It has been used extensively in social sciences, education, and communication research and is also now fairly common in health policy related research influenced by critical studies.

Although there is not a unitary theoretical framework that characterizes all work in CDA, most analyses attend to how discourse intersects with concepts of power, dominance, ideology, authority, tending to power relations of class, gender, race, and other social relations, institutions, and social structures/order (van Dijk, 2001). Discourse, as a central concept in CDA, reveals how the social powers of certain groups or

institutions operate (Freidson, 1970; West, 1984), and how this operation produces the marginalization of others (Evans-Agnew, Johnson, Liu, & Boutain, 2016). Discourses are thought of as a reflection of ideology or "a general system of basic ideas shared by the members of a social group, ideas that will influence their interpretation of social events and situations and control their discourse and other social practices as group members" (van Dijk, 2011, p. 380).

Discourse in CDA is understood as a social practice, as a form of interaction involving text, talk, and/or action, and as a way of representing social practices. Luke (1997) explains CDA as a methodology for describing, analyzing, and critiquing social life reflected in text, i.e., textual analysis. Van Dijk (1998) defines CDA as "a type of discourse analytical research that primarily studies the way social power, abuse, dominance and inequality are enacted, reproduced and resisted by text and talk in the social and political context" (p. 1). McGregor (2003) defines discourses as "ubiquitous ways of knowing, valuing, and experiencing the world" (p. 2). In these descriptions, discourse is thought to be a "communicative event, including conversational interaction, written text as well as associated gestures, face work, images and any other semiotic or multimedia dimension of signification" (van Dijk, 2009, p. 98). In analyzing discourse, "dominant discourses" are those that lead to social goods like money, power, and status in a society (Gee, 2015). Social power appropriated through disciplinary power, a focus of this study, is often defined as control (Fairclough, 1992; Foucault, 1973; Freidson, 1984).

As per this theoretical framework, there is no one accepted methodology for conducting CDA. Wodak and Meyer (2001) contend that CDA "aims to investigate

critically social inequality as it is expressed, signaled, constituted, legitimized and so on by language use (or in discourse)" (p. 2). The methodology of CDA focuses primarily on social and political issues and is interdisciplinary in scope. A commonality across differences of CDA methodology is the focus on language-power-knowledge; this acknowledges that discourse as a subject of investigation is not a neutral communicative process (Fairclough, 1993; Wetherell, 2001; Willig & Stainton-Rogers, 2008). While there are many approaches to CDA, Evans-Agnew et al. (2016) summarize some of the most frequently used CDA conceptual frameworks and examples of these frameworks as follows:

- Approaches that consider cultural contexts and view culture and language as dialectically related, e.g., Fairclough (2008).
- Sociohistorical approaches examining discourse over time, e.g., Reisigl and Wodak (2009).
- Sociocognitive approaches examining context and cognition in discourses, e.g., van Dijk (2009).
- Linguistic approaches focusing on dialectics and semiotics, e.g., van Leeuwen (2008).
- Psychological approaches focusing on thematic and narrative analysis, e.g., Willig and Stainton-Rogers (2008).

I have chosen the general research methodology of CDA because it holds promise for the investigation of processes leading to health policy development, including social practices, power structures, and social transformation. In this study, I examine PC and PHC as discourses expressed through text, talk, and action. I refer to the scholarly work

of Foucault who influenced the methodologies developed by Fairclough and Bacchi. All of these scholars have contributed to the study of power relations within the discourses of health and health policy.

From Foucauldian Philosophy to Critical Discourse Analysis

Foucault's work focuses on the rules and practices of language that produce dominant meanings and "valid" knowledge. He was concerned with how knowledge is constructed through discursive practices and he defined discursive practices as regular, interactive episodes that have socio-political and cultural significance to a community of speakers. He described discourse as representing particular interests and benefitting certain groups while marginalizing others. He included text and action along with talk in his approach to discourse analysis and focused on discursive practices that occurred in specific institutional settings like the medical clinic, prison, and psychiatric facilities where the conduct of others was observed and regulated (Fairclough, 2000; Hall, 1997; van Dijk, 1999).

As has been discussed, Foucault (1972) defines discourse as a combination of language, action, interaction, ways of thinking, beliefs, values, and use of symbols or tools, acting, and being in the world. According to this definition, discourse "creates a field of knowledge by defining what is possible to say and think, declaring the bases for deciding what is true and authorizing certain people to speak while making others silent or less authoritative" (p. 49). This is a key concept in examining the discourses of PC and PHC because it defines credible speakers within these discourses and the underlying power relations that privilege certain groups and contribute to their representative legitimacy.

Foucault also uses concepts of discontinuity and continuity as tools to deconstruct the nature and development of modern power (Scheurich & McKenzie, 2005). He does not see history as a linear progression of continuities but rather gaps or missing parts. It is these breaks, gaps, discontinuities that require attention (Foucault, 1972). The methodology for recognizing continuity and discontinuity, genealogical examination, "conceives human reality as an effect of the interweaving of certain historical and cultural practices, not a continuous development of an ideal schema but oriented to discontinuities" (Tamboukou, 1999 p. 203). Noticing that there are discontinuities in transitions from one period of time to the next is important. Where discourses overlap, are silent or become modified by disciplinary power does matter, as societal actors reconfigure the discourse to complement the current political landscape. The tools of genealogical examination (attending to disciplinary power and recognition of continuities and discontinuities) are salient constructs that are used in critical discourse analysis. They are relevant to the examination of the discourses of PC and PHC and will be applied in the analysis of the selected texts.

Today, the Foucauldian methodologies of archaeology and genealogy are focused on the characteristics and function of power (Wodak & Meyer, 2001). Foucault and later scholars used these methodologies, to categorize processes, procedures, and devices through which truth and knowledge are produced in a given historical timeframe, which he referred to as the discursive regime (Tamboukou, 1999). The purpose of his archaeological studies and later genealogical studies is to examine more closely the operation of discursive practices from which societal norms and truths have been constructed (Foucault, 1972). Foucault was drawn to these methodologies as a

philosophical method of inquiry primarily because of the principle that truth cannot be separated from the processes of its production (Tamboukou, 1999). He saw the philosopher's task as one that critiques, identifies, and demystifies what is broadly accepted as truth/progress. He suggested focusing on a particular problem and then trying to deconstruct it in its historical dimension focusing on *how* and *why* "particular words, phrases, statements, claims, and questions arise" (Springer & Clinton, 2015, p. 88). I incorporate this historical dimension in the documents under study.

Consistent with a Foucauldian approach, the methodology of this study will focus on what Foucault identifies as the *episteme* or knowledge and social practices of health professionals in a particular period of time when health care reform was the subject of public policy discourse. In my work I will show continuities and discontinuities in the discourses of PC and PHC during transitions from one period of time to the next. I will reveal where discourses of PC and PHC overlap, are silent, or become modified as societal members—or in this case health care professionals—reconfigure the discourse in ways that complement or challenge the current political or economic landscape.

The Methodological Field of Critical Discourse Analysis

Foucauldian scholars have taken direction from Foucault's critical theory and discourse analytic work to define a methodological approach consistent with archeological and genealogical methods. Prominent among these scholars is Norman Fairclough, who focuses on social conflict in the neo-Marxist tradition. According to Fairclough (1993), "discourse is shaped and constrained by social structure in the widest sense and at all levels: by class and other social relations and at a societal level, by the relations specific to particular institutions" (p. 64). Fairclough (2001) proposed that every

social practice has a semiotic element. By semiotic, Fairclough is referring to the tradition of exploring signs and symbols as significant parts of representation and communication. Semiosis is any activity, behaviour, or process that involves signs in the development of communication, representation, and meaning. These concepts are important elements within CDA as a methodology that examines significant aspects of text, talk, and interaction. Fairclough's (1995, 2010) framework comprises three analytical focuses or three dimensions as Fairclough refers to them: *text, discourse practice*, and *sociocultural practice*. In examining these, Fairclough incorporates linguistic theory, which analyses language as developed by the social functions it has come to serve (Wodak & Meyer, 2001). According to Fairclough (2001), text analysis or "description" takes into consideration the interrelationship among texts and production process. Discourse practice, or "interpretation" examines the distribution and consumption of the communicative event (e.g., text) and sociocultural, or "explanation" analyses the situational, institutional and societal processes like social relations, social identities, cultural values, consciousness, and semiosis.

Fairclough (2001) established a five-step analytical framework for investigating discourse in relation to power and ideology. His methodology combines relational and dialectical elements and has been demonstrated to be useful in revealing the discursive nature of social and cultural dimensions of society, and the prevailing discourses that reflect interests and values of dominant or elite groups. In the Foucauldian tradition, he subscribes to a logical, problem-oriented approach of investigation (Fairclough, 2001). Step 1 is the identification of the social problem and semiotic aspects of its analysis. This identification requires an understanding of the current social order and social context of

the problem. Step 2 involves identifying obstacles that are relevant in addressing the problem. This can be undertaken by analyzing the network of practices in which the problem is located and the relationship of semiosis to other elements within the practice that influence the discourse (e.g., means of production, social relations, social identities, cultural values, and consciousness). The discourse can be analyzed structurally, linguistically, or through interaction and interdiscursive analysis. Step 3 involves determining whether the social order is dependent on maintaining the identified problem or if there is no impetus for addressing the problem because the network of practices is sustained by the identified problem. Step 4 involves the identification of solutions to the obstacles, described as "unrealized possibilities for change with the way things are" (pp. 126-127). Step 5, the final step, entails critical reflection on Steps 1-4 to ensure the analysis is not compromised by subjective biases or positioning.

Fairclough's methodology has been demonstrated to be useful in revealing the prevailing discourses that reflect interests and values of dominant or elite groups. His methodology is useful for this study which focuses on hierarchical power structures prevalent in health care and the prevailing discourses that sustain them. He subscribes to a logical, problem-oriented approach in the Foucauldian tradition, where the first step is the identification or description of the social problem under analysis. Fairclough (2001, 2003) understands language as a form of social practice that shapes the way people understand a given field. I will draw on Fairclough's assumption that people are not always aware of the ideological dimensions of their own practice and that ideological practices are most effective when they have become and achieved common-sense status (Fairclough, 1992, p. 8).

There is continuity and coherence in Foucault and Fairclough's methodologies. Both are concerned with social problems and understand discourse as a social practice. In my examination of Fairclough's methodology, I became acquainted with the work of Carol Bacchi, who introduces a poststructural analytic strategy called "What's the Problem Represented to be (WPR approach)" (Bacchi, 2016, p.1). Like Foucault and Fairclough, she speaks to *problematization*, or ways in which problems are produced and represented in government policies and practices. Her work, concerned with problematizations in health policy, has particular relevance for this study. In keeping with my analysis of health policy, I draw on Bacchi's scholarship detailing the idea that policy problems are socially constructed and require interrogation of the unexamined or taken for granted ways of thinking that are assumed in policy development. Bacchi (2016) argues that WPR analysis examines the discourses on which policy formulations are based. Her approach is consistent with Foucauldian premises for excavating the "unexamined ways of thinking" that are assumed in policy development (p. 11). Her methodology offers a framework for examining the ways in which problems are described, represented, and positioned within policy. Bacchi builds on the idea that policy problems are socially constructed and require interrogation of the taken-for-granted premises embedded therein (Payne, 2014). She contends that "we are governed through problematizations, rather than through policies, signaling the importance of critically interrogating problem representation" (p. 9). Her starting point for analysis is what makes the political agenda, how the policy initiatives are shaped, what they encompass, and what they leave out. Bacchi (2016) has developed a Foucauldian-influenced, six-stage policy analytic framework as follows:

> Question 1: What's the "problem" of (e.g. "discrimination", "problem gamblers", "use/abuse", "domestic violence", "absenteeism", "anti-social behaviour") represented to be (constituted to be) in a specific policy or policies?
>
> Question 2: What presuppositions--necessary meanings antecedent to an argument--and assumptions (ontological, epistemological) underlie this representation of the "problem" (problem representation)? This question involves a form of Foucauldian archeology (Foucault, 1972).
>
> Question 3: How has this representation of the "problem" come about? This question involves a form of Foucauldian genealogy (Foucault, 1971/1977).
>
> Question 4: What is left unproblematic in this problem representation? Where are the silences?
>
> Question 5: What effects (discursive, subjectification, and lived) are produced by this representation of the "problem"?
>
> Question 6: How and where has this representation of the "problem" been produced, disseminated, and defended? How has it been and/or can it be questioned, disrupted, and replaced? (p. 9)

Bacchi's WPR is about examining the "unexamined ways of thinking" that are assumed in policy development (p. 11). She points out that the analysis can be "followed sequentially or applied as part of an integrated analysis" (p. 9). Although my investigation will not address every point in her framework, I have adopted specific aspects of her framework as consistent with my approach to CDA. Her methodologies offer a framework for examining the ways in which problems are represented, described, and positioned within policy. I have chosen to use Bacchi's framework because it brings

new questions to policy analysis and broadens the scope of analysis to consider the governing knowledges of the experts i.e. health professionals, like physicians and nurses.

In summary, a number of theoretical, methodological, and analytic approaches to critical discourse analysis were highlighted. These are all consistent with Foucauldian philosophy, his critical theory of discourse and power, and his methodologies of archaeology and genealogy. I draw on Hall and West in their emphasis on cultural contexts and the notion that culture, race, and language are dialectically related. Poststructural feminism, as articulated by Sawicki and Weedon influence my thinking related to how gender, power, and language are used to position discourses hegemonically. Given my examination of discourse over a 30 year period, sociohistorical methodologies, like those proposed by Fairclough, are influential in my analysis. Fairclough and Bacchi are intentional in their approaches with logistical steps in the analytic process. Bacchi focuses on policy analysis and her thematic and narrative approach using Foucauldian archaeologies and genealogies, is key to my study. All approaches share, as a pivotal element, the analysis of text, talk and action as it embodies discourse, power, dominance, and social inequality (van Dijk, 1998).

CDA and the Specifics of Health Policy Analysis

As established in the previous sections, CDA aims to explore the interconnectivity between discursive practices, texts, and the broader social and cultural structures and processes and how these relationships are a factor in securing power and hegemony (Fairclough, 1993). Discursive practices refer to the use of spoken and written language to represent the social world through rules, norms, and models of behaviour, or ways of being in the world (Gee, 1999). Institutional partitioning of knowledge, as it occurs in

institutions of health care, or professional practice, influences the social practices through which certain objects, concepts, and strategies are formed (Foucault, 1972). According to sociologists Green and Thorogood (2016) in *Analyzing Health Policy: Sociological Approaches*, Foucault's analytic framework has been a fertile starting point for health policy analysis. Bacchi (2016), in her Foucauldian-influenced WPR approach, offers a "poststructural sensitivity to knowledge creation" (p. 10).

Research Studies. A number of research articles using CDA as a methodology for health policy analysis were reviewed for the methodology deployed and results achieved. I begin with a study focused on government policies in Ontario.

Benbow, Gorlick, Forchuk, Ward-Griffin, and Berman (2016) examined Ontario's Poverty Reduction Strategy (OPRS) using CDA. This analysis was guided by the questions of how mothers experiencing homelessness and health needs were represented in the policy document, and how the poverty reduction strategy addressed social exclusion. The researchers used Fairclough's (1995, 2010) approach, and cited it to be "one of the most comprehensive frameworks of CDA" (p. 101). The researchers noted the absence of narratives of women living in poverty as well as other vulnerable populations including newcomers to the province. They identified the inclusion of neo-liberal discourses focusing on productivity and the labour market. This analysis, conducted by nursing researchers, brought to the forefront the absent voices and perspectives of those vulnerable populations including women and mothers living in poverty, for whom the strategy was developed. The authors concluded that the Ontario Poverty Reduction Strategy, developed by government, did not promote further understanding of the social and political factors shaping health and homeless experiences.

Evans-Agnew et al. (2016) also explored CDA as an encouraging methodology for health policy research. The authors established, using exemplar case studies, how CDA can provide insights into specific contexts, power relations, and social practices of health policy research. They followed the approaches of Fairclough (2008, 2009), Reisigl and Wodak (2009), and van Dijk (2009). They also demonstrated how CDA can provide alternative insights into revising and transforming the social practices that influence policy. The authors presented results of three exemplars of CDA and health policy research: (a) preconception care policy in China; (b) asthma management disparities in public health planning in Washington state; and (c) workplace bullying policy in Northwest U.S. hospital systems (Evans-Agnew et al., 2016). The researchers summarized the steps involved in utilizing a CDA approach, from choosing the social issue, to considering the social practices, policies, and contexts for the discourses before considering data sources. Data sources included policy documents or guidelines, such as Chinese government preconception care guidelines and hospital bullying policies. Additional data sources included interview transcripts with health policymakers and key informants from priority populations of policy action or clients/providers, i.e., Chinese women, their children, unit-level nurse managers, and other key informants. Demographic data including identities and roles within the policy context were also collected. The study illustrates how health researchers (in this case, nurses) can employ CDA to critically analyze health policies; describe social practices that surround policy formation, enactment, and implementation; and offer transformational strategies to redirect policies that will benefit those groups whose voices are often silent within policies concerning them.

Burnett, Ford-Gilboe, Berman, Ward-Griffin, and Wathen (2015), critically analyzed Canadian provincial policies impacting shelter service delivery to women exposed to violence. In this feminist CDA study, nursing researchers from the U.S. and Canada conducted a three-phase, exploratory study, guided by a critical discourse and interpretive framework designed for the study. Phase two of the study involved in-depth review and analysis of applicable policy texts using a CDA framework based on Chouliaraki and Fairclough's (2004) methodology. The results demonstrated how provincial policies have significant unintended consequences for women and children because of the extreme complexity of their needs and vulnerabilities. Burnett et al. (2015) found that the voices of women requiring the services offered under each of these programs were silenced by these policy inadequacies. Eligibility criteria required women to deplete their financial resources to qualify for programs such as social assistance. Already vulnerable, women and the children they were trying to support were rendered more dependent by this policy. According to the researchers, language contained in policies privileged government workers in the protection of children from abuse over their own mothers. The voices of women who were affected by domestic abuse were silenced. The authors concluded that government policies that were created to protect women and children lacked a gender-based analysis. Additionally, voices of shelter workers who could be front-line knowledge brokers, were also absent in the discourse of government policy. The researchers identified improvements that are required in the policies, namely, gender-based considerations. Burnett et al. (2015) noted that structural complexities and systemic challenges impede the ability of staff to improve women's access to the social determinants of health such as income, social support networks, and

housing security. The researchers concluded the study by emphasizing its importance for clinicians who work in community health, primary care, and mental health settings where policy-related barriers are often the most prevalent, and opportunities for advocacy the greatest.

Drawing on the work of Bacchi (2000), Wodak (2006), and Fairclough (2000), Sara Shaw (2010), a medical researcher and educator, illustrated how health policy might be conceptualised and analyzed using a *policy-as-discourse* approach. Shaw posits that rather than policy development being a formal, rational process that can be planned in advance, it is more likely a historically based, emergent stream of social action. Shaw used a policy-as-discourse approach to understand and explain the means by which social processes and interactions shape various realities. This approach is in contrast to the commonly applied rational approaches such as cost-benefit and evidence-based policy analyses (Bacchi, 2000; Fairclough, 2000). Shaw demonstrates that, in contrast, the methodology of CDA seeks to reveal how actions are interconnected and shaped by the social and political contexts in which they take place. Within policy proposals, problems are not depicted as benign but are instead positioned within a framework where power plays an integral role in the policy process (Wodak, 2006). Her analysis revealed how policy-makers in the UK largely ignored the development of primary care research policy until the mid-90s when political emphases shifted to a primary care-led health service. In conclusion, Shaw emphasized the benefits of using a policy-as-discourse approach especially in relation to "big" problems that are multi-faceted and complex usually involving socio-political issues.

Payne (2014), a political scientist from the UK, deployed CDA to examine the gender discourses embedded in gender equality policies in the English health sector. Drawing on the work of Bacchi (2000), Payne (2014) proposed that policy problems are socially constructed, arising at specific times and in specific policy spaces, and advocates a "what is the problem represented to be" (WPR) approach (p. 958). For Payne, Bacchi's approach to CDA is particularly valuable in policy agendas where the problem itself is presented as if it were/seems obvious and unproblematic.

The results of Payne's study indicated that gender mainstreaming strategies and policies developed by health organizations to eliminate gender discrimination and promote equality of opportunity between men and women, can be seen as contributing to discourses of gender difference. Payne noted that there was significant silence on the wider influences, the social determinants of health that go beyond the health care system. More significant was the absence of any notation in health differences between women and men resulting from external factors such as paid and unpaid work, poverty, exclusion, and the environment. Throughout the discourses identified by Payne, gender relations of power were not identified by any of the Primary Care Trusts (PCT). Silence on these relationships shaped the resulting discourse in specific and problematic ways and implied that gender justice can be achieved without challenging wider inequities based on gender differences. Payne concluded by offering a further perspective on the WPR methodology, asserting that through "articulation of the ways in which policies represent problems we might open up spaces for those involved in policy making to engage with the production of 'knowledge' and the silences embedded in policy texts and other discursive practices" (p. 971).

This concludes my discussion of CDA and its recent use in analyzing health policy. CDA is instrumental in my exploration of dominant discourses and emergence of power systems in primary health care policy in New Brunswick within the last three decades. I have chosen CDA methodology, selecting a hybrid combination influenced by Foucault, Fairclough and Bacchi, which will be discussed in more detail in the next section. The use of CDA methodology fits my study because CDA aims to explore the interconnectivity between discursive practices, texts, and the broader social and cultural structures and processes and how these relationships are a factor in securing power and hegemony (Fairclough, 1993). This is relevant to the institutional partitioning of knowledge, as it occurs in institutions of health care, professional practice, or health policy development influencing the social and professional practices through which certain objects, concepts, and strategies are formed (Foucault, 1972).

In this study, I interrogate government produced policy documents and discipline-specific, historical texts from the provincial professional associations of medicine and nursing. I analyze these documents, examining continuities and discontinuities, as these are demonstrated in the use of discourses of PC and PHC within these texts. I have chosen the disciplines of medicine and nursing as involved in representing the discourses of PC and PHC. There are instances where both medicine and advanced practice nursing take up the discourse of PC, emphasizing access to care. And there are instances in which both medicine and advanced practice nursing take up the discourse of PHC, emphasizing the importance of health promotion and health equity. However, my experience as a policy advisor and administrator, suggests that continuities and discontinuities exist. I have experienced public policy related conversations in the period under investigation in

which the discourse of PC is more strongly represented in medicine while the discourse of PHC has been more strongly represented in advanced practice nursing. I recognize that contextual factors help to explain this. In this study, I examine texts that include discourses of PC and PHC, noticing how they are taken up in professional documents and in government policy documents used to distribute, organize, and align health care resources. I also draw attention to a historically situated policy level priority focus in New Brunswick involving the introduction of PHC nurse practitioners (NPs) as primary care providers. Drawing attention to NPs is relevant because the discourse of PHC speaks to enhanced access to PC, increased emphasis on health promotion and disease prevention, attention to the social determinants of health, and use of interdisciplinary teams, all within the scope of practice of a NP and at a reduced cost than more traditional models, e.g., family physicians (DiCenso, Auffrey, Bryant-Lukosius, Donald, Martin-Misener, Mathews, & Opsteen, 2007).

Method

Research Design

This exploratory/descriptive study uses CDA methodology to explore and describe the relationship between disciplinary power and knowledge in the context of PHC reform in New Brunswick. As demonstrated in the previous section, it is an applicable methodology to examine the social practices which influence health policy (Evans-Agnew et al., 2016).

The study specifically explores how professional discourses (knowledge-power) operate in constructing and representing health policy around PHC reform. Consistent with my literature review, the design of the study focuses on how continuities and

discontinuities, in disciplinary discourses of PC and PHC appear and how these can contribute to barriers in health care transformation. The use of CDA in this study illustrates how continuities and discontinuities in the discourses of PC and PHC reflect professional practices in diverse settings where hierarchical power structures privilege some health care providers over others. The design of my investigation is similar to the previously detailed CDA study in Australia by Turner et al. (2007) that examined social discourses of advanced practice nursing within health care. Another applicable example detailed previously, is the study by Liu (2010) of birth control policies where +preconception policy language of the Chinese government penetrated local discourses (Evans-Agnew et al., 2016). Data sources included policy documents and interviews with health care providers and rural women. Dominating and marginalizing preconception care discourses were identified and then analyzed for converging and diverging discourses between policy and interview texts.

Using selected provincial government and health discipline policy documents (as detailed in Table 1), I construct a timeline of the emergence of healthcare reform or PHC discourse in NB; detail how PHC discourse is represented in provincial government and health discipline documents, e.g., what phrases, words, and symbols are the most prolific and which discourses converge/diverge. I analyze the policy documents according to Bacchi's six-stage policy analytic framework, which involves identifying: the *problem* represented in the policy, the silences in the texts, and the presuppositions or assumptions underpinning the representation of the problem. All of the texts analyzed are related to health policy reform, specifically attempting to address PHC reform and the introduction of NPs. The texts are categorized as government-produced or discipline-produced

documents. Comparative analysis between the provincial government and health discipline documents illustrates which discourses are taken up in the policy texts, what problem(s) the policy texts are attempting to address (Bacchi, 2016), and any changes in the discourses over time. A discussion of the findings and the timeline associated with these texts is found in chapter six.

My review of the documents was guided by deciding which terms or phrases in the discourses signify PC, which are PHC focused, and where these terms converge. Examples of PC discourses include entry point/gate-keeper, patient attachment, continuum of care, and cost containment. PHC discourses include the following words and phrases: influence of the social determinants of health, health equity or inequities (across gradients of sexism, racism, homophobia, colonization, age), poverty, ableism/intersectionality, community engagement or community empowerment, services organized and adapted to the needs of the population, and social justice. Examples of converging or intersectional discourses include universal, comprehensive, coordinated, collaboration/teamwork, preventative care, integrated services and chronic disease management.

I have selected 12 documents, three representing government policy and nine discipline-specific documents representing the health professions of nursing and medicine. I selected these documents because they represent the 30 years of PHC development under examination. I examine the following documents described in Table 1:

Table 1

Summary of Selected Texts

Document	Rationale	Retrieved From
Report of the Commission on Selected Health Care Programs (McKelvey Levesque Report, 1989)	Key Government of NB commissioned study to review health care services and make recommendations.	Provincial Archives
A Discussion Paper: For the Health of our Communities (NBNU, 1995)	Emerging discourse of the nursing role in PHC	NB Department of Health
The Future of Health Care in New Brunswick: The Nursing Contribution (NANB, 1998)	Emerging discourse of advanced practice nursing and PHC	NANB
Annual Report: Primary Care Collaborative Practice Project and Promoting Primary Health Care (NANB, 2007)	Emerging discourse of association with provincial health planning around PHC reform	NANB – InfoNursing
Health Centres in New Brunswick: Leaders in the Provision of Primary Health Care (Barry & Saunders, 2011)	Emerging discourse of association with provincial health planning around PHC reform	NANB – InfoNursing
Improving Access and Delivery of Primary Health Care Services in New Brunswick: Discussion Paper (GNB, 2010)	Emerging discourse of PHC reform	NB Department of Health
Igniting Change: Province's Summit on Primary Health Care (B. Davies, 2011)	Emerging discourse of PHC reform	NANB – InfoNursing
Fixing New Brunswick's Healthcare System: New Brunswick's Doctors Have a Plan CARE FIRST (NBMS, 2013)	Response to government requested input from health care professionals regarding Provincial Health Plan. Emerging discourse of PC and physician role	NB Department of Health

Rebuilding Health Care Together - The Provincial Health Plan 2013-2018 (Government of New Brunswick, 2013)	Emerging policy discourse emphasizing PHC	Public Document – available from GNB website
Position Statement – Primary Health Care (NANB, 2014)	Continuity of discourse on PHC & role of NP	Public Document – available from NANB website
Nurse Practitioners of NB- Priorities (NPNB, 2019)	Current discourse on PHC and role of NP	https://www.npnb.ca
Nurse Practitioners of NB- Infographic (NPNB, 2019)	Current discourse on PHC and role of NP	https://www.npnb.ca

I have selected three texts disseminated by the Government of New Brunswick and nine texts from the health disciplines of nursing and medicine during the period 1989-2019 as they are the most prominent health care professions documents in the PC and PHC space. All of these texts concern health policy reform, specifically PHC reform in the province. I show the continuities and discontinuities in PC and PHC discourses taken up in the document(s), as well as changes to discipline-specific discourses over time in relation to health care reform and the introduction of NPs. A comparative analysis between the provincial government and health discipline documents illustrates which discourses are taken up in the policy-related texts, what problem(s) the texts are attempting to address (Bacchi, 2016), and any changes in the discourses over time.

The design of the study employs methods of data selection and analysis that are consistent with sociocultural approaches to CDA (Bacchi, 2016; Fairclough, 2001, 2003). I draw on Fairclough's (2001) established five-step analytical framework for investigating discourse in relation to power and ideology, identifying the social problem and analyzing the social functions the discourse has come to serve. According to

Fairclough this identification requires an understanding of the current social order and the social context of the problem. I provide this analysis through the development of a timeline of the emerging discourse of PHC. I focus my analysis of texts by examining the Government of New Brunswick policy documents and those of professional organizations to determine how the problem is identified and what changes were proposed to address the identified problem(s). Fairclough's methodology combines relational and dialectical elements and has been demonstrated to be useful in revealing the discursive nature of social and cultural dimensions of society, and the prevailing discourses that reflect interests and values of dominant or elite groups.

I also adapt Bacchi's (2016) Foucauldian-influenced, six-stage policy analytic framework in examining government policy and professional documents as these are related to PHC reform. Use of the adapted framework in this study occurs by identifying what the problem is represented to be in each document and then using this process to understand the findings as a whole:

1. Identify the problem represented in the policy documents related to PHC reform.
2. Detail the presuppositions or assumptions that underpin the representation of the problem.
3. Explore how this representation of the 'problem' came about.
4. Identify the silences or gaps in the policy discourse.
5. Highlight the effects produced by this representation of the "problem."
6. Determine how and where has this representation of the 'problem' been produced, disseminated, and defended, and how could it be disrupted.

As previously detailed, the design of my study has also been supported and inspired by reviewing recent literature in nursing research, where CDA has been used to demonstrate how nursing science can engage public policy. I have examined similar studies that use Fairclough's and Bacchi's methodology (Benbow et al., 2016; Evans-Agnew et al., 2016; Liu, 2010; Payne, 2014; Shaw, 2010; Turner et al., 2007).

Analysis

I follow Fairclough's (2003) systemic framework to provide broad contextual analysis of the data. Fairclough calls for a description of the text and an interpretation of the relationship of the text to relevant activity, behavior or processes influencing players who produce the text. Analysis also focuses on how the text may influence those who interpret and enact it, with an explanation of the social practices resulting from the texts. I analyse these components by addressing how health care disciplines represent "the problem" in their use of PC and PHC, also noting which components of PC or PHC are given the greatest emphasis. I also compare how salient and prominent discourses such as neoliberalism, PC and PHC are taken up in the government health policy reform texts with an emphasis on how they are aligned with "problematizing activity" (Bacchi, 2012, p. 3).

In identifying the ideological underpinnings influencing health policy directions in relation to PC and PHC, I adapt the framework of Fairclough (1992, 2001, 2003) and remain oriented by Foucauldian assumptions, considering (a) text, (b) discursive practices, and (c) social practices. I also address *interdiscursivity* and *intertextuality*. Interdiscursivity is the aspect of a discourse that relates it to other discourses (Fairclough, 2001; Wodak, 2001) and intertextuality exists when "texts, documents, and policies are

produced from and draw on other documents within and outside the organization" (Fairclough, 1992, p. 10). Through the processes of intertextuality and interdiscursivity, some discourses, usually those promulgated by the most powerful, achieve dominant status and prominence in health policy documents (Evans-Agnew et al., 2016).

In analyzing *text*, I am searching for words, wording, statements, and assumptions describing problems with the health care system, presumed or proposed solutions for those problems, and whether the proposed solutions reflect assumptions of PC and/or PHC. The *discursive practice* level involves the examination of processes related to the production, distribution and consumption of a text (Fairclough, 1992). This is an important form of social practice and contributes to the constitution of the social world. The *social practice* level is, according to Fairclough (1992, 2003), the "explanation" analyses of the situational, institutional, and societal processes like social relations, social identities, cultural values, consciousness, and semiosis. Fairclough deems it necessary to examine discursive practice in order to understand the links between texts and the broader social practice surrounding them.

In keeping with my analysis of health policy, I also draw on Bacchi's (2016) scholarship detailing the idea that policy problems are socially constructed and require interrogation of the unexamined or taken for granted ways of thinking that are assumed in policy development. Her analysis addresses the language used in the policies, emphasizes the discourses upon which policy formulations are based, also noticing how "problems" are defined, described, and positioned within policy. Bacchi's approach includes an analysis of what makes the political agenda and how that process reflects political priorities. This includes noticing the historical significance of details that determine what

"the problem" is represented to be: "A problem representation therefore is the way in which a particular policy problem is constituted as the "real" (Bacchi, 2012, p.151).

Informed by the work of both Fairclough and Bacchi, I developed a hybrid model of analysis. My analysis of each policy document addresses four common elements: (i) **Historical significance and purpose**: I consider the historical significance of each document, the social/political environment at the time and the stated purpose behind the creation of each document; (ii) **Analytic framework**: I adapt Fairclough's (2001, 2003) framework in relation to power and ideology by detailing three levels of analysis—*text, discursive practice,* and *social practice*; (iii) **Problem representation**: In this element, I refer to Bacchi's Foucauldian-influenced, policy analytic framework. I analyze how each document introduces or relates to PHC reform. This involves identifying the *problem* represented in the policy, the silences in the texts, and the presuppositions or assumptions underpinning the representation of the problem. According to Bacchi (2016), "what is of most interest and concern are continuities within policies, across statements of "problems" and "solutions" (p. 11). I also examine, in the Bacchiian method, how the representation of the problem arose, and the effects produced by this representation. In a final element of analysis, (iv) **Discourse direction**, I explore emerging. converging and diverging discourses. This refers to directions that are demonstrated in how "the problem" is being represented, e.g., within PC, PHC and/or neoliberal discourse in these policy documents. I am using these terms as a modified version of Foucauldian genealogical examination where continuities, discontinuities and intersections are identified in discourse analysis. According to Bacchi and Bonham (2014), "Foucault illustrates how political practice necessarily takes part in the emergence, insertion and

functioning of discourse" (p. 176). Taking my lead from Bacchi, I am analyzing how discourses emerge historically. I am also examining the continuity of discourses, when discourses converge, intersect and when there is discontinuity and divergence. I am calling this section of my analysis *discourse direction* because of the emphasis on these directional elements of the discourse under examination. For example, I examine phrases and words that are most prolific and those that appear rarely or irregularly. I notice where there is ambiguity between PC and PHC; which discourses (PC, PHC, and neoliberalism) emerge, intersect, or converge; and where there is divergence, continuity, or discontinuity.

This concludes Chapter 3, where the methodology of CDA was detailed by linking it to its early theoretical origins in work advanced by Foucault. Related theoretical work addressing discourse and power was also addressed including that of Hall, West, Sawicki, and van Dijk. The salient constructs of prominent critical discourse analytic frameworks (Fairclough and Bacchi) were reviewed. The salience of Foucault's theory of discourse continuities and discontinuities was addressed. Relevant elements of PC and PHC discourses were discussed as were some recent examples of CDA in health research/nursing science. Finally, the hybrid methodology applied in this study was presented, noting the influence of Foucault, Fairclough, and Bacchi. The analysis of six of the 12 documents follows in Chapter 4. These six documents represent a period of time, from 1989-2011, when PHC discourse was emerging in government policy and in health care discipline documents.

Chapter 4

Document Analysis (1989-2011): Building PHC Momentum

This study uses CDA methodology to explore and describe the relationship between disciplinary power and knowledge in the context of primary health care reform in NB. To address the research questions, I selected six health policy-related documents that best represent the progression, intersection, consistencies/continuities, contradictions/discontinuities of the discourses of PC and PHC, in the time period examined, 1989-2011. The six documents I selected are as follows:

1. *Report of the Commission on Selected Health Care Programs* (McKelvey Levesque Report, 1989);
2. *A Discussion Paper: For the Health of our Communities* (NBNU, 1995);
3. *The Future of Health Care in New Brunswick: The Nursing Contribution* (NANB, 1998);
4. *Annual Report: Primary Care Collaborative Practice Project and Promoting Primary Health Care* (NANB, 2007);
5. *Health Centres in New Brunswick: Leaders in the Provision of Primary Health Care* (Barry & Saunders, 2011);
6. *Igniting Change: Province's Summit on Primary Health Care* (Davies, 2011).

These documents appeared early in the timeframe of this study, when policy level texts were attempting to introduce principles, discourses and possibilities of PHC. Findings will show that this introductory phase gradually gains momentum, due in part to the commitment of the nursing profession and culminates eventually in the construction of a policy framework with the potential to realize systemic change in community-based

PHC. Throughout this chapter and in Chapter 5, I refer to the use of the scholarly work of Fairclough and Bacchi (discussed in Chapter 3), both of whom have contributed to the study of power relations within the discourses of health and health policy.

Consistent with Fairclough (1992, 2001, 2003), in each document I address *text*, *discursive practice*, and *social practice*, and I identify the ideological underpinnings influencing health policy directions in relation to PC and PHC. I also address *intertextuality* (Fairclough, 1992) where texts, documents, and policies are produced from other documents within and outside the organization. Through the process of intertextuality, some discourses, usually those promulgated by the most powerful, achieve dominant status and prominence in policy documents (Evans-Agnew et al., 2016).

In analyzing *text*, I am searching for words, wording, statements, and assumptions describing problems with the health care system, presumed or proposed solutions for those problems and whether the proposed solution reflects neoliberal assumptions or assumptions of PC and/or PHC. The *discursive practice* level involves the examination of processes related to the production, distribution, and consumption of a text. According to Fairclough (1992) this is an important form of social practice and contributes to the constitution of the social world. Finally, analysis at the level of *social practice* is, according to Fairclough (1992, 2003), "about controlling the selection of certain structural possibilities and the exclusion of others and the retention of these selections over time" (p. 23) and is necessary in order to understand how prevailing and emerging practices intersect with texts.

In keeping with my analysis of health policy, I also draw on Bacchi's (2016) scholarship, detailing the idea that policy problems are socially constructed and require interrogation of the unexamined or taken for granted ways of thinking that are assumed in policy development. Her analysis addresses the language used in the policies, emphasizes the discourses upon which policy formulations are based, and how "problems" are defined, described and positioned within policy. Bacchi's approach includes an analysis of what makes the political agenda and how that process reflects political priorities. This includes noticing the historical significance of details that determine what "the problem" is represented to be: "A problem representation therefore is the way in which a particular policy problem is constituted as the real" (Bacchi, 2012b, p. 151).

Using the work of both Fairclough and Bacchi, my analysis of each policy document addresses four common elements: (i) **Historical significance and purpose**: I consider the historical significance of each document, the social/political environment at the time, and the stated purpose behind the creation of each document; (ii) **Analytic framework**: I adapt Fairclough's (2001, 2003) framework in relation to power and ideology by detailing three levels of analysis—text, discursive practice, and social practice; (iii) **Problem representation**: In this element, I refer to Bacchi's Foucauldian-influenced policy analytic framework. I analyze how each document introduces or relates to PHC reform. This involves identifying the problem represented in the policy, the silences in the texts, and the presuppositions or assumptions underpinning the representation of the problem. According to Bacchi (2016), "What is of most interest and concern are continuities within policies, across statements of 'problems' and 'solutions'" (p. 11). I also examine, in the Bacchiian method, how the representation of the problem

arose, and the effects produced by this representation; and (iv) **Discourse direction:** In this final element of analysis, I explore Bacchi and Bonham's (2014), Foucault-influenced discourse direction, specifically emerging, converging, and diverging discourses about how the problem is represented within PC, PHC, and/or neoliberal discourse in these policy documents. For example, I examine phrases and words that are most prolific and those that appear rarely or irregularly. I point out where there is ambiguity between PC and PHC, and which discourses (PC, PHC, and neoliberalism) emerge, converge, diverge, or disappear.

Document 1: *Report of the Commission on Selected Health Care Programs* (1989)

The document, *Report of the Commission on Selected Health Care Programs* or the *McKelvey Levesque Report* (named after lead commissioners E. Neil McKelvey and Sister Bernadette Levesque), written in 1989, hereafter referred to as the ML Report is foundational to my area of research. It is one of the first government-commissioned studies after the implementation of the Canada Health Act (CHA, 1984) to review health care services and make recommendations about how health services in NB could be "better structured, organized and distributed so that various components of the system can function in the most efficient and cost-effective manner" (p. 1). The ML Report consists of 131 pages, 20 chapters and contains 64 recommendations.

(i) In terms of its *historical significance* and *purpose*, the ML Report was produced 17 years after the provincial introduction of universal medical insurance in 1971. Since "cost containment" was emphasized in five of the six mandate objectives in the "Terms of Reference of the Report," it is reasonable to assume that the work of the commission, although not explicitly stated in the report, was to investigate what health

status could be achieved within a climate of fiscal restraint. In the years preceding the ML Report, universal medical coverage was the defining national and provincial social policy issue of the 1960s (Marchildon & O'Bryne, 2013). The political climate of this decade was heavily influenced by "business opposition to the continued growth of the welfare state fortified by the medical profession's opposition to state funding of medical care" (p. 151). Notably, NB was the last province in Canada to implement medical care insurance mainly because of limited provincial revenues to pay for universal health care. Although federal funding for the Medical Care Act (1966) was based on a per capita allotment, the government provided provisions for the Atlantic region, which is less populous relative to the rest of Canada. Within this concept of equalization, NB received considerably more funding from the federal government than the proposed $0.50 on every dollar spent on Medicare, balanced in part by the more populous provinces of Ontario and Quebec. Marchildon and O'Bryne (2013) note:

> The federal government estimated a national physician cost of $35.00 per capita. This was substantially above New Brunswick's per capita physician cost of $22.08. This meant that a federal contribution of $17.50 per capita would pay for almost 80 per cent of the operating costs of Medicare assuming all provinces signed on and the New Brunswick Medical Society did not increase its fees. (p. 156)

(ii) Following Fairclough's *analytic framework*, examining text, discursive practice, and social practice, it is evident that neoliberal economic discourse is prolific in the *text*. As explained in Chapter 1, neoliberal principles include: supporting the purported rule of the free market without state interference; cutting or reducing

government expenditure on social programs like income security, education and health care; reducing government regulation of commerce and services; privatization of state-owned and operated enterprises like banks, transportation infrastructure, schools, and hospitals; and the erosion of social and political commitments to the public good in favor of individualism, individual responsibility, self-reliance, and self-interest (Kirkham & Browne, 2006; Martinez & Garcia, 1997; McGregor, 2001). Within neoliberalism, there is no explicated relationship between economic growth and achieving social equity. Health and social equity are presumed to be created when individuals have a fair opportunity to reach their fullest social and health potential. Within a neoliberal agenda, private responsibility emphasizes individual rights to participate in the economy to the exclusion of collective rights (Armstrong, 2010). Braedley and Luxton (2010) demonstrated that inequalities intensified under Canadian neoliberalism. Concepts of health equity, community engagement and participation, are all prevailing elements in PHC discourse (McGregor, 2001). The ML Report raises concerns about the overuse of scarce resources causing unsustainable escalating costs to the publicly funded system with minor impact on population health outcomes.

At the *discursive practice* level, the ever-growing costs of health care dominated the ML Report. It is against this backdrop of increasing costs for universal healthcare and the fiscal policies of the liberal government of the day that the ML Report was commissioned. Fiscally responsive discourse of "achieving better value from the current level of funding" (p. 2) is evident throughout the document. The *Introduction to the Report* highlights that between 1975-1985, per capita public and private expenditures on health care in New Brunswick had increased 235% from $413 to $1,383 per person (p.

11). This was the largest increase recorded by any province in Canada. The ML Report focuses on three areas of substantial increases: hospitals, physicians, and drugs. Spending on hospital care had increased in the decade under study from $287.6 million to $445.3 million, an increase of 54.8% (p. 12). From 1982-1988, physician services, paid for under the medical care program, had risen by 52.1% from $94.9 million to $144.3 million, and the NB Prescription Drug Program increased at an average annual rate of 11.4% (pp. 12 - 13). The Liberal McKenna government was intent on reducing the size of government, balancing the provincial budget, reining in expenditures on social programs like health care and education, and privatizing state-owned and operated enterprises like power utilities and infrastructure (Lee, 2001). This neoliberal agenda of reducing government expenditure on social programs and focusing on job creation, developing public-private infrastructure projects, and ignoring the relationship between economic growth and social equity was the foundation of the then Liberal government responsible for commissioning the ML Report.

The discursive practices of NB policy makers in constructing the ML Report demonstrates their preference for using neoliberal discourse to engage questions about the reform of PC in the province. In proposing the reform of PC, they specify four distinct influential or power groups in NB, identified in the document as: the New Brunswick Hospital Association, representing administrators of the system; the New Brunswick Medical Society, representing physicians; the New Brunswick Pharmacists' Association; and the Nurses Association of New Brunswick (p. 2). The report states that these "four major provider groups involved in the delivery of the programs which are reviewed can either facilitate or impede change in health services delivery" (p. 29).

At the *social practice level*, the structure that universal health care was predicated on and the ensuing power and subsequent social practice afforded to hospitals and physicians within that structure, is challenged frequently throughout the ML Report. Physicians are highlighted as being primarily responsible for accelerating costs because of their gate-keeper function within the system: "[Physicians] admit to hospitals, prescribe medications and order diagnostic tests" (p. 31); "Ninety-nine percent of the services covered by Medicare in New Brunswick are provided by physicians. Decisions made by physicians make the entire system work" (p. 31). By explicating the role of physicians, the ML Report is inadvertently recommending that health service planners and policy/decision makers engage physicians in reform efforts as their decisions are viewed as key to the control/operation of the entire system. The ML Report further suggests that health policy experts should see it as the "physician's responsibility to society to bring the costs of health services under control" (p. 32). However, the Report acknowledges that physicians do not see this as their role, they see themselves as "the patient's advocate… [and] sees his responsibility as being primarily to the patient" (p. 32).

The discourse of neoliberalism in the ML Report intersects predominantly with the prevailing wording, statements, and assumptions of the discourse of PC, and less so with the discourse of PHC. When considered together, nurses and physicians were typically considered as a dominant group, both positioned as providers of medically oriented health care within the discourse of PC at that time. Most of the work of nurses was contained within the acute care sector, in medical office roles of PC physicians, or as providers of rehabilitation or skilled long term care. The recommendations in the ML

Report for more PC nurses working within a more independent role in the community, was consistent with an attempt to move nursing resources away from the high-cost service provision found in acute hospital care.

There was an awareness at this time by some policy makers that NPs were being considered to replace the older concept of "outpost nurses" as new sources of PC (DiCenso, Auffrey, Bryant-Lukosius, Donald, Martin-Misner, Mathews, & Opsteen, 2007). Between 1970 and 1983 approximately 250 NPs were working in mostly remote northern areas or in rural CHCs, which were usually not-for-profit organizations, governed by a community-elected board of directors, that provided "primary health care and health promotion programs for individuals, families and communities" (p. 105).

It is here that neoliberal discourse in the ML Report begins to intersect with the discourses of PC and PHC. Recommendations 21, 22, and 23 demonstrate this intersection, detailing the expansion of community based PHC programs, offered outside of the acute care sector in CHCs, and by a less expensive health care provider than a physician, a "primary care nurse" (p. 113). These three recommendations speak to elements of the discourse of PHC by highlighting CHCs' contribution to the broader health of the community.

Many of the problems and solutions described in the ML Report are related to the increased costs of providing health care. Significant prevailing discourses in the document (e.g., fiscally responsive, physician directed, hospital/acute-care-focused, provider centric), reflect the power structures, interests, values, and ideological perspectives of PC and the interests of four dominant and influential professional groups within the health care system. These four dominant groups are identified as physicians,

nurses, pharmacists and hospital administrators. Neoliberal political epitomes of rationalization and cost-cutting are embedded within a call for reform of these "provider-centric" structures, suggesting that if the province continues to view health as primarily individual diagnosis and treatment (i.e., PC), there will be no money left to support large scale policy direction that improves population health initiatives like income-support programs, housing, and education all of which are included within the discourse of PHC.

There is also a discourse thread beginning early in the ML Report under *Environmental Considerations*, that lays some responsibility for rising health care costs on consumers of health care themselves: "Since the public sector funds hospitals and medical service costs and federal legislation reinforces this, both patients/consumers and providers have been largely 'isolated' from direct awareness of costs" (p. 8). In addition, the Report speaks to the broad availability of medical information and the growing confidence of patients/consumers to understand and manage their health challenges, which leads to a consumer-driven demand for the "newest and the best" in relation to technology, investigation, surgical intervention, pharmacology, and rehabilitation (p. 32). Here physicians are characterized as erring "on the side of excess service provision in response to patient /consumers' expectations" (p. 40). This reference to the individual as a consumer of health care rather than a citizen entitled to universal health care is consistent with a neoliberal political agenda (Raphael, 2008): It aligns with the discourse of PC being the entrance point to the health care system and the physician characterized as the gate-keeper of that system.

Another element of patient/consumer responsibility for rising health care costs in the ML Report is described through a health promotion discourse: "The extent of

utilization and costs of health care will be determined by the effectiveness of efforts to improve lifestyles and risk exposures" (p. 101). This discourse is concerned with people neglecting their health and engaging in unhealthy behaviors like eating "junk food," smoking, being overweight, and avoiding exercise. The emphasis is on "a reliance on healthcare institutions such as emergency departments as a substitute for people not looking after themselves" (p. 102). This focus on individualistic lifestyle concerns is aligned with a neoliberal approach to policy development where issues of social equity are silent, and the importance of developing health promoting public policy and strengthening citizens' ability to influence the social determinants of health are neglected (Raphael, 2008). For example, the ML Report recommendation #7, speaks specifically to personal responsibility for rising health care costs: "Initiate innovative approaches to health care which are sensitive to the diverse needs of the province and which foster personal responsibility for health, the appropriate use of resources by individuals and health professions" (p. 110).

The ML Report takes up the discourse of PC to address how physicians controlled the health care system. As mentioned above, at the time of the ML Report, physicians were exclusively the entry point to the health care system, they controlled access to hospital programs, including diagnostic and intervention services such as specialty care, surgery, rehabilitation, and pharmaceutical treatment. It is notable that while the ML Report was suggesting that physicians had too much power, with little oversight, the WHO (1988) was using the discourse of PHC to offer variations to this physician exclusivity and shifting of the power structure:

> Let us point out what PHC is not:

it is not primary medical care;

it is not only first contact medical or health care;

it is not only health services for all;

and what it is and does:

it is intended to reach everybody, particularly those in greatest need;

it is intended to reach to the home and family level, and not be limited to health facilities.

it is intended to involve a continuing relationship with persons and families. (pp. 15-16)

A shift like this, away from inpatient to community-based care, is a dominant deinstitutionalization discourse and emerging social practice that also becomes evident throughout the ML Report. Prior to this time and in ongoing years, the WHO (1988, 1998, 2003, 2008) began and has continued to take up the discourse of PHC to challenge assumptions and social practices of neoliberalism in health care planning. Significantly, the 1986 Ottawa Charter for Health Promotion also spoke to building health care systems based on the principles of "equity, disease prevention and health promotion" (WHO, 1986). Hospital care, the only other type of care outside of a physician's office, covered under Medicare, is highlighted in the ML Report as inappropriate care for many. It underscores that there is "too much focus on expensive institutional care by those disabled by illness/disease" (p. 27) and an "unnecessary dependence on the acute care hospital system" (p. 35). The solutions proposed in the ML Report do involve a move to community-based care, a care environment that is perceived in the document as being less dominated by physicians and expensive acute hospital practices.

The discourse of neoliberalism in the ML Report, however, challenges the then-current arrangements of PC in NB without embracing the assumptions of PHC. It frames community based arrangements as providing "client centered care," maintaining that "programs and services should primarily reflect the interests and convenience of those who need them rather than those who provide them" (p. 44). However, while the discourse of PHC emphasizes the importance of community-based engagement, health equity, participatory models of care, and a focus on the interests of citizens who need them, these and other assumptions of PHC are not strongly represented in the ML Report. PHC discourse (as exemplified in the WHO analyses) critiques prevailing medical hegemony for failing to achieve social justice and health equity in a democracy. In contrast, the discourse of neoliberalism is used in the ML Report to present neoliberal challenges to the hegemony of biomedically oriented primary "medical" care, without addressing health equity and social justice. In short, whereas the Report proposes revisions to PC, it falls short of calling for PHC, calling for greater access to a wider range of health providers and health practices in order to control costs.

This analysis of text, discursive practices, and social practices demonstrates the intersections between neoliberalism and the discourse of PC, with less evidence of the presence or influence of the discourse of PHC. As an example, the ML Report harmonizes discourses of neoliberalism and PC in its recommendation for the introduction of CHCs, which it states have the "potential to improve access to health care, to enable introduction of a multi-disciplinary approach to primary care and to increase the provision of health promotion services" (p. 67). In this, the ML Report demonstrates intersecting commitments to PC and neoliberalism through the expansion of access to PC

in CHCs, as a way to achieve cost containment. The Report similarly demonstrates neoliberal assumptions about the benefits of health promotion as decreasing costs through disease prevention. Less evident (or missing) are more progressive sociopolitical assumptions about how PC could be organized within the context of PHC to support and achieve health equity, through outcomes that address the social determinants of health—a position that would be consistent with the discourse of PHC.

The proposal for CHCs is an important focal point of the ML Report. As part of the staffing of the CHCs, the report makes an additional recommendation for having "primary care nurses as an initial point of contact for persons seeking care" (p. 68). The report also recommends the hiring of primary care nurses for existing Health Service Centres (HSC), which were established in the previous decade as a physician recruitment incentive for rural communities. Primary care physicians being recruited to work in these HSCs were provided with a turn-key operation of office space and staffing for a small fee per patient ($1.50) back to the hospital corporation. The ML Report recommends "that the essential, full-time staff involvement in the Health Service Centres be well-trained and experienced primary care nurses" (p. 68).

It is important to note that at the time of the ML Report (1998), professional nomenclature or established "text" in the profession of nursing in Canada did not formally or widely refer to "primary care nurses." At that time, text, discursive practice, and social practices in nursing referred to what were then called "enhanced" or "expanded" nursing roles in rural, or remote areas, sometimes referred to as "outpost nurses" (RNs). Established in Canadian nursing during the late 19th and early 20th centuries, the social practice of outpost nurses were understood as improving access to

medical care in remote and underserved communities" (Staples et al., 2016, p. 3). There, registered nurses worked at the first point of access to health care in the absence of accessible physicians. They also practiced what is now called "primary health care nursing" through community engagement (Staples et al., 2016, pp. 7-8). The use of the term *primary care nurses* in the ML Report demonstrates the discursive practice of using text found within the discourse of PC to refer to registered nurses, now APNs, who are represented as increasing access to medical care, including in rural areas. In subsequent decades, these "enhanced practice" nurses would be prepared at the master's level and registered in Canada as *primary health care nurse practitioners*. This example of PHC discourse being taken up in advanced practice nursing is an important part of the history of PHC discourse in NB (and in Canada). Most recently (currently) there is continuing evidence that both terms, "primary health care nurse practitioners" and "primary care nurses," coexist in professional nursing literature in Canada (Martin-Misener et al., 2020).

Another recommendation in the ML Report of establishing CHCs, (a) speaks to two pilot sites, (b) sets lower costs as a priority, and (c) positions these Centres as defaults to status quo primary care in a physician's office or the hospital emergency department. Recommendation #21 states: "that the communities be selected on the basis of limited local access to general practice physicians, or problems of access for certain groups within the population (possibly as identified through abnormal use of urban hospital emergency department)" (p. 113). An additional subset to recommendation #21 details how a community board be established to plan these CHCs and to evaluate the "effectiveness of primary care nurses as an initial point of contact for persons seeking

care" and "the effect on utilization of Medicare and the cost of primary care" (p. 113). Although the solution identified is congruent with the evolution of some aspects of PHC discourse, the problem this recommendation addresses is growth in health care expenditure. The implementation of what may be perceived as physician "substitutes," i.e., "primary care nurses," in this report is about reducing labor costs and eroding the power and privilege of physicians as expensive gate-keepers, another intersecting point of neoliberal and PC discourse. The "problem" is not framed in terms of addressing health equity directly or intervening to address the social determinants of health, as it would be framed within the discourse of PHC.

(iii) Following Bacchi (2016), an analysis of how "the problem" is represented in the ML Report shows how specific policy priorities come together in constituting "the real" political agenda (p. 11). According to Bacchi, "What is of most interest and concern are continuities within policies, across statements of "problems" and "solutions" (p. 11). The presuppositions or assumptions underpinning the representation of the *social problem* include the growing public debt and the negative legacy of transferring this debt burden to subsequent generations (children and grandchildren). The growing public debt is characterized as occurring because of reduced federal grants, an increasing percentage of provincial revenues being spent on health care services (25% at the time), provincial taxes being the highest in the country, and a public expectation that the government match services and pay scales of more populous and prosperous provinces (p. 24). The ML Report states that in 1989, the conditions under which NB had entered the national universal health care program were no longer evident. Federal transfers were covering

approximately 40% of expenditures and costs for physician care, hospital services and pharmaceutical programs were growing at rates greater than inflation.

The problem of increased spending on the health system outpacing an ability to intervene on other determinants of health is another neoliberal cost-cutting discourse running through the ML Report. The "determinants of health" listed in the Report include: "genetic endowment, accidents, catastrophic environmental events, environmental factors, income, housing, education, family structure, lifestyles, social structure, public health services, and health status of those one lives or associates with" (p. 27). These are subsumed in the generic term "social determinants of health" throughout the document and are referred to in neoliberal discourse as becoming a precarious source of concern because of uncontrolled health care costs. This differs significantly from the discourse of PHC, which focuses on the social determinants of health as a matter of health equity. The WHO was defining the social determinants of health in 1998 using a health equity discourse of social justice. Between 1998 and today, the WHO has redefined the social determinants of health but always explicitly continues to focus on them using the discourses of health equity and social justice in PHC (WHO, 1988, 1998, 2003, 2008, 2018).

According to the ML Report, the goals for achievement of economic and social policy areas are dependent on controlling costs of health care, which were predicted to outpace the ability of the province to invest in the other programs: "If the spending on the health care system gets out of proportion, the financial ability to intervene regarding the other determinants of health is reduced" (p. 28). The ML Report does not consider how the health care system itself might productively be organized to address the social

determinants of health, as would be consistent with the discourse of PHC. The ML Report is largely silent about how health care reform should be organized to address health inequity and to complement economic and social policy goals. The ML Report is also silent about (does not discursively address) the possibility that economic and social policies have historically contributed to inequities in "population health"—a view that would be more consistent with PHC discourse. Though the document does eventually consider the social determinants of health in a cursory discussion, it demonstrates minimal text, discursive practice, or discussion of social practices in health care that are or could be related to the goals of PHC—namely intersectoral action and community engagement, positioned to address health and social *inequity*.

The prevailing cost-reduction discourse is evident throughout the section of the ML Report titled "Limitations of the Health Care Delivery System": "There is mounting evidence that the current emphasis on the medical model of diagnosis and treatment is not producing, and will not produce on its own, the level of population health that is possible" (p. 27). Bacchi (2016) proposes that analyzing "solutions" provides insight into what the "problem" is represented (constituted) to be (p. 11). The solutions proposed for these rising costs include: a controlled number of physicians, predictable salaries for physicians versus fee-for-service remuneration, the addition of *primary care* nurses, a move to more (and less costly) in-home and community-based services, health promotion and education programs, and individual primacy versus physician primacy. These proposed solutions reflect synchronized text and discursive practices influenced primarily by neoliberalism and the discourse of PC.

(iv) In terms of *discourse direction* – emerging discourses in this document include sparse and superficial references to the social determinants of health, described as "thirteen variables, many of which are influenced by public policy and have an effect on individual and hence population health outcomes" (p. 27). Also emergent are negligible references to *population health*, defined as "actions that produce a healthy population" (p. 39). In deploying a *population health* discourse, health care services are related to population health as follows: "the primary reason for expenditures on health services is to improve population health, yet the current emphasis on diagnostic and treatment services will not produce, alone, the level of population health status that is possible" (p. 39). In this ambiguous discussion, improving population health is framed as being unachievable under current service models that emphasize medical diagnosis and treatment. Neoliberalism is the predominant discourse, i.e., containing costs of PC and an emphasis on individual responsibility for health promotion. The document is silent about the ethics of achieving population health as a matter of health equity, as would be the case in a predominant discourse of PHC.

Health promotion is another emerging discourse in the ML Report. This discourse is found in sections that call for more community-based care and the establishment of community boards to implement and evaluate CHCs. Staffing models where physicians are salaried and PC nurses are the first point of contact emerge as cost effective attributes of a community-based vision of care. This is another example of neoliberal and PC discourses positioned around cost control. An emphasis on community-based care also includes converging discourses of *health promotion*, *healthy lifestyle choices*, and the

need for public policy to shape *population health*. These converge and are all represented within a number of the Report's recommendations.

For example, five of the ML Report's 64 recommendations reflect a political agenda dedicated to *population health, health promotion,* and/or *healthy lifestyle* discourses. Key among these is the establishment of a New Brunswick Premier's Council on Health Strategy. Recommendation #6 proposes that:

> A Premier's Council on Health Strategy be established, to be chaired by the Premier. Other members should include four ministers (one of whom should be the Minister of Health and Community Services who should be the vice-chairman), representatives of five provider groups (physicians, nurses, hospital administrators, pharmacists and community health service groups) and five consumer representatives of whom one should be a representative of labour and one a representative of hospital trustee. The mandate of this Council will be to select specific goals to achieve improved health of New Brunswick's residents and establish specific targets and priorities which can be measured, evaluated and implemented. (p. 110)

Recommendations #6-11 detail a policy agenda to create the New Brunswick Premier's Council, a recommendation that functioned as a precursor to the New Brunswick Health Council; several aspects of these recommendations were instrumental in eventually advancing the discourse of PHC. First, the Premier's Council included the Premier and four other Ministers and was charged with "initiating specific public policy actions which are required to improve the health of New Brunswick's residents including health promotion and those which are beyond the traditional jurisdiction of the formal

health care system" (p. 110). This discourse is aligned with WHO PHC discourse of a "whole of government approach" aiming for a "health in all policies" (WHO, 2008, p. 70). According to the WHO (2008), government system policies that need to be in place to ensure that PC is well-positioned within a PHC policy framework include:

- systems policies serve as building blocks to support universal coverage and effective service delivery;
- public health policies to address priority health problems through cross-cutting prevention and health promotion; and
- policies in other sectors – contributions to health that can be made through an intersectoral collaboration. (p. 64)

The extent to which the ML Report recommendations begin to converge with these PHC elements is complex. First in the Report, there is discursive movement away from earlier neoliberal perspectives about traditional delivery systems. This divergent discourse includes a strong critique of the traditional practice of PC in physicians' offices. There is an equally strong critique and diverging discourse away from the notion that hospitals, as influenced by physicians, can contain costs or be effective in achieving population health. These diverging discourses are combined with the promotion of multidisciplinary teams specifically mentioning *primary care nurses* versus the physicians-as-gatekeeper model. At the same time, neoliberal discourses of regionalizing traditional health care delivery systems are also proposed that diverge from a strong PHC discourse—for instance, the amalgamation of hospital services in Regions 5, 6, and 7 to save costs in acute care. These diverging proposals are positioned in contradictory ways that take up only isolated elements of PHC discourse. For example, while the

recommendations propose the promotion of more community driven health services like CHCs with community governance, they diverge away from addressing structural sources of health disparity, including income inequality, food and housing insecurity, and other social determinants of health. It is important to note that the reference in the ML Report to the social determinants of health is positioned more as a background issue to provide some contextual justification for curbing health care costs versus a precursor to what is now referred to as health equity.

In general, although it can be argued that the ML Report laid the foundation for advancing PHC discourse in NB, that groundwork was complex and sometimes contradictory. The introduction of the Premier's Council was the first attempt to address priority health problems through an all-government approach, soliciting representation and collaboration from those priority groups thought to be most influential in making the structural changes that were deemed necessary for planning the future development of the health care system. This can be seen as consistent with key elements of PHC discourse. However, the predominant neoliberal discourses of cost-reduction, rationalization, cost effective access to PC, and medical power erosion are predominant throughout the document and in most of the 64 recommendations.

The emerging discourses of community-based health services, multidisciplinary teams, salaried health care providers, and increased recognition of what would later be formally titled *primary health care advanced practice nursing* did effectively pave the way for the introduction of primary health care NPs. However, there are intersecting convergences coupled with disarticulations between PHC and PC discourse that meander throughout the ML Report. This pattern highlights the ambivalence and ambiguity about

PC and PHC discourses that appear to be present in the context at the time. This pattern eventually shows up in converging and diverging discourses concerning the role and primary function of PHC Nurse Practitioners.

Document 2: *A Discussion Paper: For the Health of our Communities* (1995)

The document, *A Discussion Paper: For the Health of our Communities*, was authored by the New Brunswick Nurses' Union (NBNU) in 1995, seven years after the release of the ML Report. This Discussion Paper, hereafter identified as DP, proposes a process for enhancing PHC in NB. The DP delves into the concept of CHCs and "attempts to answer questions about why they would and should work" (p. 15).

(i) From a *historical significance* perspective, the DP was championed by NBNU president, Linda Silas Martin, who today is president of the Canadian Federation of Nurses' Unions. The use of the term "primary health care" by a provincial nurse leader at the time, was a significant divergence from the more established terminology of "primary care" used provincially to describe services delivered outside of the traditional acute care setting. That same year, a similar document was commissioned by nursing labor leaders in three provinces: the British Columbia Nurses' Union, the Staff Nurse Association of Alberta, and the New Brunswick Nurses' Union. The national discussion paper that emerged from these collaborative efforts, titled *Community Health Centres: The Better Way to Health Reform,* called for "a bold new direction for health care system reform in Canada" (Rachlis & Kushner, 1995, p. 2). It championed the case for strengthening PC through the creation of a network of CHCs in each province. This national paper diverges from the (NBNU) DP's emphasis on PHC by emphasizing different approaches to PC as the foundation for reform: "Many primary health care services could be performed by

non-physicians but, there are very few opportunities for nurses and other types of health professionals to work in primary care" (Rachlis & Kushner, 1995, p. 7). In this quote, the convergence of PC and PHC discourse is explicit, perhaps suggesting that PC could be delivered by more nurses if it were situated in a system of primary health care.

The DP consistently uses PHC discourse throughout. Intertextuality is evident in the DP, found in citations from the ML Report and the Premiers' Council on Health Strategy. These texts are referenced as foundational for the proof of concept which introduced the CHC pilots in the McAdam and East Restigouche areas of the province. Based on the reported success of these pilots, the DP advocates for the development of a network of CHCs throughout New Brunswick. The ML Report strategically recognized the important role of organized labour and invited response from them when it included a representative from this stakeholder group in the creation of the New Brunswick Premiers' Council on Health Strategy (p. 110). Although the DP references the ML Report, it does not subscribe to the PC and neoliberal discourse evident throughout the ML Report. Rather the DP adopts a more populist discourse, though one that was explicitly progressive populist supporting PHC, which would have been expected from a union-based perspective in nursing at that time.

Populism has been defined as a political discourse and an ideology representing politics and society as structured by a fundamental antagonistic relationship between "the elite" and "the people" (DeCleen & Stavrakakis, 2017). At the time and in the context of the release of the DP, a progressive populist perspective was provided by the nurses' union. This was a kind of populism that made sense then and in that context, in that the foundational principles of unions are generally "to improve the working conditions for all

workers, to reduce their exposure to material hazards, work-related stress, and health-damaging behaviors" (WHO, 2008, p. 82). In this instance, the nurses' union was, importantly, representing the professional interests of nurses by advocating for PHC in the DP as a practice condition in NB. This is similar to Fraser's (2019a) ideas about redistribution and recognition as topics through which 'progressive populism' can take effect both subjectively and objectively, reach people and change conditions related to social uncertainties felt by large parts of the population and the struggles discriminated groups face to assert their rights. Unions can be integral in asserting those rights and balancing power between employees and employers, which becomes even more pronounced in market-dominated political economies where public health policy tends to favor the dominant classes, like physicians (Raphael, 2009).

The DP follows on the heels of the provincial creation of eight hospital corporations replacing local community oversight of the previous 22 hospitals throughout the province. It proposes four steps "to facilitate the implementation of mechanisms for improving primary health care at the community level" (p. 6). These steps provide a blueprint for the creation of a network of CHCs throughout the province by: presenting a governance model; emphasizing that programs offered within each CHC be based on an assessment of the community's needs; that other services already offered in the community such as public health, mental health and social services be gradually incorporated into these organizations; and that these CHCs promote multidisciplinary service delivery and teamwork with a "realistic" role for nurses (p. 6).

(ii) In accordance with Fairclough's (2005) *analytic framework,* discussion papers treated as text, have a distinct purpose, i.e., to identify trends and opportunities in a

particular domain or sector and usually to set forth a proposal to address the opportunities (Collins, 2020). Whereas the ML Report recommended several opportunities for the nursing profession, the DP expands upon these opportunities citing a more efficient use of nurses within a CHC model. However, despite a more progressive populist discourse in the DP, the neoliberal discourse of fiscal responsibility is reiterated: "Community Health Centre patients cost 10-30% less than comparable patients served by traditional services" (p. 2) and "Better primary health care will save lives and money" (p. 5). Although the words and phrases used most frequently throughout the DP include similar words and phrases used within the ML Report, the discourse is presented more prominently as PHC discourse. In addition to the explicit use of the term *Primary Health Care,* examples of PHC discourse found in the DP include: consistent references to health promotion and illness prevention, community based health and social services, multidisciplinary teams, and care coordination regardless of whether health problems are biological, behavioral, or social.

Of significance in the DP text is the explicit predominant use of PHC discourse versus the predominant use of PC discourse in the ML Report. PHC is defined using the 1978, WHO definition that "Primary Health Care is essential health care made universally accessible to the community, by means acceptable to them, through their full participation and at a cost the community and country can afford" (p. 4). There is also a recognition by WHO of the effect of "social, economic and environmental factors" on health (p. 4). Opportunistically, the paper outlines some key labor issues which "need to be considered as changes are implemented" (p. 6). These include responsibility for "workforce adjustment, the transfer of employment, seniority and training, and the need

for diploma-prepared nurses to have their years of experience and skill recognized by the community sector" (p. 6).

The *discursive practice* level can be approached in various ways, including the social action in which the text is embedded. In this analysis, I focused on intertextuality, noticing what and how other texts are incorporated into the DP. The DP further develops recommendations made in ML Report around CHCs by describing how they could be established and governed, providing concrete options for their establishment: "Each hospital corporation should become a regional health authority with responsibility for governing the public funds for the spectrum of services in the system" (p. 6). Other jurisdictions' positive experiences operating CHCs are shared as additional examples of established success, for example, "In Quebec, each CLSC serves an average of 40,000 people, although some CLSCs in Montreal have a catchment area of up to 100,000. Ontario CHCs have catchment areas from 10,000 to 70,000 people, with each serving about 5,000 primary care patients on average" (p. 8).

The DP also strategically uses quotations, ranging hierarchically, from the NB Premier's Council to the Minister of Health and finally the Premier. These quotations add political perspective to complement the positions being promoted in the text, namely an expanded role for nurses: "The New Brunswick Premier's Council's 1992 report *Community Health Centres,* called CHCs an ideal vehicle for introducing an enhanced role for nurses" (p. 6), and included a quotation from the then-Minister of Health: "Health means too many things to different people. The system is bulging at the seams because it tries to be all things to all people" (Hon. Russell King, M.D., September 1993, p. 7). And from the Premier of the day:

> Health Care Professionals must be dedicated in becoming a client oriented delivery system. You must think in terms of quality, and you must think like the customer [emphasis added]. We must realize that your patients…our taxpayers…are really consumers of government services. (Premier Frank McKenna, March 1995, p. 15)

The intertextuality contained in these quotations affirms complex discursive practices used to persuade diverse audiences about the advantages of community-based PHC. The weaving together in this document of neoliberal, PC, and PHC discourses in different arguments for PHC is ultimately aimed at the establishment of a network of CHCs in the province. These CHCs will eventually feature prominently in the role of primary health care nurses. The vision articulated in the DP is for additional training in primary health care for nurses to assume an advanced nursing role in communities. That role is now recognized and regulated in Canada among primary health care nurse practitioners (PHCNP). Additionally, in the DP, there is a call to Faculties of Nursing to create post-graduate courses in primary health care advanced practice nursing and to "examine the potential of the nurse practitioner-whose training program is now being restored in Ontario after an eleven-year hiatus" (p. 13).

At the *social practice* level, the promotion of community-based care in CHCs and an enhanced role for nurses is a predominant discourse throughout the DP. It was the beginning of a vision for reforming PHC in NB. I have included references to the national discussion paper, also advocating the CHC model of PHC. I include these references to exemplify, that even though Linda Silas Martin was an author on both the national discussion paper and the provincial one, the tone is significantly different in the

provincial (NB) DP. As referenced earlier, the national text does not textually describe any other dimensions of roles for nurses except "primary care nurses" (Rachlis & Kushner, 1995, p. 11). It is more physician "centric," and PC (in the sense of being oriented to first point of access to care) is the dominant discourse applicable to physicians with nurses in the traditional subservient role. The national discussion paper also references a historical time in Canada when there were many different types of caregivers, "nurses and midwives plied their trades alongside traditional medical doctors" (Rachlis & Kushner, 1995, p. 24). In contrast to more recent historical analysis about the origin of PHC NP's among "outpost nurses," the national discussion paper (Rachlis & Kushner, 1995) focused on a historical analysis of how physicians exerted their power and privilege over other practitioners:

> In the late nineteenth and early twentieth centuries, physicians succeeded in convincing the provincial licensing authorities that more exclusive regulation of health professionals was required to protect the public. Nurses and other professionals found that their scopes of practice were defined by the medical profession. (p. 24)

The dominant discourse in the DP is PHC, with emphasis on an enhanced role for nurses. The tone is collaborative with minimal focus on the discourse of primary (medical) care or medical hegemony. The term "enhanced nursing role" found throughout the DP, was then frequently used when referencing the earlier history in Canada, where registered nurses provided extended access to *primary care* in northern and isolated areas like the Northwest Territories, parts of Labrador, Newfoundland, Ontario, and Quebec (Staples, Ray, & Hannon, 2016). The "enhanced practice" wording is understood to refer

to that period when nurses could provide this kind of extended PC without advanced degrees. In the period when the DP was created, however, Canada was moving to establish regulatory authority for NPs--eventually requiring their completion of an advanced (masters) degree in nursing.

It is important to point out that in 1995, Canada led the way internationally in establishing a mandatory requirement for all RNs to earn a baccalaureate degree. In the 1970's, NP practice first emerged in Canada among registered nurses, usually involving certificates of relatively brief training with physicians. In later decades, NPs practiced in both acute care and in community settings. Legislation and regulation accompanied this history in Canadian provinces, eventually resulting in a requirement for master's level education in nursing. In 2002, New Brunswick moved to establish the master's degree as a minimum educational requirement for advanced practice nursing. Beginning in 2002 and beyond in NB, RNs holding a master's degree in Nursing in Primary Health Care were registered to provide advanced practice nursing, and their registration was titled (under regulatory authority) Primary Health Care (PHC) Nurse Practitioner.

The history of these events demonstrates how the discourse of PHC played a role in changing the *text* from *enhanced nursing practice* in Canada and in New Brunswick to *primary health care advanced practice nursing*. The DP reflects an important historical moment when elements of the discourses of PC and PHC converged in that nursing text. That history illustrates how converging and diverging discourses can intersect in real social practices. The analysis also demonstrates how ongoing ambiguity surrounding the meanings of PC and PHC eventually were taken up and addressed in the profession of nursing, in this case, using regulatory authority (power) to establish professional

privilege. In the present context, primary health care nurse practitioners (PHC-NP) practice in all 10 provinces and territories in Canada (Donald et al., 2010). This recognition of PHCNPs provides important evidence of how discursive practices involving PHC influenced social practices in Canadian nursing.

(iii) The representation of the *problem* in the DP emphasizes "current fiscal challenges" (p. 1). The proposed solution to the problem is a process for "enhancing primary health care" and involves creating a provincial network of CHCs staffed by multidisciplinary health teams, including PHC nurses with advanced training. The DP reframes the neoliberal political discourse of the day by demonstrating the cost-effectiveness of CHCs as a model of PHC and suggests a community needs-based approach to program planning.

(iv) Textual analysis of the *discourse directions* in the DP illustrates emerging, converging, and diverging discourses within the document. Emerging discourses include the convergence of PC and PHC with the proposed expansion of the concept of "primary care nurses" (mentioned in the ML Report 1989, p. 103), as well as an advanced role for "primary health care nurse practitioners" (p. 13). The DP outlines an expanded role for re-trained hospital and other nurses to become primary health care nurses working within community-based multidisciplinary teams. The introduction of PHC Nurse Practitioners in an "expanded primary health care" role and a recommendation for a nurse practitioner educational program in NB is another emerging PHC discourse. The concept of "specific programming content based on an assessment of the community needs" (p. 1) and the development of a network of CHCs were emerging discourse threads that garnered support and were implemented in subsequent years.

Converging discourses of PC and PHC are represented in the DP within the role described for primary health care nurses. The DP states,

> Nurses wanting to work in collaborative practice with family doctors in a CHC may need additional courses to enhance their physical assessment skills or to learn more about family counselling, problem solving, and conflict resolution or to develop community needs assessment skills. (p. 12)

The early DP description of this expanded role articulates elements of the discourse of PC while also referring to a PHC role. The converging discourses of PC and PHC in the DP are also evident in early visions of the role of staff working within CHCs:

> Staff in CHCs would fall into one of two categories – those providing clinical services to individuals and families and those providing population-based services such as promoting mental health, security, non-destructive lifestyles, safer workplaces, health and hygiene education in schools and a healthier environment. (p. 10)

It is significant that the authors of the DP saw these roles as complementary, i.e., by practicing within the framework of PHC, clinical roles could address population-based services, first point of access to care, and population health.

Diverging discourses within the DP include, once again, a movement away from traditional acute care and resource-intensive delivery systems, like hospitals and physician offices, toward the promotion of multidisciplinary teams, including the roles of community based "primary health care nurses." There is also discontinuity away from the WHO (1978, 1986) analysis in the way this language is taken up in this document. For example, there is no consistent emphasis on elements like income inequality, income

security, food security, housing security and other material components of social justice found in the WHO analysis of the determinants of health. Though these are crucial components of PHC discourse from the WHO perspective, the DP followed closely along the lines of other NB texts at this time by not explicitly addressing the ethics of social justice or equity in health.

The DP also introduced the idea of an enhanced role for nurses within a community-based PHC model of service delivery, CHCs. The proposal was for a provincial network of CHCs with a much broader role of services than is available today. The DP called for a "one-stop shopping" for PHC and social services. The predominant neoliberal discourse of the ML Report of cost-reduction is repositioned in the DP as a rationale for establishing a cost-effective solution with emphasis on PHC being more efficient and effective care and therefore less costly. The emerging progressive populist discourse of amalgamated community-based health services under a community governed board was a recommendation/idea that eventually was not retained in the subsequent establishment of CHCs. However, community needs assessments, multidisciplinary teams, and an increased reference to and emphasis on primary health care nursing were incorporated into the models that were implemented in coming years. This discourse further positioned primary health care as a strategic direction for health care reform.

This divergence from "rural and remote" PC ("outpost") nurses to focus on PHC nurses with expanded roles and subsequent advanced degrees moved the concept and integration of PHC NPs closer to becoming a reality in NB. Although the DP suggests PHC as a framework for health care reform in NB, there is nevertheless ambiguity with

regard to PHC discourse in this document. Consistent with the times, the DP remains largely silent about socioeconomic inequalities that lead to health inequities, although it does reflect important progressive populist elements of PHC. Also consistent with the times, DP does not explicitly address racial justice by focusing on health equity related to race, nor does it address health inequity based on sexual orientation, gender identity/expression, ability, immigration or refugee status, Indigenous decolonization, etc. As such, the extent to which the DP paves the way to a strong PHC discourse in NB is attenuated.

Document 3: *The Future of Health Care in New Brunswick: The Nursing Contribution* (NANB, 1998)

The Future of Health Care in New Brunswick: The Nursing Contribution, is a NANB policy brief, hereafter referred to as PB, presented to the province's Health Services Review Committee. A policy brief is a short concise summary of a social problem or government policy. It is most often offered as a written presentation of an argument or point of view. It usually sets forth main points with supporting precedents and evidence (McIvor, 2018).

(i) Historically, the PB is positioned at a time when a Ministerial task force, the Health Services Review Task Force, was tasked (in 1998) with reviewing all health services and making recommendations about these services to the Minister of Health. More specifically the mandate of the Task Force was to "recommend how to manage, protect and secure health care in New Brunswick" (Trenholme Counseil, 1998). The Health Minister resigned his cabinet post in 1998 and returned to (PC) medical practice. His seven-year tenure as Health Minister was marked by a period of rationalization and

restructuring of the health care system aligned with the neoliberal policy agenda of the governing Liberal administration. In 1999, when the Report of the Task Force was completed and tabled, the Liberal government had been defeated by the Bernard Lord-led Conservatives. The Conservative platform included a commitment to restructure the provincial health-care system to make it "more patient-focused and community-based" (Demont, 2000). As part of his commitment to taxpayers, Premier Lord promised to fulfil 20 campaign promises in 200 days. Included in those 20 commitments, which he did attain, was the creation of 300 new nursing positions and the creation of the Premier's Health Quality Council, accountable for making recommendations around health care restructuring. The PB slightly predated this transition in government. Nevertheless, elements of PHC were evident in the policy directions pursued by the incoming Conservative government.

(ii) From the perspective of the PB's *analytic framework*, the focus of the *text* was to highlight,

> three key issues which hamper revitalization of the health care delivery system: the continued reliance on a medical model of health care delivery, the lack of integration between components of the health care system, and the under-utilization of nurses in alternative delivery models. (p. 1)

Within the PB text, the words, wording, statements, and assumptions that describe problems with the health care system and the proposed solutions for those problems reflect assumptions of PHC. For example, the PB makes 10 recommendations, leading with recommendation #1, "That the government of New Brunswick officially adopt

primary health care as the policy direction for health care delivery in the province" (p. 3), and concluding with recommendation #10,

> That the appropriate legislation be enacted to allow Nurse Practitioners to practice independently in New Brunswick, including the ability to issue prescriptions from an approved formulary, to order and interpret tests from an approved list and to assess, treat, discharge or transfer clients. (p. 5)

The PB text reflects a collaborative discourse aligned strongly with elements of PHC: "involve stakeholders from various sectors, within and outside of health care to design a renewed, integrated system" and "strong alliances between health disciplines are required and partnerships are essential" (p. 1). The PB uses the words "advanced roles" when presenting the logic for the NP role. Intertextuality with both the ML Report and DP is evident in the PB statement on the position that nurses hold in the health care sector: "Nursing is the largest group of health human resources in New Brunswick" (p. 7). This statement suggests that with this number of resources, a certain amount of power within and from nursing should follow to influence the system. Of note, as health policy academic Stephen Lewis (2010) argues, "Nursing's combination of numbers, reputation and reach should translate into power and influence over how healthcare is financed, organized and delivered. Yet politically, the profession punches below its weight" (p. 116).

The PB emphasizes details about three problems with the configuration of the NB health care system: (a) "it is still largely based on the medical, illness, curative model," (b) it is a "hospital-based, physician-driven health delivery model," and (c) "the actual and potential contributions of nurses …. have not been fully realized" (p. 8). These areas

of emphasis are components that are (in part) consistent with emerging PHC discourse. The PB supports the definition of PHC as articulated by the WHO (1978) and provides the associated definition of PHC in full as an appendix to the document. Additionally, an update from the WHO (1997) document is provided that references the WHO (1997) acknowledgement of some of the failures of the original PHC strategy: "Decision-making in the health care sector is still dominated by professional interests that favour curative medicine over preventative and promotive public health" (WHO, 1997, p. 10). The PB speaks to the difference between primary (medical) care (PC), and PHC: "Primary medical care is primary care provided by a physician. Therefore, primary medical care should be seen as one component in the whole spectrum of health services which contributes to Primary Health Care" (p. 10). From here, the PB provides examples of where PC has "been unsuccessful in addressing many of today's major health issues such as cardiovascular disease, childhood injuries, adolescent pregnancy, family violence, and substance abuse" (p. 10). In referencing the WHO (1997), the PB PHC discourse aligns with the WHO's renewed strategy of *Health for All in the 21st Century* (1997), presenting PHC as the text's dominant discourse.

At the *discursive practice* level, or the way in which the discourse is acted upon, the PB argues for how the health care system could be "revitalized" by adopting PHC as a policy direction for health care delivery. The PB asserts that PHC provides a framework for health care delivery "which is accessible, affordable and responsive to the health needs of the communities" (p. 11), and asks, "*What if* we began to think outside the box of prescriptive formulas and, with the courage of our convictions, became more daring in developing creative strategies for new times and new events?" (p. 11).

The PB also questions the role of physicians as gate-keepers to the system: “Is the physician the only logical person to access the system and to manage population health?” (p. 11). In response, the PB poses the following solution:

> *What if* government brought people together at the same table to begin the team building journey at the higher level of the spectrum, at the system’s level? For it will not be an individual, a group or any profession that achieves the mission of a healthier society. It will be the interdisciplinary efforts of many, of those who are willing to make difficult decisions based on the needs of the community rather than the needs of one. (p. 12)

The NANB through its PB, puts forward an endorsement of an integrated system as a key priority to achieving optimal health care delivery: “*What if* our health care system were more integrated and brought down barriers between sectors and disciplines? *What if* more resources were dedicated to wellness programs in communities?” (p. 11). The PB points to PHC as a framework for improving integrated services:

> In many ways the Primary Health Care concept paves the way for the integration of all components of the health care system integration…(and) is the next logical transition for health professionals and the service delivery system to meet the complex health needs of the general population. (p. 13)

The PB proposes broad-based collaborative practice, integration of health services, continued movement toward more community-based services, and the refocusing of health care spending as solutions to the health-system fragmentation: “With an integrated health care system, we can begin to understand the bigger picture in terms of the range of services, costs and outcomes” (p. 14). With this statement, the PB may be suggesting that

the scale of PHC reform is so significant that it cannot be fully understood (or supported) until some components, i.e., integrated services, are realized as a first step. It also argues that the framework of PHC is necessary to support reforms in NB, in ways that do more than simply identifying a different gatekeeper or bureaucratically engineering an integrated system of access to PC.

In broaching the topic of the scale of reform needed to achieve PHC, the PB points toward wider population health concerns. Those concerns are articulated by addressing three key population groups: "women, children and youth, and the elderly" (pp. 16-18). In relation to these population groups, the PB speaks to "consequences to the fragmentation of the health care system, one of which is the risk that the needs of certain population groups will be overlooked" (p.16). According to the PB, "women have a unique relationship to the health care system because women serve as *health guardians* of their families" (p. 16). The PB continues on to describe the role of women as informal care givers and addresses other equity issues, including, "In comparison to men, women in Canada earn significantly less, suffer more chronic and debilitating diseases, and present lower levels of self-esteem. They far outnumber men among seniors, single parent families, and the poor" (p. 16). It is for these reasons that the PB recommends that gender be added to the list of "key determinants for health" (p. 16), an observation that was consistent with later updated revisions to the social determinants of health by the Public Health Agency of Canada (2021).

Children and youth are depicted in the PB as a vulnerable group because of "the large number of them living in poverty" (p. 17). According to the PB, a "Primary Health Care model, where it is being implemented, leads to the creation of initiatives in each

community to assist families who live in poverty" (p. 17). In making explicit the need to address population health among these age and socioeconomic groups, the PB takes up key elements of health equity in PHC discourse. According to Raphael (2009), "Health inequalities result from social inequalities and a public discourse that justifies these inequalities" (p. 146). The incorporation of these target groups into the PHC discourse of the PB, aligns with social justice discourse rather than the neoliberal discourse of the ML Report. As per Lewis (2010), "Medicare has always been and will always be about politics, its core idea is distributive justice" (p. 116).

The inclusion of target populations in the PB and the statement that "gender be added to the list of social determinants health" (p. 16), positions NANB as an invested stakeholder in addressing distributive and social justice by reducing health inequities, emphasizing the social determinants of gender and age. In relation to making explicit this concern about health equity, Browne and Tarlier (2008) note, "One of the most significant consequences of current neoliberal policy … is the powerful association between neoliberalism and increasing inequities within our communities" (p. 88). The PB positions NANB in ways that speak to the "feminization of poverty" (Jaggar, 2002, p. 428) through its recognition of these social inequities. As an organization representing a predominately female labour force, NANB's focus on gender in this document positions it within a critical social justice perspective, to advocate for health care reform grounded in PHC. This text in the PB suggests that NANB had a vision for reform that was conveyed first as a matter of caring about and for vulnerable populations rather than being focused first or primarily on preserving power and control. As per Hanlon, Reay, Snadden, and MacLeod (2019) "the way actors talk about health care, and their

positioning within it, exerts an influence on the material practices of health care delivery and reform" (p. 52).

Against this social justice backdrop, the conclusion of the PB is nevertheless dedicated to a "strengthened role for nurses in the delivery of health care" (p. 23). This strengthened role is characterized as "advanced practice nursing, an increase in the number of clinical nurse specialists (CNS) and to introduce and legitimize the nurse practitioner role in New Brunswick" (p. 23). While making the argument for PHC as a health policy direction and also refuting the "older conceptualizations of nurses as simply physicians' assistants" (p. 25), the PB also positions NPs in somewhat contradictory ways in roles that tend to emphasize illness care in institutional settings. For example, the PB provides examples of NPs practicing in nursing home settings and hospital emergency rooms, roles which emphasize PC and which diverge from other elements of PHC discourse that would position NPs in CHCs where they would be addressing illness prevention and population health, in addition to providing greater access to PC. Later implementation of NP roles in NB would correct this diverging view by emphasizing the integration of PHC NPs in diverse community health care centres.

At the *social practice* level, the shift from the physician-based, hospital focused system is again the underlying PHC reference point for the PB. Evidence is highlighted in the PB from a number of studies that verify the value and care outcomes of NPs in PHC settings: "NPs achieved equivalent outcomes or scored more favorably than physicians on most variables" (p. 24). As per Hanlon et al. (2019), health care is understood as a complex entity comprising different social actors, governance structures, belief systems, and values, each vying for resources and legitimacy. Discursive positioning of actors in

the reform process assists in explaining the inertia related to health care reform. Attempts to "transform health care systems are prone to generate conflict between conflicting interests" (Hanlon et al., 2019, p. 52). As these authors argue, attempts to shake up medical hegemony often lead to stronger entrenchment of the status quo. The PB clearly does not support the existing "primary medical care delivery model" (p. 10), but instead promotes the value of PC within a PHC context and policy framework. In its demonstration of the dominant discourse of PHC, the PB is conciliatory in tone, collaborative, focused on strong alliances, partnerships and integrated service delivery. Less obvious in this discourse, however, is explicit reference to complex and highly contested socioeconomic/racial justice and political reforms that are required to address the social determinants of health in PHC.

This analysis of PB illustrates how discursive practices and social practices come together and influence PHC discourse in the text, found in references to the intersections between health inequities and the social determinants of health. The PB demonstrates the prevalence of the discourse of PHC, with less influence of the discourse of PC. Examples of converging PC and PHC discourses in the PB include a pattern of "harmonized" discourses in its recommendations. This harmonization is found, for example, in recommendations for a change in legislation to allow NPs to practice independently (Recommendation #10) and for the adoption of PHC as a policy direction for health care delivery (Recommendation #1).

Intertextuality is evident in recommendations #3 and #4, which speak to governance and oversight: "developing fully integrated services by establishing a regional health structure which will include all health services" and "reactivating the

Premiers Council of Health Strategy renamed the Provincial Council on Primary Health Care Strategy" (p. 3). These governance structures are all recommended in the ML Report, the DP, and the PB. Although they are consistent with a WHO emphasis on a whole-of-government engagement in PHC, in hindsight it has become apparent that none of the proposed governmental oversight structures have had much influence on the highly centralized and predominantly secretive process of negotiation between provincial ministries of health and provincial medical associations (Hanlon et al., 2019).

(iii) As per Bacchi's (2016) approach, the presuppositions or assumptions underpinning the representation of "the social problem" included an ever-declining access to (primary) care and poor integration of the health care system. The PB clearly articulates NANB's position on three "problems" with the current configuration of the health care delivery system:

> 1) the health system is still largely based on the medical, illness, curative model that has been successful in dealing with many of today's health issues;
>
> 2) the hospital-based, physician-driven health delivery model is not integrated with any other component of health care delivery, i.e. public health, mental health, nursing homes and others; and
>
> 3) the actual and potential contribution of nurses within the health care delivery system have not been fully realized, partly due to a misunderstanding of the contributions nurses can make to patient outcomes. (p. 8)

The idea of extending or continuing current "relationships and practice models" is refuted throughout the document (p. 9). Alliances between health care professionals, organizations and governments are promoted as a new model to sustain systems level

change. The PB argues for a new PHC policy framework that is said to be more responsive to patient and community needs, is better able to consider and "manage population health" (p. 11), and necessary for bringing "down barriers between sectors and disciplines" (p. 11).

As per Bacchi (2016), the continuities that exist across statements of "problems" and "solutions" is a persistent call for changes to primary (medical) model of care, following from the inadequacies of primary medical care to address "many of today's major health issues such as cardiovascular disease, childhood injuries, adolescent pregnancy, family violence, and substance abuse" (p. 10). As indicated earlier, the PB does not dwell on the neoliberal discourse of economic costs of the current system. Rather it refocuses attention on the prevailing discourses aligned with PHC like the social determinants of health, health inequities, community needs, research evidence to demonstrate "positive clinical and financial outcomes, and robust workload measurement systems" (p. 5). These recommendations reflect the synchronicity of text and discursive practices influenced primarily by the ethics of social justice and the discourse of PHC.

(iv) From a *discourse direction* perspective, emerging discourses in this document include the identification of health inequities in vulnerable populations like women, children/youth, and seniors. Population health discourse is further reinforced as a goal, unachievable by one profession, but a potential reality of an interdisciplinary, community based effort. Poor access to physician services and inappropriate use of the hospital emergency room for PC and "entry to the system" (p. 12) are all elements of an emerging discourse that fuels the recommendation for integrated, coordinated services provided by a multidisciplinary team. The call for removal of "administrative and legislative barriers

which restrict the ability of the system to make more appropriate and complete utilization of nurses" (p. 24) is an emerging discourse that advances the eventuality of NPs practicing in NB.

Converging discourses of PC and PHC are evident in alternative care delivery models intended to address problems with non-urgent health-related experiences showing up in emergency departments. Although the PB makes a strong argument for adopting PHC as a policy direction, NPs are nevertheless sometimes positioned in this document as practicing in traditional settings like hospital emergency departments and nursing homes. Converging PC and PHC discourses are also present when PHC more narrowly supports the role of NPs in PC while not discussing how systemic structural issues like income inequality, housing insecurity, food insecurity, implicit bias, and structural discrimination could be addressed. In these instances, PHC loses its focus by converging back to the language of community based models of PC. When present, the PHC discourse of social justice and health equity in this document is aligned with the WHO (1997) renewed strategy, *Health for All in the 21st Century*. WHO (1997) acknowledged in this renewed strategy, that some of the failures of the original policy document were that "decision-making in the health care sector is still dominated by professional interests that favour curative medicine over preventative and promotive public health" (p. 10).

Diverging discourses, or discourses that deviate from the current state, include a call for movement away from siloed, stand-alone delivery systems like hospitals and physicians' offices, and the promotion of multidisciplinary teams. Ambiguity between PC and PHC discourse is demonstrated in the divergence from focusing on CHCs as a practice site in PHC for APNs and multidisciplinary teams. The replacement of the term

multidisciplinary with interdisciplinary, described as teams based on a collaborative, integrative partnership model, is described in detail within the PB.

Through its PB, *The Future of Health Care in New Brunswick: The Nursing Contribution,* NANB further developed PHC as a policy direction for health care reform in New Brunswick. The PB laid the framework for legislative changes that were required to introduce the advanced practice of NPs to the province. When the legislation for the introduction of NPs was presented in the Legislative Assembly in May 2002, Premier Lord began by saying:

> Nurses want to do more in providing health care to our citizens. They are in fact, capable of doing more, but they have been restrained by legislative and administrative barriers within the system itself. We are working with our health-care professionals to remove these barriers. (GNB News Release, 2002)

The PHC discourse of the PB is recognizable in these words, but the advanced practice role that nurses lobbied for was, at that time, still dependent on other health-care professionals (i.e., physicians). Legislation was subsequently enacted to remove the barriers to collaborative advanced practice.

Document 4: *Annual Report: Primary Care Collaborative Practice Project and Promoting Primary Health Care* (NANB, 2006)

This short excerpt from the Nurses Association of New Brunswick's Annual Report (2006), profiles two articles, each half a page in length. The first article, *Primary Care Collaborative Project*, describes a pilot for improving access to PHC, called "Primary Care Collaborative Practice Project." The second article, *Promoting Primary Health Care*, provides an update on the activities of the Primary Health Care

Collaborative Committee (PHCCC). The PHCCC, established by the NB Department of Health, was made up of health administrators, PC physicians, and representatives of NANB and the NBMS, reporting to the Minister of Health on PHC.

(i) *Historically*, the *Primary Care Collaborative Practice Project* (PCCPP) originated as a negotiated item under the 1999 Fee-For-Service contract negotiations between GNB and NBMS. The purpose of the two-year demonstration project, conducted by the Department of Health and Wellness (GNB, 2002), was designed to "evaluate the feasibility and desirability of establishing nurses as semi-independent health care providers in doctors' offices" (p. 3). Despite what will be discussed below as less than stellar outcomes and a cost of $1.6 million, the project was rolled out to five additional sites in 2004. The Government's stated intention was to "improve primary health care services" (GNB, 2004). The joint announcement was made by the then-Minister of Health, Elvy Robichaud, and the President of the NBMS, Paul Cloutier. Dr. Cloutier was quoted as saying, "Physicians fully support initiatives like this one that are aimed at increasing access to family doctors' offices. Community-based family doctors' offices are the backbone of the PC system, and it makes sense to build on that foundation" (GNB, 2004, no page).

The purpose of the project was to introduce a "primary care nurse into medical practices, with the nurses' salaries funded by DHW but routed through the medical practices so that the nurses were formally the employees of the physicians" (GNB, 2002, p. 3). The goal was to "measure the impact of nurse employment on increasing patient access to PHC services, increasing the proportion of preventative health services in the PHC mix" (GNB, 2002, p. 5). It was expected that the nurse or NP would be able to

assess/treat additional patients and follow up with patients who had chronic illnesses. This was expected to "free up the physician's time to see new and more complex patients" (GNB News Release, 2004). The PCCPP involved five sites throughout the province: four in northern NB and one in southern NB. Registered nurses were added in four of these sites and a NP was added in the fifth.

The second article in the NANB Annual Report (2006), titled *Promoting Primary Health Care*, provides an update on the role of the PHCCC and its mandate. The PHCCC was established in 2005, as an Advisory Committee to the Deputy Minister and Minister of Health. The mandate of the Committee was to "review and make recommendations on more accessible and effective primary health care service delivery models for use around the province" (p. 19). Historically, this committee was a significant addition to the policy framework and operations of the Department of Health. Assembling primary care providers, managers of primary health care, health discipline associations (e.g., NANB, NBMS), and government leaders together to deliberate on improved primary health care delivery models was an unprecedented achievement.

(ii) In examining the *analytic framework*, the *texts* (PCCPP and PHCCC) can be read as using the terms *primary care* and *primary health care* somewhat interchangeably. While briefly explaining the activity of the PCCPP and the PHCCC, critical details about the meaning of PHC and PC were not included in the texts. The overlap of the terms PHC and PC in these proximate short documents further adds to ambiguity and confusion (elision) about these two discourses (PC/PHC), especially among uninformed readers. While the primary audience for this document was assumed to be members of NANB (registered nurses), even this audience may not have fully understood the difference

between PHC and PC. This superficial representation of PC and PHC discourse in the texts appears to mirror similar ambiguity and confusion in social practice(s) among providers (including nurses) and policy experts.

In response to the social practices addressed (or not addressed) by the PCCPP, analysis suggests that access to PHC would not have been improved, because the project emphasized the employment of RNs to assist in the delivery of PC, not to provide PHC. NPs practicing PHC were not meaningfully represented in this project. As the name of the PCCP project implies, only access to PC delivered by "supervising" PC physicians—and assisted by generalist RNs—was considered. The project more or less continued to perpetuate the power relations that existed between an earlier generation of actors within this medically dominated PC space, i.e., registered nurses assisting primary care physicians. Only one hired NP was retained within this practice model (GNB, 2004). In this project, NPs were not widely engaged to work as they were registered to practice—as autonomous PHC providers in collaboration with physicians—as the NANB had advocated. The project became a "collaborative" practice perhaps only from the standpoint of medically oriented primary care physicians. In the case of a single NP who saw two physicians' patients for health problems within the scope of NP practice, the physicians billed Medicare for the NP's work.

The RNs employed in the four other PCCPP sites maintained the traditional family physician-practice model, working under the direction of the physician (GNB, 2002). The text referencing "collaboration" in this part of the document is situated in the discourse of medically oriented PC. It clearly reflects a power-imbalanced model of PC where the physician retains medical hegemony in the practice, directing the practice

model through medical treatment decisions related to complex health problems, and engaging the generalist RN as an employer who may bill for RN's scope of practice.

Juxtaposed in this same text, is an equally brief report to NANB membership on the PHCCC. The PHCC Committee was briefly described as a committee struck to advise the Minister and his designates on all matters related to PHC renewal. Again, the discourse of collaboration is an inviting one, described as bringing all of the actors to the table. This kind of a collaboration was recommended in the NANB PB (1998): "*What if* government brought people together at the same table to begin the team building journey at the higher level of the spectrum, at the system's level?" (p. 12). The original PHCC committee consisted of approximately 12 members, mostly appointed by the Minister of Health. Half of the members were physicians, with remaining representation from NANB, and managers/directors and policy advisors from the Department of Health. The committee later morphed into the PHC Steering Committee, which produced a number of policy documents including the PHC Framework (2012). The committee was dominated by physicians, many of whom had been in traditional family practices for many years. As a result, the PHC practice models and ideas that flowed from the committee were largely refurbished examples of the status quo, i.e., focused on primary medical care (PHCCC, 2006).

Hanlon et al. (2019) appropriately note that "to make sense of the politics of reform efforts, careful attention is paid to the discursive (re) positioning of actors in the reform process" (p. 52). At the *discursive* and *social practice* levels, the discourse of collaboration took on a different meaning than what was articulated by the NANB PB. In

both instances, the PHCC Committee and the PCCPP, collaboration became a method to entrench or preserve medical dominance and power in medically oriented PC.

The PCCPP was discontinued for all the sites except one in 2006. Outcomes of the demonstration project included a decrease in the number of medical services provided by the physicians but an increase in net income by up to 8% (GNB, 2002, p. 27). Some of the lessons learned included: "incompatibility of collaborative practice with the fee-for-service remuneration model, orientation to collaborative team building should enhance effectiveness, emphasis should be placed on the affinity for independent practice for nurses" (GNB, 2002, p. 5). Although this model did not serve as the regulatory blueprint for PHC NPs, all NPs do have a collaborating physician as part of their practice. Learnings from this early project demonstrate the importance of addressing possibilities of a collaborative relationship between physicians and NPs. But they also point to the importance of addressing collaboration between RNs and physicians, as well as between RNs and NPs (GNB, 2002).

The PHCCC was rebranded in 2007 with additional representation from Regional Health Authorities, Social Development, a Nurse Practitioner, and an Occupational Therapist. The committee was renamed the Primary Health Care Advisory Committee (PHCAC) and two years later, the Primary Health Care Steering Committee (PHCSC), each dropping the word collaborative. This fairly benign name change, in retrospect, signaled a power shift from a collaborative relationship amongst committee members to a controlling (steering) relationship by those with the greatest numbers and influence on the committee.

(iii) The *problem representation* of how to make inroads in PHC reform in NB, is positioned in both of these texts as focusing on a strategy to engage PC physicians in the PHC reform process. The official road to PHC reform in NB began in 2002 as part of a national strategy to strengthen PHC. With strategic federal investment through the Primary Health Care Transition Fund, numerous provincial improvements were realized through this influx of investment, such as the establishment of seven CHCs as well as the introduction of NPs and PC paramedics and enhanced telecare services. Despite this substantial investment and bipartite commitment to reform and renewal, the traditional PC delivery system of solo, fee-for-service physicians in office practices remained intact.

Both texts presented in the NANB Annual Report (2006) represent how methods were used by Government to bring physicians to the table. These methods were implemented to facilitate collaboration, engagement, and consensus in generating innovation around health care reform. They were also intended as opportunities to provide resources to physicians' practices to help them service their ever-growing patient rosters. Bacchi (2016) cautions about this kind of focus on problems: "The political focus becomes how we influence people to behave in desired/desirable ways instead of how we can produce a just society" (p. 8). The dominant discourse of collaboration within these texts, discursive, and social practices are more about one-way collaboration with physicians, rather than a reciprocal social practice of genuine collaboration to commit to the goals of PHC.

(iv) With respect to *discourse direction,* the predominant emerging discourse is the questionable use of the word *collaborative* in both entries of the text. The emergence of the discourse of collaboration is aligned with the relationship between NPs and their

collaborating physician as described in legislation (Bill 44, 2002). Though the founding title of the project and the committee both included the term "collaborative"—the PCCPP did not involve a collaborative relationship with nurses in its design, and the PHCCC was not a collaborative committee in terms of composition as it was overrepresented by physicians in traditional practices. Other emerging discourses reflected references to both "primary health care framework" and "a chronic disease management strategy" (NANB Annual Report, 2006, p. 19). Used in close association, both demonstrate an intersection of PC and PHC discourses. Converging discourses of PC and PHC are demonstrated in the vision for the PCCPP, but these convergences fall short of PHC as articulated by the WHO (1997) due to the retention of remuneration models (physician fee-for-service), role misunderstanding, and lack of autonomous PHC practice for nurses. Diverging discourses include a movement away from curative treatment and alignment with chronic disease management. Further adding to the ambiguity between PC and PHC discourse was the suggestion that adding nurses (generalists) to physician office practices would presumptively improve access to PHC.

The brief texts, "Primary Care Collaborative Practice Project" and "Promoting Primary Health Care" are updates provided to the NANB membership in the 2006 Annual Report. Both texts however convey minimal analysis, in "neutral" or "objective" reporting, remaining relatively silent about the complexity of misnomers contained in these entities. In the end, the PCCPP was not a collaborative practice project (though it was named as such) and it did not improve access to PHC. It was essentially an employer-employee model that reduced medical visits and increased income for physicians. Similarly, the PHCCC was not a collaborative committee; it was

overrepresented by physicians in an effort to strengthen physician engagement and influence practice patterns. It seems reasonable that both of these texts were included in the NANB Annual Report to update the membership on NANB's efforts to participate in and influence health care reform and demonstrate their solidarity in bringing PHC forward as a framework for reform. At the time of publication of these texts, there may still have been optimism that PHC reform would include effective collaboration to transform medical hegemony.

Document 5: *Health Centres in New Brunswick: Leaders in the Provision of Primary Health Care* (NANB, 2011)

The Nurses Association of New Brunswick published this one-page document in the NANB's professional journal, *INFO NURSING* (2011). The article, *Health Centres in New Brunswick*: *Leaders in the Provision of Primary Health Care*, hereafter referred to as *Health Centres* (HC), was written by two community health nurses, Joanne Barry and Cheryl Saunders. The stated purpose of HC was to provide an update to all registered nurses in NB about a recent conference hosted by the Association of New Brunswick Health Centres/Association des Centres de Santé (ANBHC/ACSNB) at the Albert County Health and Wellness Centre, a CHC in Hillsbourough, NB. HC also describes the role of the ANBHC/ACSNB as well as developments related to health centres and their role in providing community based PHC. The document's authors, Barry and Saunders, worked in two different CHCs in the province. The text presents details from the conference as well as an update about the ANBHC/ACSNB.

(i) In terms of *historical context* and *purpose,* HC demonstrates a provincial discourse about the sustainability and development of CHCs in NB. It highlights that in

2011, ANBHC/ACSNB, representing 50+ health centres, publicly embraced the discourse of PHC: “Health Centres offer a range of primary care, social and other services that encompass all aspects of health promotion and education, disease prevention and community development” (INFO NURSING, 2011, p. 33). The ANBHC/ACSNB had been in existence for close to 10 years before becoming incorporated in 2008. The stated vision of the Association, as documented in the INFO NURSING text, is that “all New Brunswickers’ have access to community-driven, primary health care provided by an interdisciplinary team, in cooperation with individuals, families and the community” (p. 33).

(ii) In considering the *analytic framework*, HC takes up PHC as the dominant discourse and embeds PC within the overall framework of PHC. The authors describe the mandate of Health Centres as providing an opportunity to “work with organizations in other sectors to improve the health of individuals and groups and to strengthen communities” (p. 33). The ANBHC Conference, titled *The Tides of Change*, reported in HC, was hosted at the Albert County Health and Wellness Centre, a CHC, committed to “addressing health inequities through community engagement and development” (p. 33). The conference was an opportunity to showcase some of the initiatives of the CHC around the social determinants of health,

> As a result of networking efforts throughout the community and partnership development, the community has a local food bank, a local, easily accessible GED program, a nurse practitioner providing health services at the high school, a growing community market and a yoga program for young girls. (p. 33)

HC provides details about the conference hosted by the ANBHC, which reportedly included concurrent educational sessions about "asset-based community development, chronic disease management and patient self-care portals, nurse practitioners, population health and the New Brunswick Health Council" (p. 33). The predominance of PHC discourse in this brief document is demonstrated in language that emphasizes community-based models of care with multisector and interdisciplinary/interprofessional collaboration. HC presents CHCs as community-oriented organizations that deliver health and social services through what are described as interprofessional teams: "In optimum situations, the Centre works in partnership with organizations in other sectors, to improve the health of individuals and groups and to strengthen communities" (Barry & Saunders, 2011, p. 33). The words and phrases used in this text are consistent with the discourse of PHC, i.e., the role of CHCs in the community is to endorse the interdisciplinary relationship of the health centre team to the community and promote the role of the provincially focused ANBHC/ACSNB to uphold these values.

In terms of *discursive practice* being linked to social practices (Fairclough, 2003), HC unambiguously demonstrates the governing and ideological discourse of PHC being used to describe CHCs by the actors. In this case, RNs and APNs that inhabit this policy space are demonstrating social and professional practices of community-based models of care through the discourse of PHC and, in so doing, are also subscribing to the philosophical underpinning of PHC. The ways of acting, speaking and writing as reflected in HC position nurses within the social role of promoting and advancing a PHC discourse. As per Gee (1990), "Discourse is a sort of identity kit which comes complete

with the appropriate costume, instructions on how to act, talk and often write, so as to take on a particular social role that others will recognize" (p. 142).

HC demonstrates the common-sense discursive practice and belief that "all New Brunswickers have access to community-driven primary health care provided by an interdisciplinary team; in cooperation with individuals, families, and the community" (p. 33). CHCs are held up as a model of care that can provide this level of PHC. This is consistent with the *Declaration of Astana on Primary Health Care* (WHO, 2018), which states, "We need PHC that: empowers people and communities as owners of their health, as advocates for the policies that promote and protect it, and as architects of the health and social services that contribute to it" (p. 1). According to De Maeseneer et al. (2019), "CHCs provide countries and non-governmental organizations a model to operationalize PHC as articulated in the Declaration of Astana, and to achieve sustainable developments goals" (p. 2). This statement is indicative of membership in a social group, in this instance, a group of health care professionals, identified as APNs who are dedicated to the potential of CHCs, and to the role of nurses being "leaders in the provision of primary health care" (Barry & Saunders, 2011, p. 33).

HC, at the *social practice* level, illustrates the broader structural and social perspectives of the relationship between text and the discursive practice (Fairclough, 1993). The origins of CHCs in the United States began at the turn of the twentieth century, including efforts by nurses such as Lillian Wald at the Henry Street settlement, which served refugees, migrants and immigrants in New York (Fee & Bu, 2010). Continuing into the twentieth century these efforts by public health nurses supported ongoing development of modern CHCs whose origins "are found in the country's civil

rights movement and the War on Poverty initiative of the 1960s, where they were deployed as vehicles for working with poor and disenfranchised communities" (De Maeseneer et al., 2019, p. 6). In Canada, the first CHC was established in Winnipeg in 1926 and was intended to meet the needs of Jewish immigrants who, although invited to Canada to provide needed labour, were excluded from health services and municipal benefits/opportunities (De Maeseneer et al., 2019). According to De Maeseneer et al. (2019), close to 80% of CHCs worldwide deliver programs in six sectors including healthcare, housing, education, seniors' services, mental health and addictions, immigration/settlement, and other sectors depending on the community needs. A significant attribute of CHCs is to integrate access to PC with other health services, health promotion, and social/community services as well as take action on the social determinants of health through inter-sectoral services and cooperation (International Federation of Community Health Centres, 2017). Despite the gradual expansion of team-based PC across Canada there is still a tendency for governments, including in NB, to fund models of primary (medical) care where care providers are isolated from other social sectors and do not actively address the social determinants of health (De Maeseneer et al., 2019).

(iii) As per Bacchi (2016), a close examination of the discourses taken up in HC illuminates how "the problem is represented" and "what they (the discourses) encompass and what they leave out" (p. 8). During this period, CHCs in NB were primarily a repurposing of small community hospitals (GNB, 2010). Of the eight CHCs established between 2000–2006 with funding from the federal *Primary Health Care Transition* fund, seven CHCs (Riverside Albert, St. Joseph's in Dalhousie, St. Joseph's in Saint John,

Tobique Valley, Queen's North in Minto, Lameque, and Caraquet) were decommissioned community hospitals. In each community where this occurred, there was a severe community backlash related to the loss of the hospital and associated emergency room services. The widespread critical reaction to hospital closures was largely due to the general perception amongst these communities of significant foundational institutional loss; it may also have been due in part to a lack of understanding about CHCs and not being persuaded that the CHC model could address both PC as well as the broader social determinants of health.

From a policy perspective, these reactions beg the question of whether the vision for PHC reform was actually a bona fide strategy to support the creation of a network of CHCs, especially in rural NB, or a vision to decommission expensive, physician-dominated hospital/emergency care. There is little policy evidence to support a widespread fundamental belief in the potential of CHCs to deliver expanded PHC. If that were the case, why has the establishment of additional CHCs not occurred? De Maeseneer et al. (2019) note that in relation to CHCs "opposition to change from entrenched interests such as health professional associations (most commonly medical associations)" is a predominant discourse with regard to CHCs and other models of PC (p. 7).

The NBNU DP (1995) promoted the establishment of CHCs and the NANB PB (1998) promoted "alternative care delivery" (p. 29) where "health promotion activities, health education and self-help techniques" (p. 2) could be provided. Both documents positioned NPs and RNs as community-based resources who would also work to address the social determinants of health in PHC. In these texts, nurses positioned themselves in a

public health/ public policy discourse where collaboration with communities and with physicians has been deeply complex and contradictory. Both documents are silent on the relationship of PHC to hospital services, which suggests that the authors of this article (nurses) are, in 2011, explicitly addressing the importance of locating PHC in CHCs or at least within a community-based framework.

Discursive analysis of HC suggests that CHCs are being endorsed by RN advocates of PHC, who are conveying to NANB members that CHCs should be embraced as "leaders in the provision of primary health care" (p. 33) and models for delivering "community-driven, primary health care provided by an interdisciplinary team; in cooperation with individuals, families and communities" (p. 33). Given this endorsement by NANB, a recognized voice in provincial health policy development, it is reasonable to ask whether the government of NB has been similarly persuaded about the merit of CHC's. Investment in this model of PHC has not occurred. Since the initial network of CHCs was created between 2002–2006, only two additional CHCs have been added to the network. Of particular note here is the reversion of Caraquet to a hospital and the maintenance of Lameque as both a CHC and a hospital after intense local community and political pressure.

Since the establishment of the original eight CHCs, Fredericton Downtown CHC and the Oromocto CHC have been the only new CHCs added to the network in 15 years. Most of the new investment in the province's health system has been in PC with the establishment of physician-directed Family Medicine NB models (NBMS, 2021).

CHCs in NB fall under the governance of the Regional Health Authorities (RHA). The Canadian Association of Community Health Centres (CACHC), however, is

challenged to recognize the CHCs of New Brunswick because CACHC promotes a governance model as one operated by a community board where "ongoing engagement of community members in health and planning of health and social services" occurs (De Maeseneer et al., 2018, p. 2). Whereas the key element of community-driven and community governed structures is a foundational principle for CHCs in Canada, the oversight from the RHAs in NB has constrained some CHC operations, namely the ability to act on and connect with other sectors, such as mental health and addictions, housing, income assistance, justice, and education. These elements are key structural features of operationalizing PHC (De Maeseneer et al., 2018). The governance model of CHCs (under the authority of the RHA), was also the undoing of the ANBHC. Leaders active within the ANBHC were questioned by NB RHA administrators about the duplication of mandates of the RHA and the ANBHC. Opportunities for education and networking were seen as redundant to RHA efforts. The Association was discontinued in 2015 due primarily to provincial apathy and a lack of sustained funding (Central Miramichi CHC staff, 2017). The oversight of the ANBHC rotated annually to the various member Health Centres and CHCs. In 2015, the staff of the Central Miramichi CHC sent an email to me, as director of PHC for the region, saying they were no longer committed to the work of maintaining the Association (personal communication, 2015). No other group stepped forward to assume the oversight function and the ANBHC ceased to exist.

(iv) With regard to *discourse direction*, converging, divergent, and emerging discourses in HC are present in comments associated with the inclusion of "community based organizations" (p. 33), and also in the description of educational offerings of the

ANBHC, *Tides of Change* conference. An innovative approach to group learning and community activation is evident in PHC discourse with the concurrent sessions offered at the conference: "asset based community development, chronic disease management, increasing access to NPs and population health" (p. 33). In these comments, HC imbeds access to PC within the discourse of PHC, demonstrating a diversion from a narrow focus on access to PC. Other emerging PHC discourse in the text includes comments like "building community capacity," offering educational opportunities through an "easily accessible GED program," and supporting a "local food bank" through partnership development between the CHC and community organizations (p. 33). This emerging discourse about acting on the social determinants of health through a broader lens of equity oriented health promotion, population health, and community development is strongly oriented to PHC discourse.

Converging discourses of PC and PHC are also demonstrated in the HC's discussion of the vision of the *Bennett & Albert County Health Care Foundation*, once a hospital foundation, now supporting the building of community capacity. The document appears to rely on knowledge of local history that demonstrates how PC and PHC may converge. The development of initiatives like a GED program and a community food bank located at the CHC where PC is also provided, were realized through the support of this local foundation. Other converging PC and PHC discourses in HC include the inclusion of PC services (e.g., regular medical appointments, immunization, well-woman services, nutrition counselling, etc.) as well as "social and other services that encompass all aspects of health promotion and education, disease prevention and community development" (p. 33) offered by health centres. Even though there is a difference in the

services offered by health centres and CHCs, there is no differentiation noted in ANBHC's stated vision: "All New Brunswickers have access to community-driven, primary health care provided by an interdisciplinary team; in cooperation with individuals, families and the community" (p. 33).

Diverging discourses taken up in HC again include a movement away from emphasis on curative treatment and an alignment with chronic disease management and patient self-management. A divergence away from funding hospitals and the equipment used in hospitals by the former hospital foundation, and instead investing in building community capacity is another significant aspect of this text.

HC provided a brief update on CHCs for nurses in the province. PHC is the predominant discourse contained in this text with an introduction to concepts of community development, capacity building, and partnership with community organizations, government, and health care staff. The document speaks to intersectoral action for intervention in the social determinants of health and advocates for nursing involvement, through leadership, in PHC.

Document 6: *Igniting Change: Province's Summit on Primary Health Care* (NANB, 2011)

This one-page document, hereafter referred to as IC2011, is an update I provided, in my capacity as Executive Director of Community Services at the Department of Health responsible for leading provincial PHC reform efforts. The article provides a summary of a historical Primary Health Care Summit that took place in Fredericton, NB, October 2011, published in the NANB publication *INFO NURSING* (2011).

(i) In terms of *historical context* and *purpose*, the PHC Summit was the culmination of a year of consultation by the then NB Minister of Health, Madeleine Dubé. The consultation was centered on a discussion paper, developed by the NB Department of Health Primary Health Care Steering Committee, titled *Improving Access and Delivery of Primary Health Care Services in New Brunswick* (GNB, 2010). The 2011 Summit engaged stakeholders to address the Steering Committee's recommendations and centered on "igniting change in primary health care" (IC, 2011, p. 15). Summit participants were strategically invited from various sectors including "primary care providers, community leaders, policy and decision makers, academics, and representatives from health care-related organizations" (p. 15).

(ii) In examining the text, discursive practice and social practice (*the analytic framework)*, IC2011 explains PHC as, "the core of a sustainable health care system" and argues that "change in primary health care" is required. The Summit is described as including breakout sessions that were offered to summit participants under the broad categories of "Access, Teams and Healthy Living" (p. 15), which are described as having been introduced during the National Primary Health Care Awareness Strategy (Government of Canada, 2009). With funding from the Primary Health Care Transition Fund, a national working group developed a social marketing strategy to raise awareness about the role and importance of primary health care in the health care delivery system. A four-pillar concept was created after extensive study. The four "pillars" or elements, that were shown to resonate with the public as key components of PHC, were: Access, Teams, Timely Information, and Healthy Living (GNB, 2010). These four "pillars" do not include discourses of health equity connected to the social determinants of health as

established by WHO. The Healthy Living pillar is the closest to this PHC discourse, but evades structural factors such as income, food and housing security. Healthy living was defined by the national working group as follows:

> Healthy living takes into account the positive choices made by individuals regarding their personal physical, mental and spiritual health. These choices include eating nutritious foods, building a circle of social contacts to create a supportive environment, being physically active, choosing not to smoke, and putting an end to other negative lifestyle practices. The focus of healthy living is the prevention of illness, disease and injury. Closely associated with healthy living is the concept of primary prevention which refers to specific activities or measures, either by the individual or at the population level, that are directed at reducing the risk or consequences of exposure to a risk factor, disease or health related event. Examples of primary prevention include immunization programs and provision of safe drinking water in the community. The healthy living pillar is also concerned with enabling individuals living with chronic disease to self-manage and make decisions to improve their overall health and quality of life. (GNB, 2010, p. 19)

In a historically consequential way, the New Brunswick PHC Advisory Committee, later to become the PHC Steering Committee, used these four pillars as the basis for the consultation document, *Our Health Our Future Improving Access and Delivery of Primary Health Care Services in New Brunswick* (2010). This document, as well as informing the consultation, also became the organizing framework for the NB Primary Health Care Summit. The titles of the Summit's concurrent sessions mirrored

three of these four pillars: Access, Teams and Healthy Living. Specific sessions offered under the "Access" pillar included, "delivery system design; patient engagement, patients as partners; unattached patients; and 24/7 care" (Davies, 2011, p. 15). Under the "Teams" pillar, sessions were offered in, "integration; performance indicators; team remuneration; governance, accountability and care coordination" (Davies, 2011, p. 15). Although health disparity was not included in the national working group's definition of healthy living, it was taken into consideration as an offering for the Summit. The "Healthy Living" pillar sessions included, "facing health disparities; mobilizing communities around healthy living; citizen centeredness; and (chronic disease) self-management" (p. 15).

The IC2011 text highlights a process used at the conclusion of the Summit to solicit simultaneous, public feedback. Summit "delegates were given keypad voting devices to vote on a series of questions relating to the main themes of the Summit" (p. 15). Results overwhelming indicated that 90% of delegates agreed that a team approach was the preferred model for delivering PHC and 60% agreed that defining a governance model was the next step in the process (p. 15).

From a *discursive practice* perspective, analysis of the discourse found in IC2011 reveals intent to influence and persuade primary care providers, mostly physicians, to embrace and support the broader concept of PHC. The link between text and social practice reveals that to influence change in PC, to truly ignite transformation, PC physicians must be invested in the change. Analyzing the discourse used in the promotion of the Summit and the descriptors of each break-out session suggests that PC practice is the established social practice. Although the Summit was promoted as being about transforming PHC it is more likely that it was about transforming PC and attempting to

incorporate PC into a broader context of PHC. In 2010, 70% of PC was delivered by physicians working within a fee-for-service remuneration model (NB Department of Health, 2010). In that same year, there were 51 salaried NPs employed by the RHAs in a variety of settings including 38 nurse practitioner/physician collaborative sites throughout NB. Most of the care providers invited to the Summit were practicing within a PC environment.

As detailed above, the consultation paper, *Our Health Our Future Improving Access and Delivery of Primary Health Care Services in New Brunswick* (2010), informed the consultation process leading up to the Summit, and highlighted one overarching strategic approach that "all New Brunswickers will have access to a family practice team that is able to provide them with, personalized, comprehensive and coordinated primary health care services" (p. 10). This strategic approach was supported by 12 actions. The first of the 12 actions perpetuated the entrenchment of medical hegemony, in that "all New Brunswickers must have access to a family physician" (p. 10); the second action was about the establishment of "family practice teams with a minimum core staff of a family physician, a nurse and/or nurse practitioner with appropriate administrative support that will provide a 'medical home' for their registered patient populations" (p. 4). The interchangeability in language between "nurse" and "nurse practitioner" in that consultation text exemplified complex existing barriers to broadening this narrow "family practice medicine" PC discourse. The Summit introduced participants to expanded PC models from other provinces and also explicitly explored opportunities within these models to address PHC through action on health disparities and mobilization of communities around health promotion and population health.

At the *social practice* level, the broader structural and social perspectives of power and privilege are again grounded in medical hegemony. The model described in the consultation paper, i.e., medical home, was essentially a PC model (mis)labeled as PHC. Recommendations for resourcing "medical homes" echoed status quo physician-directed models based on the diagnosis and treatment of illness and funded through the Medicare fee-for-service funding model, which does not have any specific billing codes for prevention-related services or any kind of teamwork. The Romanow Report (Royal Commission of the Future of Health Care in Canada, 2002), provided a relevant pathway for reform, stating:

> Good primary health care is based on interdisciplinary teamwork, with care available to all, 24-hours a day, seven days a week. Currently, primary care in Canada is out of balance, concentrating on the entrenched practice of workers with particular skills being assigned to cure people when they are ill. There is not enough focus on broader efforts to prevent illness and injury and keep the population healthier. (p. 116)

Ideological-discursive formations, where actor's speech is connected to the position they occupy, is an important element when considering the relationship between discourse, power, and ideology (Fairclough, 1995). According to IC2011, the Summit attempted to provide opportunities for reflection, new learning, and the exposure of, or critical reflection on, hegemonic thinking and practice. However, the power dynamics and ideology of those not willing to consider the broader discourse of PHC explains and further reinforces the ambiguity (i.e., mystification) around PHC and PC. The social practices of physicians, their use of the discourse of primary (medical) care, and their

gate-keeping power had significant influence in discouraging a full "ignition" of change for PHC. The overall consensus from Summit participants of interdisciplinary team models of care was encouraging but did not translate into reality. The models of care that were eventually implemented were team models of care among groups of physicians with nurses in standard office practice roles (NBMS, 2021).

The IC2011 document suggests that important next steps of PHC reform, reached through a democratic process of consultation and transparency during the second day of the Summit, still reflected the social practice and influence of medically oriented PC. The 10 themes that had emerged from the first day of the Summit were voted on at the end of the second day. The premise was that the top themes would assist in determining implementation priorities for the PHC Steering Committee. Themes with the highest percentage of votes were: "community involvement is important in the development of a primary health care model (99%); a team approach is the preferred model to delivering primary health care (90%); greater collaboration among government departments and communities is required to improve the overall health of the population (93%); and New Brunswick needs an electronic medical record (88%)" (p. 15). When asked to vote on the most important criteria for PHC team development in NB, the option that received well over 50% of the votes was "defining a governance model" (p. 15). This became the mandate for the PHC Steering Committee who were charged with developing "an action plan to be submitted in the New Year" (p. 15).

(iii) In alignment with Bacchi's (2012) WPR approach, what is left out of the text, *Igniting Change,* is the overall goal of the Summit. In the world of policy formation, summits are typically staged to encourage breakthrough thinking, and celebrate shared

vision for new opportunities (Baker & Rhea, 2015). The PHC Summit was the first of its kind in NB, and stakeholders were strategically invited for their perspectives, experience, and contribution to health system reform and the broader discourse of PHC. There was a focused effort to balance participants between PC providers and community leaders, academics, policy and decision makers, and health-care related organizations. The aspiration was to provide an opportunity for "influencers" to learn together about the possibilities for PHC transformation by considering policy level work from other jurisdictions. It was also an opportunity to showcase the pockets of excellence in PHC in NB (e.g., CHCs) and ask questions about why these models were not more widespread. The Summit was a culmination of a year of consultation conducted by the Minister of Health, with the consultation paper, *Our Health Our Future Improving Access and Delivery of Primary Health Care Services in New Brunswick* (2010), as the foundation. Above all, the Summit provided a common foundation for the Primary Health Care Steering Committee to create an action plan on how to renew PHC in the province.

(iv) In terms of explicating *discourse direction*, IC2011 continued to demonstrate and perpetuate the ambiguity (perhaps interchangeability of meaning) at the time between PC and PHC. Although the term PHC is used throughout the document, the discourse is primarily that of PC—used as a misnomer for PHC. The Summit itself was envisioned as an emergent discursive instrument, to bring all of the actors together. Within this environment, new and innovative practices were on display and emerging discourses were encouraged. The voting component during the final hours of the Summit was an emerging technology, revealing Summit delegates' opinions on community involvement

in PHC, team approaches to care, governance models, and funding tied to performance and clinical outcomes.

My role as organizer and convener of the Summit included a conscious effort to have the conference appear and be welcoming for participants who practiced as primary care providers in more traditional settings (i.e., fee-for-service, sole-provider family practice). There was an initial foregrounding of existing issues in broad categories of presentations (i.e., Access, Teams, and Healthy Living) because these had become familiar pillars for the participants. However, the Summit offerings under these categories were innovative and allowed for/invited careful consideration of emerging PHC practices from other provinces (e.g., Family Health Teams) as well as promising and little known practices within NB (e.g., UNB Brunswick Street Clinic). Emerging discourses within these broad categories included "facing health disparities, mobilizing communities, and citizen centeredness" (p. 15). These strands of discourse diverge from prevailing PC discourse and invited participants to engage in "emergent" new discursive practices. The other emerging discourse present within the document points to the expanded use of communications technology, such as electronic medical records (EMR) as a quality improvement tool for PHC teams. This technology was highly controversial at this time and was accompanied by discourses of ownership, affordability, and integration (with the broader health care system).

Converging discourses of PC and PHC in the text of IC2011are evident in statements like "patients as partners, self-management, patient engagement and unattached patients" (p. 15). This language, present in the summit and appearing in the NANB text reporting on the summit, acknowledges the role of the patient as an equal

participant in their care plan and their inherent right to autonomy, but the word *patient* still implies a power dynamic and subservient role of the person receiving PC. Use of the word "patient" in emerging discourses, like self-management, may have made these innovative ideas more palatable to those attending the summit who were primarily responsible for delivering PC. Nimman and Stenfors-Hayes (2016) note that "language strategies physicians use when interacting with patients is a reflection of their habitus-produced in part from exposure to the field of medicine, a field imbued with symbolic power" (p. 2).

Diverging discourses, already discussed in previous texts, are again present in this text. Discourses of "delivery system design, integration, care coordination and community involvement" (p. 15) represent a divergence from predominant models of acute care and emergency departments located in hospitals. Other diverging discourses include team-based PHC, and the responsibility of communities for the formation of PHC teams versus RHA responsibility.

In summary, the document, *Igniting Change*, provided an update to nurses in the province through the NANB newsletter, *INFO NURSING*, about the proceedings of a Summit on PHC. Although PC is the predominant discourse contained in this article, elements of PHC are introduced through the integration of concepts such as facing health disparities, mobilizing community, patients as partners, and introducing EMRs to team practice. Much of this PHC discourse had already been realized within the CHC model familiar and celebrated by NANB.

Summary

This concludes the analysis and examination of six NB documents pertaining to the introduction and development of PHC reform discourse spanning 22 years, from 1989 to 2011. Drawing on Fairclough (2001, 2003) and Bacchi (2016) I have shown how the discourses of PC and PHC were represented in one Government of New Brunswick health policy document and in five discipline produced nursing documents developed, for the most part, as a response to emerging government policy direction. These six documents illustrate how international discussions of PHC (e.g., WHO), and national collaborative models of PC, PHC and APN concepts were taken up in NB. I have provided examples of consistencies/continuities, contradictions/discontinuities, intersections, and gaps in PC and PHC discourses as reflected in these health policy and professional discipline documents. Additionally, I have shown how the discourses of PC and PHC in Government of New Brunswick health policy documents and professional discipline documents may be interpreted specifically in relation to the introduction of NPs in New Brunswick.

The policy documents examined from this period, demonstrate a history of discursive struggle between the discourses of neoliberalism, PC, and PHC. With the Government commissioned ML Report as the foundation, the time period 1989-2011 was characterized by an attempt at a major shift in focus, from hospital-based care to the promotion of more community-based, multidisciplinary team care. PHC discourses of health promotion, healthy living, limited versions of references to the social determinants of health, and population health outcomes were introduced and sometimes expanded. The ML Report attempted to align health care reform with the then progressive liberal

discourse of PHC. In that effort, the discourse of PHC in the government text was itself attenuated by appeals to neoliberal commitments of containing cost and improving access to PC.

The ML Report (1989) was historically significant, occurring during a time when the discourse of PHC was emerging nationally and internationally. The Government's impetus for healthcare system reform was the perceived unsustainability of a provincial health system centered around hospitals, a costly service delivery option, driven primarily by physicians, with little impact on overall population health. Neoliberal discourse of cost containment dominated discussions of Government health care reform in the province. At that time, however, emerging PHC discourse internationally, as represented by WHO (1988), was beginning to emphasize the re-organization of health care to achieve health equity by addressing the social determinants of health. The ML Report demonstrated the influence of neoliberal discourse and also attempted to champion the discourse of PHC by introducing the focus on how social determinants of health should be "influenced by public policy" (p. 27), ultimately influencing population health outcomes. The ML Report also spoke to more accountability in the system, a move to community-based services for PC, piloting of a community health centre (CHC) model, and a broader scope of practice for nurses working in community within Health Centres and CHCS.

In comparison, documents from the nursing profession privileged the discourse of PHC. The NBNU Discussion Paper (DP, 1995) and the NANB Policy Brief, *The Future of Health Care in New Brunswick: The Nursing Contribution* (PB, 1998), took up PHC discourse as introduced by the WHO and referenced in the ML Report further, developing and applying the discourse in NB. Both texts highlighted the possibilities of

CHCs as a way to strengthen PHC and reduce reliance on the acute care system. The historical significance of both of these discipline produced texts was not only their explicit use of PHC discourse, but also the precedent of their timing. The texts emerged at a time when nurse practitioners were first being prepared and licensed to practice PHC advanced practice nursing in NB. Both nursing texts took up the discourse of PHC as a policy framework for health care reform and presented the opportunity to re-examine the role of NPs in light of this PHC policy direction. Where the DP provided detailed recommendations for educational enhancements to support an expanded role for nurses, the NANB Policy Brief (1998) detailed a PHC framework for re-thinking how health services are organized and delivered. It promoted an expanded role for nurses as PHC providers within this reimagined system.

Promoting PHC and supporting collaborative PHC practice was also demonstrated in the three texts originating from the NANB newsletter INFO NURSING. The three texts, *Annual Report: Primary Care Collaborative Practice Project and Promoting Primary Health Care* (NANB, 2006); *Health Centres in New Brunswick: Leaders in the Provision of Primary Health Care* (Barry & Saunders, 2011); and *Igniting Change: Province's Summit on Primary Health Care* (Davies, 2011), were highlighted in the Nursing newsletter as positive examples of progress in the implementation of the principles (and discourse) of PHC. Released nine years after the PB, the Annual Report highlighted concrete action, or what is perceived as progress in the integration of PHC. NPs, having been introduced to the system in 2002, were beginning in 2006 to realize limitations to their practice in the relatively unchanged, fee-for-service, medically dominated PC system. Despite these limitations, the 2006 NANB newsletter, which

contained the two articles, *Primary Care Collaborative Practice Project* and *Promoting Primary Health Care* (2006), reflected an optimism, that progress toward an integrated model of PHC, including an expanded role for nurses, was coming to fruition.

Discursive struggle is also evident throughout this period with the representation of the problem being fiscal challenges and ever declining access to existing PC (ML Report, 1989). Solutions to these problem representations, like introducing nurses to existing fee for service medical practices and creating a Ministerial collaborating committee created tensions with nurses and their associations who contended that the underlying representation of the problem was the configuration of the health care system, the focus on the illness model, inadequacies of primary medical care to address the complexity of health problems and the overall contributions of nurses not being fully realized (DP, 1995; NANB PB, 1998).

Despite these discursive tensions, optimism for PHC continued in the two additional articles from the NANB quarterly newsletter, *INFO NURSING*. Both articles, *Health Centres in New Brunswick, Leaders in the Provision of Primary Health Care* (2011) and *Igniting Change* (2011) spoke to the transformative thinking that was occurring in the province through the work of collaborative, community-responsive models like CHCs. The interdisciplinary teams that practiced within these entities followed many of the PHC principles articulated by the WHO (2003) of equity, universal access, community participation, intersectoral approaches, a focus on broader population health issues, linking prevention, acute care and chronic care across all components of the health system. The importance of this text, authored by two nurses experienced in providing care within a CHC model of care, was an inspiring reminder of the possibilities

of PHC within a community-focused setting. The *Igniting Change* (2011) NANB text described the culmination of this period of progressive alignment of the actors within the PHC space. It utilized PHC discourse to comment on the need for PC providers, politicians, administrators, civil servants, community groups, patients and patient advocates to collaborate. This occurred when all of these actors, as mentioned above, assembled together to learn about both the principles of PHC and existing models that embodied these principles during the PHC Summit. A different and brief element of emerging PHC discourse also occurred in this period, focusing more explicitly on equity, social justice and access to the broader social determinants of health (HC, 2011; NANB PB, 1998) while also expressing optimism and confidence in the aspirations of PHC as a policy framework for health care reform.

Chapter 5

Document Analysis (2012-2019): Attenuation of PHC

Chapter 5 continues where Chapter 4 concluded, reporting findings from documents that appeared in the period following the PHC Summit. This chapter is focused on the years 2012-2019 and begins with the document produced under the cover of the New Brunswick Government's PHC Steering Committee, *A Primary Health Care Framework for New Brunswick*.

In this chapter, I examine six remaining documents: two from government and four from health professions. In relation to all documents (#1-12) reviewed in this dissertation, the documents reviewed in this chapter are documents #7-12:

7. *A Primary Health Care Framework for New Brunswick* (GNB, 2012);
8. *Rebuilding Health Care Together - The Provincial Health Plan 2013-2018* (GNB, 2013);
9. *Fixing New Brunswick's Healthcare System: New Brunswick's Doctors Have a Plan CARE FIRST* (NBMS, 2013);
10. *Position Statement – Primary Health Care* (NANB, 2014);
11. *Nurse Practitioners of NB-- Priorities* (NPNB, 2019);
12. *Nurse Practitioners of NB-- Infographic* (NPNB, 2019).

As per Chapter 4, my analysis of each policy document addresses the same four common elements: (i) Historical significance and purpose, (ii) Analytic framework, (iii) Problem representation, and (iv) Discourse direction.

As detailed in Chapter 3, I refer to the scholarly work of Fairclough and Bacchi. Fairclough's work (2001, 2003) is most evident in section (ii), the analytic framework

that details three levels of analysis; *text, discursive practice,* and *social practice.* Bacchi's (2016) policy analytic framework is featured in section (iii), *problem representation* or how a particular policy problem is constituted as "the real" (Bacchi, 2012, p.151) and section (iv) *discourse direction*, is a combination of Bacchi and Bonham's (2014) work building on Foucault's genealogical work related to emergence, convergence and intersections of discursive practices.

Document 7: *A Primary Health Care Framework for New Brunswick* (GNB, 2012)

The document, *A Primary Health Care Framework for New Brunswick*, hereafter referred to as PHC Framework, was released in 2012 by the then NB Minister of Health, Madeleine Dubé. The Minister described the purpose of the document as "a long-term strategic plan for improving primary health care in New Brunswick" (p. 3). The PHC Framework was the culmination of approximately eight months of consultation with citizens and stakeholders on the discussion paper, *Improving Access and Delivery of Primary Health Care Services in New Brunswick* (2010). As detailed in Document 6: *Igniting Change* (2011), a text about a PHC Summit, was informed by this consultation process and the New Brunswick Health Council's PHC survey results. Document 7 taken up here, presents the outcome of this extensive consultation process, the PHC Framework, which attempted to lay common groundwork for PHC transformation. The origin of the document occurred when it was commissioned at the conclusion of the Summit, as the Health Minister tasked the Primary Health Care Steering Committee (PHCSC) with the development of a "framework for action" by the Spring of 2012.

(i) In terms of *historical significance*, the release of the PHC Framework in 2012 was an important moment in the evolution of PHC in New Brunswick. It was a crucial

opportunity to continue and expand difficult conversations about the social determinants of health and health disparity introduced during the PHC Summit that preceded the framework's release. From a political perspective, the framework had the potential to be a legacy document and to disrupt the prevalence of sole-practice, fee-for-service physicians as the mainstay of the delivery of PC in the province. The document release came under the auspices of the Primary Health Care Steering Committee (PHCSC). This committee, co-chaired by Dr. Aurel Schofield (Assistant Vice-Dean, Faculty of Medical Sciences, Universitié de Moncton) and Ken Ross (Assistant Deputy Minister of Health), had been assembled under the Premier Bernard Lord administration (1999-2006). It had evolved through a number of iterations beginning as the Primary Health Care Collaborative Committee (PHCCC). Committee membership included seven physicians (including the co-chair and Chief Medical Officer of Health), six nurses (including the two Vice-Presidents of Primary Health Care in the RHAs, the Director of Wellness, Director of the Extra-Mural Program), and one NP. The remaining six members included four Department of Health leaders (ADM co-chair, Associate Deputy Minister of Health responsible for Medicare, Executive Director of PHC/Community Services, and Director of Medicare—Insured Services and Physician Remuneration), an executive director from the Department of Social Development, and an RHA Director of Therapeutic Services. The steering committee's mandate was "to develop and implement new ways of improving access and delivery of primary health care" (PHC Framework, 2012, p. 8).

During this period of time, I was the Executive Director of Community Services at the New Brunswick Department of Health. The coordination and management of the PHCSC fell under my area of responsibility as did the work of the PHC Branch within

the Department of Health. I participated, as a member of the PHCSC, and supported the Co-Chairs in their leadership of this committee. The oversight and leadership for the development of the PHC Framework (2012) was a priority outcome tasked to the PHC Branch of the Department of Health.

When the PHC Framework was released, PHC reform had been an area of focus in New Brunswick for over a decade, since the inception of the federal government's *Primary Health Care Transition Fund*. Over a period of approximately six years, from 2000-2006, this $800-million national fund provided strategic investment opportunities to provinces and territories in an effort to improve primary health care nationwide (Health Council of Canada, 2010). New Brunswick's share, approximately $15-million, was used primarily for "establishing community health centres, implementing collaborative practice models with physicians and nurse practitioners and delivering interdisciplinary provider education" (PHC Framework, 2012, p. 8). Roy Romanow, head of the Royal Commission on the Future of Health Care in Canada, and Senator Kirby, both strong national advocates for transformation in PHC, "noted the glacial advance of primary care reform" (Lewis, 2005, p. 275). This rings true in New Brunswick where, despite this substantial investment in PHC, the majority of PC was still delivered by family physicians. As a community of practice, family physicians at this time were being criticized for resisting change and lobbying for their role in team models with hegemonic discourse like "head of the team," "quarterback," "most responsible," and "ultimate responsibility for the care delivered to patients by all health professionals" (Cashin et al., 2009, p. 125).

The 30-page PHC Framework contains an overall vision, "better health and better care with engaged individuals and communities" (p. 13) and includes five broad recommendations: "Integration of primary health care services, community-specific team-based care, accountability, stakeholder and patient engagement and leadership for system transformation" (p. 14-15). Each of the five recommendations contains a number of action items, 13 in total. Of the 13 action items contained in the PHC Framework, eight, having to do mostly with improving administrative processes have been implemented and continue to be monitored by the Department of Health. Other recommendations related to the vision of interdisciplinary PHC teams, embedded within the community and responsive to community needs, are still largely unmet. At this writing, those recommendations are only practiced in CHCs where physicians are, for the most part, salaried employees of the RHAs (NB Department of Health, 2020).

(ii) In terms of the *analytic framework*, the presuppositions or assumptions underpinning the *text* are, much like in the ML Report (discussed in Chapter 4), characterized by a neoliberal economic discourse. The *text* is focused on describing the "province's current economic and fiscal climate, with health care consuming over 40 per cent of the province's overall budget," and noting that "our province's spending on health care is among the highest in Canada (when health expenditures are represented as a percentage of GDP)" (PHC Framework, 2012, p. 10). The text also highlights the aging of society and the increasing prevalence of chronic disease: "as many as seventy per cent of New Brunswickers are affected by at least one chronic disease which is a significant cost-driver on the health system" (PHC Framework, p. 10).

The PHC Framework provides a neoliberal definition of PHC as "cost-effective, low intensity care, focused on prevention/management" and "the solution to avoiding costly hospital care and reducing health care spending" (p. 10). The text includes data from a PHC Survey conducted by the New Brunswick Health Council in 2011, which indicates that "approximately 93% of New Brunswickers have a family physician but only 30% of respondents could get a same-day or next-day appointment and only 22% of respondents indicated that their family doctor had an after-hours arrangement" (p. 11). Despite this use of convincing data, there is no attempt in the PHC Framework to address, in 2012, the indisputable difference between PC and PHC. There is no effort to imbed PC within the broader context of PHC, to address the problems of the inaccessibility of family physicians, even for those people "fortunate" enough to have a family physician, or to address structural factors of health inequity found in the social determinants of health. Instead, the text describes a nebulous vision for PHC transformation as "better health and better care with engaged individuals and communities" (p. 12).

The recommendations to achieve a transformation are through five far-reaching areas: "Integration of primary health care services, community-specific team based care, accountability, stakeholder and patient engagement, and leadership for system transformation" (p. 5-6). The solution/recommendations under each of these categories include:

> Conduct community health needs assessments, develop community-specific Collaborative Services committees post assessment (terms of reference to be defined by the PHCSC), assemble team-based models of care, establish electronic

> medical records in team-based care settings, create a provincial unattached patient registry, implement an accountability framework including performance indicators and clinical outcomes, implement a stakeholder engagement strategy including a *Patients Voices Network*, implement a team to lead change and enhance the PHCSC with membership from patients and First Nations. (p. 14-20)

The discourse of neoliberalism in the PHC Framework intersects with the wording, statements, and assumptions of the discourses of PC and rarely takes up the discourses of PHC. Although the PHC Framework is centered on transformation in PHC, much of the discourse is that of PC. Similar to the discourse of the PHC Summit, transformation in PC is positioned minimally if at all within a PHC discourse. The thinking at the time was to maximize engagement and not alienate PC providers, mostly physicians. The PHC Framework extends the title of PC provider beyond the family physician to the "nurse practitioner, physiotherapist, pharmacist, psychologist and others" (p. 7). It emphasizes some philosophical underpinnings of PHC as "health care in the community" and also ironically positions PHC providers as playing "a pivotal role in linking the community and the hospital system" (p. 7). Collaborative team models of care are promoted, and the naming of these teams occurs interchangeably in the text as either interdisciplinary or PHC.

Many of the problems and solutions discussed in the PHC Framework are described as related to a "lack of coordination and integration in the primary health care system" (p. 7). The document lists the substantial "primary health care" infrastructure in the province as:

> family physicians' offices; community health care centres; health service centres; community mental health centres; collaborative practices (i.e. nurse practitioners and physicians); Tele-Care; public health offices; First Nations health centres; addiction services; the Extra-Mural Program; emergency departments; after-hours clinics and private allied health practitioners. (p. 7)

The emphasis on the extensive community-based infrastructure highlights the problem that the PHC Framework is trying to address, that of tightly siloed systems that are heavily oriented toward illness care, with minimal integration and coordination. A *community* system is therefore implied and considered, one that presumably has adequate infrastructure but is difficult for PC providers, patients and their families to navigate. Missing from the document are comments and analysis about health equity and how it would be addressed differently in a PHC context where the social determinants of health are addressed throughout the systems.

At the *discursive* practice level, the production, distribution and consumption of the PHC Framework signifies an effort to form consensus amongst the key actors (e.g., physicians, nurses, allied health professionals, health administrators and government representatives). The membership of the PHCSC in developing the PHC Framework represented all of these entities, many of whom were appointed by the Minister of Health to represent their professions' interest. By signing off on the PHC Framework, each member endorses their participation in and agreement with the process and the final recommendations. By allowing their name to be published at the end of the document, each committee member publicly sanctioned the transformative recommendations

required to create “a sustainable health-care system and meet the health-care needs of future generations” (p. 11).

The publishing of the committee members’ names is important because the PHCSC operated under a consensus model of decision-making. In this approach, people are not simply for or against a decision, but have the option to situate themselves on a scale that lets them express their individual opinion more clearly. This model allows all committee members to state where they are according to the following six levels:

> 1. Fully Support, 2. Support with reservations, 3. Acceptable, 4. Will not block it, can live with it, 5. Need more information or more discussion, 6. No, cannot accept it. If everyone is at level #4, level or above, consensus has been reached. (PHCSC Terms of Reference, 2010, Appendix A).

The recommendations of the PHC Framework represent a consensus from all members of the committee, physicians, RHA administrators and Department of Health representatives. Fairclough (2001) characterizes such texts as *negotiated texts* where the goal of text producers is to create a consensus document without a need for arguments that take up other discourses that may not be aligned. In this case, not taking up other arguments included not taking positions which challenged the status quo of sole-practice PC providers, mostly physicians.

The PHC Framework uses the discourse of PC to promote the concept of PC integration in the community, e.g., “The committee heard on numerous occasions that in many of New Brunswick’s communities there are weak linkages between primary health care providers and RHA resources (i.e., nurses, allied health professionals, etc.)” (p. 14). Most health care services in New Brunswick are managed and controlled by the RHAs.

Although some self-sustaining private health services—physiotherapy, dentistry, and chiropractic, for example—exist outside of the RHA system, the only publicly funded health services that exist outside of the RHA are physician services. The funding for these services is negotiated and administered through a closed process between the New Brunswick Medical Society and Medicare services within the Department of Health. It is noted here that a recommendation by the PHCSC to implement interdisciplinary "primary health care teams" (PHC Framework, 2012, p. 17) was later revised and modified by this closed negotiation process. By suggesting that RHA resources be made more available to communities, the ask is really about providing these RHA resources to family physicians working within the community.

The recommendation to "conduct community health needs assessments" and "implement corresponding Collaborative Services Committees" (p. 14) had the potential to erode the power of the RHA by inserting a community governance model that would "manage the integration and re-profiling of RHA resources into team-based settings and determine investment needs" (p. 14). As a support for this recommendation, the PHC Framework refers to the Health Council of Canada's indication that "primary health care needs an organizational body, like a Collaborative Services Committee (CSC), at the community level to act as an integrative force and serve as the link between government and professionals providing care" (p. 15). As a subtext to this recommendation, the PHCSC recommended that each CSC be "co-chaired by a physician representative and an RHA representative" (p. 14). This recommended oversight function by representatives from the RHA and physicians further perpetuates the ambiguity of PHC and PC,

reversing the discourse back to health care systems dominated by hospitals and physicians and away from community focused and community led PHC.

At the *social practice* level, the PHC Framework promotes a shift away from siloed health programs and services to an integrative PHC approach both at the community (micro/meso level) and Department of Health (macro level). Recommended changes at the Ministry of Health level are related to structural reorganization and/or collaboration: "within the structure of the Department of Health, physician remuneration, e-health and primary health care which are separate divisions, require opportunities for collaboration and shared planning and funding roles" (p. 15). This recommendation is consistent with interdisciplinary assumptions for social practice in PHC, although it does not specify how those assumptions will change the reality of primary care. At the community level, the framework advocates for "collaborative team-based care as one way to improve accessibility to PHC, since teams can focus on the prevention/management of chronic disease, offer better access to services, shorter wait times and achieve better coordination of care" (p. 16). The PHC Framework does not prescribe team membership or specific models, saying that "there is no one-size-fits-all primary health care team model that will best serve the needs of all New Brunswick communities" (p. 17).

The PHC Framework speaks to the unique *population health* profile that will be revealed through the process of the community health needs assessment. According to the PHC Framework, "The formation of primary health care teams must be derived from the needs of the community and those teams must be made up of primary health care providers who can meet those needs" (p. 17). In order to address concerns expressed by

physician members of the PHCSC, a section was added to the PHC Framework under *Team Membership*. This section was dedicated to responding to a contentious statement that appeared in the PHCSC's (2010) discussion paper, *Improving Access and Delivery of Primary Health Care Services in New Brunswick*: "All New Brunswickers must have access to a family physician" (p. 17). It should be noted that the debate at the time was triggered by the physician committee members lobbying to have the wording changed to "All New Brunswickers must **have a** family physician." Consensus in this new negotiated section of text was achieved through revision in wording because if a New Brunswicker had a nurse practitioner as a primary care provider, they would still have **access** to a family physician as required under the nurse practitioner legislation, which stated that nurse practitioners are required to have a collaborating physician.

The PHC Framework also advocates for improved accountability specified through "shared accountability with interdisciplinary team performance indicators and clinical outcomes" (p. 15). This recommendation, based on the Canadian Health Services Research Foundation (CHSRF) findings, and quoted in the PHC Framework as follows: "achieving a high-quality health-care system is facilitated by accountability, supported by a culture of continuous quality improvement and ongoing measurement and monitoring" (p. 20). This CHSRF-inspired recommendation challenges the social practice of the traditional, sole-provider, primary care medical practice. Traditional office-based medical practices have been critiqued because they are "neither formally part of, nor meaningfully accountable to health regions or their equivalents" (Lewis & Sullivan, 2013, p. 1-2). In an effort to address this accountability, the types of key performance indicators included within the PHC Framework all relate to the discourse of PC. They include,

> mean number of days that a patient will wait until the first available appointment, availability of same-day appointments, arrangements for extended office hours, and appropriate screening for traditional conditions like PAPs, mammography, colorectal and prostate cancers, blood pressure and blood sugars. (PHC Framework, p. 21)

Although PC discourse dominates the PHC Framework, there is a divergence to PHC discourse in Recommendation #4, dedicated to stakeholder and patient engagement. PHC discourse is evident in the discussion of literacy and socio-economic status: The PHC Framework highlights that "addressing the social determinants of health is an integral component to renewing PHC" (p. 24). The supporting government departments of Social Development and Education are referenced as important collaborators in addressing the social determinants of health and supporting "linkages between patients and community resources [that] can be better facilitated than in sole-practitioner practices" (p. 24). These statements are consistent with the discourse of PHC.

(iii) As per Bacchi's (2016) approach to policy analysis, the document analysis reveals that determining "what the problem is represented to be" involved an eight-month long process of collaboration and consultation via the PHCSC, of which I was a participating member, and positioning over what would eventually make the political agenda. There was considerable time and political investments made by participants over these months in a process led by the Minister of Health, with iterative consultation among key provincial stakeholders, eventually culminating in the PHC Framework.

Political priorities for policy development were in play during the development of the Framework, as actors engaged to determine what the problem was represented to be.

At the outset, the problem of annual increases in provincial health care spending (approximately 40% of the province's overall budget) were juxtaposed with the consistently poor health outcomes. Poor outcomes, despite this increased spending, seems to have precipitated a political response and focus (Health Council of Canada, 2010). According to the PHC Framework, the province was at "the tipping point, a point where the health-care system as it currently operates is no longer sustainable" (p. 10). Another problem addressed in the PHC Framework is the aging population and subsequent increase in chronic disease. This is linked to the unstated problem of heavy reliance in the PC system on family physicians, sole-practitioners, or as Lewis and Sullivan (2013) argue, "independent contractors to the government, who operate as cottage industry entrepreneurs with often only fleeting attachments to their place of work and its corporate objectives" (p. 1).

The work of the PHCSC, to create "a long-term strategic plan for improving primary health care in New Brunswick" (PHC Framework, 2012, p. 3), was also an intentional strategy to engage physician leaders in the transformation of the PC system. The PC system was dominated by fee-for-service physicians and the paymaster (government), which had no control and very little influence over physician practice patterns or patient outcomes (Lewis & Sullivan, 2013). Under this common remuneration model for PC physicians, "there are neither rewards for prudent system resource consumption nor penalties for profligate use" (Lewis & Sullivan, 2013, p. 2). This type of remuneration gets in the way of an efficient division of labour between doctors and other providers and discourages integration and collaboration (Lewis & Sullivan, 2013, p. 3).

The PHC Framework attempts to solve another problem: accountability within the PC system. It introduces accountability, by way of performance indicators and clinical outcomes, to a system that traditionally has minimal oversight surveillance and accountability. The recommended enhanced accountability extends to patients and their families. PHC discourse is inserted strategically to describe these enhancements, for example, with a change in focus from provider-centric to "patient-centered primary health care [which] can have a significant impact on the health of the population, especially in the prevention and management of chronic disease" (PHC Framework, 2012, p. 23). Similarly, the introduction of an *Unattached Patient Registry* for people looking for a primary care provider, transformed this haphazard function from medical staff offices in hospitals to a provincial entity (Tele-care 811), which improved transparency and access to the registration process, either by telephone or online. Pejorative terms like "orphaned patients" or patients characterized by their illness (e.g., psychiatric patient, diabetic) are absent in the recommendations and the forging of a new relationship between patients and providers is highlighted. This new relationship is characterized by "shared decision-making between patients and providers, engaged patients (who) have improved knowledge and understanding of their care and patients engaged in planning and designing health-care services" [sic] (pp. 23-24).

The PHC Framework is largely silent about other aspects of PHC, namely models like community health centres that would meet many of the recommendations contained within the PHC Framework. The discourse is mainly that of PC with tangential, disjointed, or unarticulated elements of PHC discourse. In a few instances, community engagement, intersectoral action, and addressing social inequity are interspersed in the

document, in disarticulated ways. Generally, the "problem" that the PHC Framework is addressing is the dominance of one biomedically oriented model of PC. Options for enhancing this sole-provider focused model include integration of elements of the then-current "PHC" infrastructure and associated programs, specifically interdisciplinary models of care, enhanced accountability, and different relationships with patients.

(iv) With respect to *discourse direction*, a dominant emerging discourse in the PHC Framework is the recommendation for community health needs assessments to support decisions surrounding investment in PHC and resourcing of community based PHC teams. Aligned with this emerging PHC discourse is the establishment of previously mentioned, Collaborative Services Committees (CSC), co-chaired by RHA and community physician representatives. Although discussed vaguely in the ML Report (1989), this idea is developed further in the PHC Framework. CSCs have the potential to erode the power of traditional health care structures and bring decision-making about community health closer to those clients, patients, and consumers who are most affected. A significant emerging idea in the framework is the value of forging different relationships with patients, as equal members of the PHC team, deserving of better access to care and part of the decision-making process including "planning and designing health care services" (p. 24). The final emerging discourse is that of improved accountability on a number of different levels including the requirement for electronic medical records at the interdisciplinary team level and the recommendation that "meeting performance standards will be tied to ongoing financial and resource support" (p. 20).

There are numerous examples of converging discourses of PC and PHC throughout the PHC Framework. The creation of a "culture focused on chronic disease

prevention and self-management" (p. 12), highlights the importance of PC and expands this to intersect with and include elements of the PHC related discourses of health promotion and disease prevention. Another example is the intersection of neoliberal discourse of "finding efficiencies in an effort to reduce the province's debt" (p. 10), with cost effective PC discourse, as in "the first place people go when they have health concerns" (p. 4), and with PHC discourse as in "a health care system focused on primary health care is more likely to produce better health outcomes and greater patient satisfaction, all at a lower cost" (p. 10). Missing from these statements are comments consistent with PHC discourse concerning the importance of wide-scale attention to population health, illness prevention, and addressing social determinants of health that influence health equity.

Each of the five broad recommendations contain converging elements, attempting to combine aspects of the discourses of PC and PHC, while preserving medical hegemony in PC. Recommendation #1, *Integrating primary health care services*, for example, focuses on PHC discourses of conducting community health needs assessments and establishing CSCs, but then recommends that these CSCs be co-chaired by a physician and an RHA representative (p. 14). As a subset of integration, the PHC Framework recommends that community health needs assessments provide "family physicians and allied health professionals with support and the ability to influence patient care" (p. 14). Recommendation #2, *Community-specific team-based care*, highlights responsiveness to community needs as being a key element of team-based care and promotes a team approach as being a superior method for "delivering comprehensive care, particularly for people with chronic conditions" (p. 17). Absent from this discussion

are comments consistent with PHC discourse related to achieving health equity through action on the social determinants of health. The recommendation then proceeds to promote the idea that "all New Brunswickers must have access to a family physician" and "that each primary health care model will include a family physician" (p. 17). Furthermore, the recommendation promotes the electronic medical record (EMR) as a requirement for each PHC team established and that "the College of Family Physicians of Canada found, through a comprehensive evaluation of peer-reviewed literature, that cost-sharing or financial support from government is necessary to support the high cost of EMR adoption" (p. 18). Though the benefits of adopting the EMR would likely support and strengthen PHC, these elements of text demonstrate the use of medical hegemony in efforts to preserve medically oriented PC.

The PHC Framework also demonstrates some tendencies to pursue a divergent path, for example speaking of replacing expensive acute and emergency hospital care with "cost effective, low intensity PHC focused on prevention/management" (p. 10). The PHC elements of interdisciplinary, community-based teams, along with including patients as integral team members who are competent in self-management, illustrate a tendency in the discourse to diverge from the traditional (patriarchal), sole-practitioner led, office-based practice to community based interdisciplinary teams with the patient as a central member and active participant of the team.

The PHC Framework does also contain some elements that have facilitated transformation in community-based PHC, accomplishing some of what the WHO (2008) affirms needs to be in place to ensure that PC is well-positioned within a PHC policy framework, namely "system policies that serve as building blocks to support universal

coverage and effective service delivery and public health policies to address priority health problems through cross-cutting prevention and health promotion" (p. 64). Following the development of the PHC Framework, collaboration with the New Brunswick Health Council has informed later policy decisions that divide the geographical areas of New Brunswick into 33 unique communities (NBHC, 2018). Community health needs assessments are now regular activities, occurring every four years, under the authority of the RHAs. This process has strengthened community involvement and action around the social determinants of health and led to innovative models of PHC to address health and social inequity. An *Unattached Patient Registry* was established in 2013 with a consistent process for becoming attached to a primary care provider (including a NP) and three additional CHCs have been added to the network.

In its attempt to engage primary care physicians in the transformation of PHC, the PHC Framework nevertheless also contributed to ambivalence and misunderstanding about PHC. At the time of this writing, the vision for fully collaborative interdisciplinary, team based PHC, not dominated by biomedical hegemony, focused in and with communities to achieve health equity through action on the social determinants of health, and with the partnered involvement of PHC oriented physicians (who are still practicing on a fee-for-service basis) has not been universally realized.

Document 8: *Rebuilding Health Care Together – The Provincial Health Plan 2013-2018* (GNB, 2013)

Rebuilding Health Care Together – The Provincial Health Plan 2013-2018, hereafter referred to as PHP2013, was released by the Alward government's Health Minister, Hugh J. Flemming, on September 26, 2013. The focus of the health plan was to

support a sustainable health-care system one that "New Brunswickers can count on to be there when they need it, for generations to come" (p. 3). The previous Provincial Health Plan (PHP2008), *Transforming New Brunswick's Health-care System: The Provincial Health Plan 2008-2012*, was introduced by the Shawn Graham, Liberal government under the leadership of Health Minister, Michael Murphy. The vision for that health plan was "a greater emphasis on the provision of primary health care services" and a "better balance between the promotion of health and the provision of care" (GNB PHP, 2008, p. 3).

(i). In terms of *context*, the difference in emphasis between the two health care plans marks an important discursive turn, moving (in 2013) away from the (2008) discourse of PHC reform in New Brunswick toward a system more focused on sustainable PC. In PHP2008, provincial investments included $154 million in new and enhanced health services. The broad categories of investment commitments included: "early childhood development, primary health care, mental health and addictions and chronic disease management" (p. 3). Specific investments included, "primary health care nurse practitioner positions will be increased by 40" (p. 9), and the introduction of legislation to regulate the provision of midwifery in the province with the anticipated hiring of "eight midwives followed by four per year afterwards" (p. 13). Sustaining these 2008 investments in PHC would change under a different discursive practice in 2013.

In terms of *historical significance*, PHP2013 was significantly different than its predecessor, PHP2008. Rather than a PHC investment plan, the PHP2013 is described as a blueprint for "managing existing health-care services and resources, developing new programs and policies, and making financial decisions" (p. 5). The public consultation

leading up to the development of the PHP2013 included a presentation at the beginning of each public session devoted to describing the cost of health care including how much was being spent per minute: $6000 dollars. This sum was quoted frequently by the government of the time, a neoliberal, austerity focused government (Bissett, 2018). The PHP2013, reflects a return to previous patterns of neoliberal discourse prevalent in the ML Report discussed in Chapter 4.

PHP2013 represents the third provincial health plan since provincial legislation was introduced in 2002 under the *Regional Health Authorities Act* (RHAA), mandating provincial health plans. Under the terms of this RHAA legislation, the Minister of Health "shall – in consolation with the RHAs – develop a Provincial Health Plan" (RHAA, 2002, p. 6). This Provincial Health Plan (PHP) was to contain the following elements: "principles, objectives and priorities for the delivery of health-care services, a list of health-care services to be offered by each RHA, an accountability framework," and "a comprehensive financial plan for the health-care system" (p. 6). The thinking in 2002 was that the generic PHP process would become a tool for a collaborative relationship where the eight RHCs and Department of Health officials would come together and "focus on the common needs of a single health-care system" (Castonguay, 2002, p. 4). When in the 2008 restructuring, the then eight Regional Hospital Corporations (RHCs) were amalgamated into two new entities, i.e., RHAs, the Government embarked on a new approach to health-care management. The first PHP predated this amalgamation and was developed in 2004, the second in 2008 and the third, the focus of this analysis, in 2013. Although the unique characteristics and distinct needs of the first seven regions (the Extra-Mural Hospital was the eighth

RHC), and later the two regions would be considered, the provincial health plan was to ensure that "access to health services is available to all New Brunswickers in an equitable, consistent and rational fashion" (p. 4).

With two RHAs in place (Vitalité Health Network and Horizon Health Network), PHP2013 is bookended by opening remarks from the Premier of the time, David Alward, and Health Minister, Hugh J. Flemming, and concludes with the public consultation results. The document highlights three broad sections: "New Brunswick's Role in Canadian Health Care; Health Care and Population Health: A Report Card; and A Blueprint for Sustainability" (pp. 6-18). The bulk of the PHP2013 is found under Section A Blueprint for Sustainability, which contains four subcategories: The Foundation; Rebuilding Our Health Care Together; Rebuilding Our System; and A Strong Vision (pp. 9-16). The Rebuilding Our Health Care Together section contains two appendices: Appendix A lists initiatives that are in progress (Year 1 Initiatives); Appendix B details the public consultation process, coordinated by the New Brunswick Health Council, which informed the content of the PHP2013. The historical significance of the PHP was the consultation process with RHAs and the potential for equitable access for all citizens in New Brunswick.

(ii) The *analytic framework*, beginning with the *text* of PHP2013 represents the problem as a legislative requirement, with the underlying social problem characterized as a "sustainable, safe and high quality" health care system (p. 3). The text reflects the Conservative government's "strategic vision of a stronger economy and enhanced quality of life while living within our means" (GNB, 2013). Neoliberal discourse is prevalent

within the text with health care organized into seven principles: access, appropriate range of services, effective, efficient, equitable, safe and clinically sustainable" (p. 5).

Under section #1, *New Brunswick's Role in Canadian Health Care,* the PHP2013 articulates the federal and provincial roles in providing health care: "The provincial government is largely responsible for funding the health-care services provided to New Brunswickers" (p. 6). The initial funding formula, which had enticed New Brunswick to join the national universal health care program some 40 years prior, had been eroded from 40% cost-sharing to approximately 20% of expenditures (p. 6). The PHP2013 emphasises the growing costs of health care, from "$2.4 billion in 2004 to $3.1 billion in 2013" (p. 6). The New Brunswick "health-care math" of health care costing "$6,000 a minute" (p. 6) is reiterated again in this section of the text. Feedback from the public consultations is woven throughout the PHP2013. In this section, related to rising costs, the PHP2013 references the public consultations: "New Brunswickers told us in consultations that the province is simply living beyond its means" (p. 6). The section concludes with a statement about investments: "Improving health involves more than hospitals and equipment. The right investments, supported by evidence, must be made in the right places, delivered by the most appropriate health provider" (p. 6). Positioning the Conservative political platform of rationalization and reduction within the voice of the citizen, as "what was said", is an overall neoliberal strategic direction in the PHP2013.

The PHP2013, Section #2, *"Health Care and Population Health: A Report Card"* (p. 7), begins with a statement attributed to citizens: "New Brunswickers clearly understand that the health-care system in New Brunswick is under financial pressure that is not likely to ease as the population ages" (p. 7). From here the PHP2013 details "what

the system does well and where it can do better" (p. 7). The first focus of this section is dedicated to health professionals: "over 20,000 health professionals, mostly doctors, nurses and other allied health professionals" and "74% of health expenditures directed to employee remuneration" (p. 7). Emergency care or serious illness care is cited to be better, and more accessible than regular non-urgent care: "getting access to timely care for more routine problems or preventative check-ups, however, is a regular frustration for New Brunswickers" (p. 7). Data are presented to demonstrate the significance of health human resource staffing in the province, a neoliberal discourse focused on, in this instance, primary care providers: "New Brunswick's health human resource staffing levels are generally higher than the Canadian average. For example, New Brunswick has 113 general or family physicians per 100,000 people while the Canadian average was 106 per 100,000" (p. 7).

The next focus of PHP2013 is described as "population health challenges": "New Brunswickers have been investing heavily in acute care, advanced technology and health human resources, but evidence suggests we could do a better job looking after our personal health" (p. 7). Intertextuality is demonstrated by the similarity of neoliberal discourse found in the ML Report (1989), discussed in Chapter 4, concerned with people neglecting their health and engaging in unhealthy behaviors like smoking, being overweight, and avoiding exercise and therefore responsible for their own health challenges. The PHP2013 notes, "The CIHI statistics state that New Brunswickers exceed the Canadian average in smoking rates, adult obesity rates, unhealthy alcohol use, diabetes, heart and respiratory disease" (p. 8). This focus on individual lifestyle concerns is aligned with an individualistic, neoliberal approach to policy development where issues

of structural inequity are silent (Raphael, 2008). Instead of speaking to the importance of developing health promoting public policy and strengthening equity in relation to the social determinants of health, the PHP2013 emphasizes the minimal role that health care systems play in achieving health: "In fact, the health-care system only has a 10 percent impact on a person's overall health" (p. 8). In puzzling ways, this return to neoliberal discourse appears to absolve the health care system of any responsibility in addressing population health and health equity. The PHP2013 implies that chronic diseases like "cancer, heart disease and diabetes", are the result of an individual's poor lifestyle choices, and "are the major causes of illness and death in developing countries like Canada," and "management of these diseases is a costly and often life-long process" (p. 8).

The PHP2013, Section #3, *A Blueprint for Sustainability,* speaks to "a blueprint that guides the involved partners in their work. Each partner reads the plan to understand how their work and expertise contributes to the bigger picture" (p. 9). The document claims that the blueprint will "move the province's health-care system from a 20th Century model structured around providers and facilities to a more modern approach focused on patients living healthy lives in their communities" (p. 9). It predicts that the future will be one of "New Brunswickers supported by top-quality, more accessible health professionals" (p. 9). A hybridized form of discourse emerges in this section, with elements of PC discourse (more accessible providers, client-centered care), PHC discourse (community-based health promotion and healthy individuals in healthy communities) appearing alongside examples of strategically positioned neoliberal

discourse. This pattern of competing strands of discourse being woven together continues through other sections in the PHP2013.

Section #3 is divided into four subsections: *The Foundation, Rebuilding Our Health*, *Rebuilding Our System*, and *A Strong Vision* (pp. 9-17). *The Foundation* is about "stakeholder input and public engagement, sustainable budgets, performance excellence process and health intelligence" (p. 9). The *Foundation* claims that "for the first time in history, the New Brunswick health-care system's most important stakeholders--its clients and patients--were given an opportunity to contribute to the development of the provincial health plan" (p. 10). This is promoted as a significant accomplishment, facilitated by the New Brunswick Health Council, involving nine communities across New Brunswick (NBHC, 2013). In the context of the then active work of the Truth and Reconciliation Commission of Canada (2015), it is notable that public engagement in PHP2013 specifically included input from First Nations communities. First Nations are the only specific group mentioned in this section: "First Nations communities spoke of the impact their history has had on the health status of Aboriginal persons" (p. 10).

The *Foundation* indicates that "sustainable budgets" (pp. 9-11) is a significant policy direction of the Alward Conservative government. The health care budget, which had grown consistently, by approximately eight percent annually since 2000, had been reduced to three percent growth in the early years of the Alward administration (NBHC, 2010; PHP, 2013). The PHP2013 states that the NB Government projects a "rate of growth for 2012-13 as 1.6 percent" (p. 10), and "is targeting a zero percent growth rate in health-care" (p. 10) for 2013-2014.

Another element of *The Foundation* titled *Performance Excellence* (p. 10), was a Conservative government-wide program, implemented during the Alward administration, and still prominent at this writing, to change the mindset of employees and administrators to one that reduces costs, while also being focused on growth and continuous improvement through process optimization (GNB, 2021). According to the current GNB website, *Performance Excellence* indicates that this strategy has contributed to,

> a profound cultural change that has increased efficiency and accountability, improved services to the public, streamlined administration, and seen continuous improvements across the provincial government. This is leading to a more focused workplace, and more efficient and affordable services for New Brunswickers. (GNB ECO website, 2021)

Since its implementation in 2011, political leadership has credited *Performance Excellence* with increasing efficiency and accountability and improved services to the public (GNB, 2014).

Performance Excellence is modeled on Lean Six Sigma methodology, borrowed from business and industry and applied to government services including health care. Health system outcomes, measured by key performance indicators, are foundational to this methodology. It is a collaborative, team-based effort to improve organizational performance by systematically removing waste and reducing variation. It combines "Lean" manufacturing techniques around waste reduction perfected by Toyota in Japan with "Six Sigma" based metrics developed by Motorola to reduce variation. Overall improvement is guided by a process that incorporates a cyclical model of "define, measure, analyze, improve and control" (Summers, 2011, p. 3). This neoliberal cultural

shift in the New Brunswick civil service, has become a foundational way of operating (GNB, 2021).

From a health care perspective, the NB Government has credited *Performance Excellence* with substantial savings and reduced wait times for hospital-based services (GNB, 2014). According to the neoliberal discourse around *Performance Excellence* in the PHP2013, it was implemented to "save money and reduce waste while increasing quality of care and patient satisfaction" (PHP2013, p. 10). *Performance Excellence* uses a formal management system built on what PHP2013 describes as "leading business practices to develop, communicate and review strategy (p. 10). The PHP2013 states that "performance excellence can save money and reduce waste while increasing the quality of care and patient satisfaction" (p. 10). These elements of neoliberal discourse point to the commodification of health care in ways that are consistent with manufacturing and commerce, marking a divergence from the WHO discourse of PHC as a paradigm of practice for achieving health equity.

In a similar way, the final element of the *Foundation* described in PHP2013 is that of "Health Intelligence" (p. 11), which speaks to the development of health policy based on intelligent understanding and the use of a multitude of sources of health data that are collected by the Health Ministry: "The Department of Health manages a wealth of data about what services have been offered to New Brunswickers, the outcomes of care and associated expenditures" (p. 11). This neoliberal discourse of tracking and controlling costs and outcomes of care in PHP2013 states that health intelligence data will be used to "predict, forecast and support evidence-informed decision-making" (p. 11).

Rebuilding Our Health (p. 11), another significant component of the PHP2013 *Blueprint for Sustainability*, also speaks to a system shift away from "hospital-based care to prevention interventions and primary health care (p. 11). PHC is credited with improving health outcomes: "A system focused on primary health care and population health is also more likely to produce better health outcomes and greater patient satisfaction (p. 11). This section of PHP2013 demonstrates a modest element of PHC discourse. This occurs by mentioning a shift away from hospital-based care and acknowledging that PHC and population health may produce better health outcomes. However, a focused discussion of addressing the social determinants of health and structural sources of health inequity is not found in this document. Instead the text weaves elements of PHC discourse into "hybrid" (PHC-PC) references to primary care providers: these include "better access to patient-focused care, better access to necessary medications, more services at home and a healthier population" (p. 9).

The PHP2013 section *Better Access to Patient-Focused Care* (p. 11-12) affirms that the PHC Framework "provides a strategic plan to renew the delivery of PHC in New Brunswick" (p. 11). Without specifying an explicit framework for addressing the social determinants of health and addressing structural sources of health inequity, the PHP2013 endorses the importance of PHC teamwork:

> The research is clear: New Brunswick must build multi-disciplinary teams that will provide residents with timely access to primary health care, and coordinated support and treatment from other health care professionals such as nurses, dieticians, counselors and respiratory therapists. (p. 11)

Its reference to PHC teams in this section reflects a hybrid definition of PHC, i.e., a composite of discourses of PHC and PC. PHP2013 also highlights other initiatives, including an *Action Plan for Mental Health in New Brunswick 2011-2018* that promotes an all-government approach to service delivery and *A Comprehensive Diabetes Strategy for New Brunswickers*, under which insulin pumps to children with diabetes are provided (p. 12). The discussion of PC occurring through multidisciplinary or interdisciplinary practice is silent on defining how these teams will address the elements of PHC.

The PHP2013 section *Better Access to Necessary Medications* (p. 12) is an example of attempting to address health inequity using some elements of the discourse of PHC. It speaks to the unaffordability of medications by a number of citizens, especially those managing chronic illness or those who "need access to one very expensive (catastrophic) drug" (p. 12). Although remaining silent about the social determinants of health, the PHP2013 recognizes the inequity of unaffordable medication and offers a solution: "The government of New Brunswick is developing a new prescription drug insurance plan which will help prevent New Brunswickers from experiencing financial hardship because of prescription drug costs" (p. 12).

The PHP2013 section *More Services at Home* (p. 13) promotes home care as a shining example of cost-effective, "integrated, patient-focused health care" especially for "seniors and those requiring palliative care" (p. 13). In this section, the discourse again weaves elements of neoliberal cost containment with concerns for access to PC and palliative care provision – especially among vulnerable elders. The PHP2013 endorses the Extra-Mural Program as one that can "provide improved access to appropriate health care" (p. 13) and speaks to providing greater emphasis on home-based care for seniors. A

new inter-departmental (Social Development, Health and Healthy and Inclusive Communities) initiative, *Home First* is highlighted as an initiative that "will help seniors age well at home and avoid unnecessary hospital admissions or premature placement in long term care facilities" (p. 13). Within this section the PHP2013 promotes the government announcement of the "creation of over 1,000 new beds for both nursing homes and special care homes to "help alleviate the pressure on the hospital system" (p. 13). It should be noted that these 1,000 beds are available to everyone irrespective of ability to pay but a financial evaluation is completed by the Department of Social Development and those who have the ability to pay are required to do so.

Healthier Population, a subsection of PHP2013 *Rebuilding Our Health*, describes a smorgasbord of initiatives under Public Health, the RHAs and the provincial Cancer Care Network. Public Health is promoted as an entity that is, "critical to keeping people healthy by examining the needs of the population as a whole; emphasizing the prevention of disease, injury and premature death at the population level; and protecting the public from the risk of harmful events and exposures" (p. 13). This acknowledgement of Public Health and its role in population health is an important component of PHC and its presence is an important part of PHP2013. The WHO's Astana Declaration on Primary Health Care (2018) addresses the critical relationship between public health and PC in achieving PHC for all. The Astana Declaration states: "We need PHC that ensures strong public health and primary care throughout people's lives, as the core of integrated service delivery" (p. 1) and emphasizes the need to "put public health and primary care at the centre of universal health coverage" (p. 2). The PHP2013 describes initiatives that address "longstanding health inequities in various sectors" (p. 13) with particular

emphasis on “First Nations’ populations and children’s health” (p. 13). Using the discourse of population health and specifically public health, the document amalgamates discourses of PC and PHC – advocating something that approaches PHC discourse. Although it does this without addressing the social determinants of health (i.e., early childhood development, education, employment and work, food security, health services, housing, income distribution, social exclusion and the social safety net [Health Canada, 2013]). This silence about the social determinants of health and structural inequity erodes confidence that the document is consistent with the principles of PHC described in the Astana Declaration. On the other hand, other initiatives highlighted in this subsection include cancer screening such as cervical, colon and breast screening programs where “the New Brunswick Cancer Network will work with primary health care practitioners and the regional health authorities to implement organized and targeted screening programs” (p. 13). These aspects of the text employ terms (e.g., public health and population health) that are consistent with crucial aspects of PHC. At the same time, different aspects of the text continue to deploy terms that blur the difference between discourses of PHC and PC. For example, referring generically to “primary health care practitioners” perpetuates ambiguity between specific PC providers and PHC providers. While family physicians are not registered/regulated as “primary health care practitioners” in NB, they are assumed in this government text to be de-facto providers of PHC. Nurse Practitioners on the other hand are specifically educated and registered to provide advanced practice nursing in primary health care – which is recognized as a form of primary care.

The section *Rebuilding Our System* (p. 14) is depicted in the schematic representation of PHP2013, as the balance block to the overall vision for *Rebuilding Our Health*. Subsections of the *Rebuilding our System* include: "principled decision-making, bench-marking, and equitable delivery of services" (p. 14). This section of the text highlights a "commitment to excellence" and the "right to safe services in the (official) language of choice" (p. 14). It promotes clinical sustainability in that services provided must have "enough patient volume to make it financially viable and possible to maintain clinical expertise" (p. 14). This is a familiar neoliberal discourse: clinical sustainability based on volume. Many rural hospitals do not have sufficient volumes in surgery or hospital based obstetrical care to meet the key performance measures of sustainability (McDonald, 2020).

The *Rebuilding Our System* section of PHP2013 demonstrates an emphasis on the discourse of PC, i.e., biomedically oriented physician-based medical primary care, provided mostly in hospitals. Under principled decision-making, the PHP2013 clearly articulates four principles pertaining to health care that will be applied to all decisions made by government: "quality, efficiency, access and clinical sustainability" (p. 14-15). Each of the principles relates to care, by physicians in hospitals. The principle of "quality" focuses on volume: "Better outcomes in high-volume hospitals have more to do with a greater institutional proficiency with all aspects of care than a reflection of a physician's skill" (p. 14). "Efficiency" concentrates on avoiding duplication: "An efficient health-care system avoids the unnecessary duplication of services and makes the best of available human and financial resources" (p. 14). "Access" addresses services provided in a system of medically oriented PC, considering wait times and other

characteristics: “The following must be given consideration: whether the target population is receiving the service in question; how long a wait is required; what distance must be traveled to obtain the service; whether the service is provided in the official language of choice” (p. 14). The final principle, “clinical sustainability”, speaks to “volume of services provided and to the health-care human resources available” (p. 15). It specifies that in order for a clinical service to be sustainable “requires four or five physicians in one specialty to ensure a program is available 24 hours per day, seven days per week, 365 days per year” (p. 15); It also speaks to “an adequate volume of patients for physicians and other providers to maintain their skills” (p. 15). The PHP2013 strategically leverages a quote from the NBMS to conclude its comments on clinical sustainability, “partner with professionals to develop a roadmap…that outlines which tertiary centres provide which service, reducing the need for each hospital to have identical expensive equipment and services” (p. 15).

The *Rebuilding Our System* subsection, *Benchmarking*, highlights how hospitals will be compared to each other and to “similar facilities across the country” (p. 15). This idea perpetuates neoliberal discourse in likening successful performance of hospitals to the corporate sector: “Businesses measure their market share” (p. 15). The strength of benchmarking is endorsed: “This process allows system administrators and health professionals to see what is being done well in New Brunswick and how those lessons and innovations can be applied to other services” (p. 15). While the sustainability of hospitals is critically relevant to PHC, this section of the document is silent about a context of PHC as necessary to support sustainable care, when it is required in hospitals, consistent with health equity.

The final subsection of *Rebuilding Our System, Equitable Delivery of Services*, equates the equitable delivery of services as "high-quality health-care services without any linguistic barriers" (p. 15). The potential of this subsection to also describe health equity through the lens of intersecting social determinants of health like ethnicity, racialization, gender, sexual identity, First Nation ancestry, immigration status, poverty—or to focus on geographical/demographic and urban/rural tensions—is lost, a missed opportunity. Instead the PHP2013 focuses almost exclusively on linguistic tensions. Though of crucial importance, this singular emphasis reflects long-standing tensions in NB framed around linguistic barriers to health equity. While crucial, it falls short of addressing the complexity required for PHC. Within this section, the PHP2013 announces the development of "a five-year *Action Plan for the Equitable Delivery of Services*" that is intended to fulfill "the provincial government's commitment to improve distribution of services to the Francophone population across New Brunswick" (p. 15). This subsection does not address the importance of community engagement to determine effective community based models of PHC, does not address action on the social determinants of population health, nor does it address system level changes needed for interprofessional collaboration across ministries to improve health equity. The section concludes with a glimpse into the future: "If a new service is added or a service is extended, it will be provided, where possible, in the health authority not currently offering it" (p. 16). This final sentence does speak to providing equitable services to both an Anglophone and Francophone population and ensuring that a similar menu of health services are available in both RHAs.

The final component of PHP2013, the apex of the *Blueprint for Sustainability,* is the section titled *Strong Vision*: "Just as a home requires a strong roof to protect the family living inside, the provincial health plan needs a strong vision to protect it and ensure its success" (p. 16). The two visionary components detailed in this section include: "connected by technology" and "greater integration and co-operation" (p. 16-17). The component *Connected by Technology* (p. 16) describes "the next phase in the evolution of the electronic health record (EHR)" (p. 16), implementing the electronic medical record (EMR) for physicians' offices and a drug information/prescription monitoring system for pharmacies.

The component *Greater Integration and Co-operation* (p. 17) encourages New Brunswickers to "work together to address the province's health-care challenges" (p. 17). In addition, this section of the PHP2013 compels health care workers to be more cooperative and integrative: "Health-care providers must also work together, so that the system is integrated, affordable, and reflects the key principles" (p. 17). An endorsement for interdisciplinary teams concludes the section: "It is also important to have integrated teams of health care providers and to allow health professionals to work to their full scope of practice" (p. 17).

The conclusion of the PHP2013 highlights the need for transparency and a commitment to accountability. The Conservative government, through the PHP2013, will publish "a list of key initiatives for the health system, each spring on the Department's web site, that will outline the strategic activities the health partners will undertake in support of the provincial health plan" (p. 18). Appendix A of the PHP2013 provides a

detailed table of “Year 1 Initiatives” (p. 19-21), all of which are highlighted in the various sections of the document.

At the *discursive practice* level, the PHP2013 belongs to a genre of texts that are representative of values in “western healthcare that often reflect neoliberal discourse and focus on the values of the modern liberal state” (Anderson et al., 2017, p. 2). The ideological underpinnings of PHP2013 reflect what Miller and Rose (2008) refer to as “technologies of government” that shape and normalize certain understandings of practice or reality (p. 32). As discussed in Chapter 2 the term “governmentality” was first introduced by Foucault (1997) as part of his investigation of political power. It is understood broadly as “techniques and procedures for directing human behaviour” (p. 82).

As an example, governmentality was demonstrated beginning with the public consultations that informed the development of PHP2013, where the sustainability of the current healthcare system was the focus of each session. PHP2013, Appendix B, details the consultation process: “The Department of Health has a legislated mandate to consult about the development of the provincial health plan” (p. 22). The PHP2013 asserts that “for the first time,” the department had engaged “its most important stakeholders: New Brunswickers” (p. 22). While important, the generic “New Brunswicker” who did participate in the sessions appears also to have been deemed less knowledgeable about health care than those who work in government and in the health care system. The text explains next that those who work in the health system are acutely aware of the challenges New Brunswick is facing. The government felt strongly that this information

should be shared with all New Brunswickers so that they, citizens, could provide meaningful input to the provincial health plan (p. 22).

As part of the knowledge acquisition, a video, developed by the Communications Branch of government, "which succinctly provided the facts and outlined the realities facing the province was played at the beginning of each consultation session" (p. 22). The video (http://youtu.be/iVp_8DatO-s) focuses on the cost of health care: $6000 a minute, $3.1 billion a year, and highlights the largest expenditures, i.e., remuneration for health care professionals. The video takes a pessimistic stance regarding an aging and otherwise unhealthy population, the use of emergency rooms for non-urgent conditions, and the lack of team-based care. The use of the video at the beginning of each public session laid the foundation for the dialogue that would ensue. As introduced in Chapter 2 governmentality consists of relationships and practices that result in particular ways of governing from afar and attempting to shape the behaviour of individuals and groups (Foucault, 1997; Miller & Rose, 2008). This strategy of governmentality narrowed the discourse and created a values-based framework within which ideas and dialogue would be considered. The PHP2013 additionally endorses its own consultative approach: "Those who participated in the consultation sessions said that the video is essential viewing for all New Brunswickers" (p. 22). This manipulative discursive process is again aligned with the concept of "technology of government" or governmentality, a complex mechanism that helps governments shape the decisions or conduct of others to achieve their objectives (Miller & Rose, 2008).

The PHP2013 draws on neoliberal discourse through the use of the performance excellence management processes, an all of government approach adopted by the Alward

government as a "results-oriented, long-term approach to doing business" (p. 10). In application to health care "performance excellence can save money and reduce waste while increasing the quality of care and patient satisfaction" (p. 10). The focus on individual responsibility is an element of prevalent neoliberal discourse in the PHP2013. The implication is that individuals, especially those with chronic disease, and the aging of the population are reasons for rising health expenditures: "The real challenge [exists] in New Brunswick, where 70 percent of the senior population has at least one chronic condition and the province's fastest growing demographic is aged 65 or older" (p. 8). Missing from this text is the discourse of PHC, which draws attention to taking action on the social determinants of health and eliminating structural sources of health inequity. For example, focusing on income security and housing as structural sources of inequity leading to health challenges in an older population would reflect a discourse grounded in primary health care.

The concept of intertextuality as discussed in Chapter 2, or how the text seeks to justify statements through direct or indirect references to other texts (Fairclough, 1993), occurs in direct reference to the public consultations, the NBMS, the PHC Framework and evidence generators like CIHI and the NBHC. Indirect references are made in relation to value-based "public management and political discourse based on the values of market-economy thinking" (Andersen et al., 2017, p. 5). Examples of this market-economy thinking in PHP2013 include: "The Provincial Health Plan 2013-2018 -- supports the New Brunswick government's strategic vision of a strong economy and an enhanced quality of life while living within our means" (p. 5); "The province is simply living beyond it means" (p. 6); "The right investments supported by evidence must be

made in the right places" (p. 6); and "They told us that simply throwing money on the table is not a solution" (p. 6).

Despite the predominance of neoliberal discourse in the PHP2013, there are other instances in this document that reflect *interdiscursivity* in relation to PHC. *Interdiscursivity* is the aspect of a discourse that relates it to other discourses (Fairclough, 2001; Wodak, 2001). There are ambiguous attempts in the document to refer to PHC. However, these instances are consistently silent about the social determinants of health and health equity, elements found in PHC discourse. Instead, the document appears to seek convergence between PC and PHC, conflating the latter with the former.

Interdiscursivity is also evident when the PHP2013 refers to what "New Brunswickers" shared during both the public consultation sessions or by way of invited written submissions. In this way the PHP2013 is presented as a negotiated text, or a text that has achieved public consensus without a need for debate or argument (Fairclough, 2001). This consensus is depicted both through the use of the word "we" and or "New Brunswickers." Examples of this include: "This leaves New Brunswickers with 80 percent of the costs of the province's most expensive and rapidly growing program" (p. 6); "New Brunswickers clearly understand that the health-care system in New Brunswick (and the rest of Canada) is under financial pressure that is not likely to ease as the population ages" (p. 7); "New Brunswickers are satisfied with their quality of care" (p. 7); "New Brunswickers have been investing heavily in acute care, advanced technology and health human resources" (p. 7); "We could do a better job looking after our personal health" (p. 7); "We can and should measure performance in health care" (p. 15); and "People naturally measure their success against the performance of their peers" (p. 15).

The implication of these statements is that collaboration has been achieved and that the people of New Brunswick, including health care professionals, will support the values and vision of PHP2013.

A hybrid discourse, a fusion of PC and PHC, appears in the sections *Better Access to Patient-Focused Care* (p. 11) and *Healthier Population* (p. 13). These sections include references to "multi-disciplinary teams with timely access to primary health care" (p. 11), and an all of government approach to taking action on mental health, referencing the *Action Plan for Mental Health in New Brunswick 2011-2018* (p. 12). In these sections, PHP2013 credits public health with being "critical to keeping people healthy by examining the needs of the population as a whole" (p. 13). This hybrid convergence of discourses of PC and select elements of PHC is also found in superficial references to the social determinants of health, for example with "an action plan for children's health, improving health among First Nations' populations and addressing longstanding health inequities in various sectors … all areas of interest for Public Health" (p. 13). Even given rare references to PHC in the document, details about achieving health equity and a strong emphasis on this are absent from the text.

At the *social practice* level, this analysis further demonstrates how the PHP2013 is an example of governmentality. In analyzing this document, governmentality as a practice became evident. The use of preemptive public consultation and universalizing references to New Brunswickers throughout the text implies that citizens support and will support the proposed government policies found in the Plan: "This plan could not have been developed without first talking to New Brunswickers" and "They also recognize that change is necessary if we are to protect our universal health-care system" (p. 1). The use

of this phrase is somewhat manipulative and a misnomer. Although universal health-care is one of the tenets of the Canada Health Act, health outcomes in Canada provide empirical verification of health inequities (CIHI, 2015, 2018). Silence about those inequities is replaced here by a scare-tactic appeal to "protect the universal system." This strategy is clearly not consistent with foregrounding PHC discourse to address health equity.

Governmentality is similarly found in the neoliberal discourse throughout the PHP2013 as the threat of an unsustainable health care system is aligned with references to the need for reigning in costs through strategies vetted in a consultation process: "The process also made one thing very evident: New Brunswickers understand the reality that our health-care system is at a crossroads and decisions need to be made" (p. 3), and "They told us very clearly that they don't want more money spent on health care" (p. 3).

The PHP2013 also demonstrates governmentality in its challenges to existing patterns of health human resource allocation and existing emphasis on acute care. This response seems related to (presumably) frequently heard narratives from professional organizations and unions about the need for more health human resources: "New Brunswick's health human resource staffing levels are generally higher than the Canadian average" (p. 7). In relation to health human resources questions, the PHP2013 specifically challenges medical hegemony with numbers and facts: "Getting access to timely care for more routine problems or preventative check-ups, however, is a regular frustration of New Brunswickers" (p. 7), and "New Brunswick had 113 general or family physicians per 100,000 people while the Canadian average was 106 per 100,000" (p. 7). As per the ML report, examined previously, the PHP2013 similarly attempts to shift the

focus of health care from (expensive) acute care hospitals to selfcare: “New Brunswickers have been investing heavily in acute care, advanced technology and health human resources, but the evidence suggests that we could do a better job looking after our personal health” (p. 7).

In the recommended shift away from acute care, PHP2013 does refer to PHC, employing intertextuality to reference the *Primary Health Care Framework*: “shifting the focus from hospital-based care to preventative interventions and primary health care has been linked to improved overall health” (p. 11). But the document does not take up a discussion of PHC as a framework for health care reform and it contains only fleeting references to health inequities and the social determinants of health. The purported focus on PHC is presented ambiguously - conflating discourses of PHC with PC and using neoliberal arguments to support the Government of New Brunswick’s agenda of better health outcomes at a reduced cost: “A system focused on primary health care and population health is also more likely to produce better health outcomes and greater patient satisfaction” (p. 11). Concurrently (in the same paragraph), the status quo of PC delivery through stand-alone physician offices is challenged in the promotion of team care: “The research is clear: New Brunswick must build multi-disciplinary teams that will provide residents with timely access to primary health care” (p. 11). Here the text is conflating PC and PHC discourses while advancing neoliberal reforms. This includes promoting team oriented PC as an option for better integration and coordination: “A team approach will allow for the development of an integrated and holistic treatment plan to combat chronic disease and obesity” and “coordinated support and treatment from other

health professionals such as nurses, dieticians, counselors and respiratory therapists" (p. 11).

The PHP2013 is also an example of an important opportunity for the Alward government to apply/assert its neoliberal thinking around performance excellence, Lean Six Sigma, and key performance indicators to health care. Performance "excellence" is high-lighted intertextually as a foundational element of the section *Blueprint for Sustainability:* "Horizon Health Network was one of the first six early adopters in the Government of New Brunswick's Performance Excellence Process, which is a results-oriented, long-term approach to doing business" (p. 10). The *Rebuilding Our System* section is characterized by heavy intertextuality in this regard, dedicated to performance excellence as a foundational element, and highlighting alternative methods for decision-making in health care: "principled decision-making, clinical sustainability, benchmarking, equitable delivery of services" (p. 14-15). Consistent with elements of performance excellence, "quality" in this section is aligned with volume: "Better outcomes in high-volume hospitals have more to do with a greater institutional proficiency with all aspects of care than a reflection of a physician's skill" (p. 14). "Efficiency" in health care is defined as avoiding "unnecessary duplication of services" (p. 15) and making the "best use of available human and financial resources" (p. 15). "Benchmarking" is portrayed as a natural process: "People naturally measure their success against the performance of their peers" (p. 15). Performance excellence is also promoted as a must-do activity occurring within all Alward government departments: "We can and should measure performance in health care. The office of Health System

Renewal has undertaken a benchmarking process to determine how well New Brunswick's hospitals are performing" (p. 15).

The Office of Health System Renewal (OHSR), mentioned above, warrants further explanation. The OHSR was an entity established by the Alward government in 2012 tasked to "provide focused leadership and accelerate efforts to build a sustainable health-care care system in New Brunswick" (GNB Press Release, 2012). The co-leads of the OHSR were Rino Volpé and John McGarry, who after two years with the Office, were inducted as Chief Executive Officers of the Vitalité and Horizon Health Networks respectively. Although the intent was health system renewal, the focus of OHSR work was dedicated almost exclusively to the hospital system and this focus is reflected in PHP2013.

The social practice of governmentality at work in PHP2013 is an attempt to propagate the Government of New Brunswick's agenda of cost reduction accompanied by disengagement from challenges in population health and health equity. This included stepping away from social programs by disguising the predominant neoliberal discourse as public will and public backlash against the medically dominated hospital system. PHC discourses are limited in PHP2013.

Still, there are some important examples of concerns related to health equity in PHP2013. These include brief comments in relation to medication coverage: "The Government of New Brunswick is developing a new prescription drug insurance plan which will help prevent New Brunswickers from experiencing financial hardship" (p. 12). Other comments mention strengthening "culturally appropriate services for First Nations communities and addressing longstanding health inequities" (p. 13). Although

the social determinants of health are not mentioned specifically, food safety and healthy nutrition are referenced, as is an "action plan for children's health and improving health amongst First Nations' populations" (p. 13). In the context of the TRC and children's health, these references demonstrate interdiscursivity attuned to population health.

While neoliberalism is the dominant discourse, PHP2013 strings together other discursive elements in ways that obscure a neoliberal preservation of biomedical and corporate hegemony. Other elements like community-based care, multidisciplinary teams, more patient-centered care at home, a *Comprehensive Diabetes Strategy* and an *Action Plan for Mental Health* are inserted into the text, exemplifying the agenda of performance excellence and cost reduction. The emphasis in these aspects of the text demonstrates the commodification of "performance" in health care practice, viewed through the lens of market forces rather than social justice (Raphael, 2009).

(iii) The *problem,* as presented in PHP2013, is the fiscal sustainability of the New Brunswick health care system. However, the unarticulated problem includes the less than satisfying accountability of the hospital system, the biomedical establishment, and those who manage these interests. The Alward government used the year leading up to the development of PHP2013 as a time to inform the public of the "facts" of health care spending and to use these "facts" to socially produce the forms of knowledge that were required to constitute "the real" (Bacchi, 2016). This governmentality discourse, of speaking through citizens about the cost of health care, is the most coherently dominant discourse of PHP2013: New Brunswickers are said to agree that "the province is living beyond its means," "increases in health-care spending are far outpacing the province's ability to afford them," and "simply throwing money on the table is not a solution" (p. 6).

Governing takes place through this full range of knowledge that has been shared and extended to the public (Bacchi, 2016). With this foundational document and its assertion of public support for cost reduction and reform, an established neoliberal discourse of performance excellence and accountability is introduced. It is here that PHP2013 speaks to first *Rebuilding our Health* through individual accountability: "The need for New Brunswickers to live healthier lifestyles and a desire to improve access to health care at the community level was an important topic at all of the sessions held" (p. 11). The PHP2013 follows up with the system accountability in "rebuilding our system" (p. 14). The use of the word "our" in both of these sections suggests a general consensus in and universal ownership of the proposed plan.

In "*Rebuilding our System*" PHP2013 stresses performance excellence and introduces a new entity, the OHSR, to monitor accountability: "The Department of Health and the Office of Health System Renewal are working together to optimize the delivery of clinical services province-wide" (p. 14). Areas high-lighted for more accountability are basically all hospital-based services. Examples include those services that are not clinically sustainable, and these are defined exclusively as a function of physician presence and hegemony: "A clinically sustainable service typically requires four or five physicians in one specialty to ensure a program is available 24 hours per day, seven days per week, 365 days per year"; "An adequate volume of patients is also necessary for the physicians and other providers to maintain their skill" (p. 15).

The underlying problem that PHP2013 is attempting to tackle is the lack of accountability for health outcomes prevalent in the current medically dominated system (Lewis & Sullivan, 2013; Simpson, 2012). The final section of PHP2013 appeals to those

working within the system and the problems with lack of collaboration: “Health-care providers must also work together, so that the system is integrated, affordable, and reflects the key principles described earlier” (p. 17). There is also an emphasis on hospital-based care: “Acute care is increasingly specialized and smart decisions need to be made to ensure their quality, safety and efficiency” (p. 17).

(iv) An *emerging discourse* (Bacchi, 2012, 2016) in PHP2013 is the focus on “performance excellence” and the introduction of the Office of Health System Renewal (OHSR). As previously discussed, performance excellence is a management philosophy that was adopted by the Alward government under the leadership of then finance minister, Blaine Higgs, and continues today under his leadership as Premier. It is described on the Government of New Brunswick’s website today, as it was in 2013 as “a profound cultural change that has increased efficiency and accountability, improved services to the public, streamlined administration and strives for fiscal sustainability” (GNB, 2021). The OHSR was mandated to oversee the elements of performance excellence as applied to health care, namely principled decision-making (quality, efficiency, access and clinical sustainability), benchmarking, and equitable delivery of services. Through this neoliberal discourse that privileges concepts such as strategic alignment, change management and fiscal sustainability, health care is conceptualized as a corporate versus a social organization or social safety net that addresses health equity.

Another discourse emerging in PHP2013 is the description of equitable services defined as services without “linguistic barriers” (p. 15) and particular attention is paid to “a five year *Action Plan for the Equitable Delivery of Services* (p. 15) that details the “government’s commitment to improve distribution of services to the francophone

population" (p. 15). In 2012, under pressure from Égalité Santé en Français, the Alward government committed $9 million over five years for a "catch-up" plan to help Vitalité Health Network match some of the services offered in Horizon Health hospitals. These aspects of the text demonstrate discursive (and presumably social) practices focused on health equity for Francophone New Brunswickers. To its credit, other vulnerable populations that are mentioned in the document are First Nations, children, and seniors. These are important examples of interdiscursive practice, addressing key elements of PHC.

Converging discourses in PHP2013 include the interchangeable use of PC and PHC, and the alignment with neoliberal arguments that emphasize reducing costs and achieving efficiency. Interdiscursivity is demonstrated in this pattern, through use of the neoliberal discourse of prioritizing the need to find efficiencies in all areas as an effort to ensure sustainability of the health care system. There is an example of this convergence, referencing population health discourse in the expressed combination of Public Health, PHC and Population Health under the "*Rebuilding our Health*" section. While the WHO (2019) lists public health and population health as essential components of PHC, the PHP2013 document only mentions these elements in cursory ways. There are only a few isolated instances where the terms "PHC" or "population health" have been dispersed into sections-in ways that conflate PHC with bio-medically oriented PC. In this, PHC discourse has been woven into the text tactically, converging in ways that ultimately say nothing about PHC.

Over time, this pattern of token reference to elements of PHC will also be found in other documents, continuing in ways that eventually involve the minimization and

disappearance of PHC discourse in Government of New Brunswick documents. That pattern begins in PHP 2013, where the process of equating PHC with PC becomes especially obvious, for example, as contained in recommendations for strengthening primary care through "community health needs assessments, family health teams and a registry for New Brunswickers without a family doctor [or nurse practitioner]" (p. 12).

Diverging discourses in PHP2013 that do take up PHC discourse include only one weak reference to primary health care providers: "The New Brunswick Cancer Network will work with primary health care practitioners" (p. 13); here and elsewhere in the document there is no mention of PHC-NPs, though their presence in preceding years (2003-2011) had been an element of attempting to implement social practices of PHC. This silence about PHC-NPs in 2013 is consistent with the period of time (2012-2019), which was characterized by a "disappearing" focus on PHC in NB. In PHP2013, key structural elements of PHC discourse are largely absent in the document, especially regarding broader references to addressing the social determinants of health, achieving social justice and equity in health, and intersectoral collaboration to achieve this, such as the role non-government organizations play as partners in community-based PHC.

Document 9: *Fixing New Brunswick's Healthcare System: New Brunswick's Doctors Have a Plan CARE FIRST* (NBMS, 2013)

The document, *Fixing New Brunswick's Healthcare System: New Brunswick's Doctors Have A Plan CARE FIRST*, hereafter referred to as *CARE FIRST*, was released by the New Brunswick Medical Society (NBMS) in 2013. The NBMS is the provincial professional division of the Canadian Medical Association. All physicians practicing in New Brunswick must be registered with the College of Physicians and Surgeons of New

Brunswick and be members of the NBMS. The NBMS, founded in 1897, is the professional association representing and serving more than 2000 practicing, future, and retired physicians in the province. The mission of the NBMS is professional advocacy to advance the interests of physicians and to improve the health care system in New Brunswick for the benefit of patients (NBMS, 2020).

(i) In terms of *purpose* and *historical significance*, *CARE FIRST* was released within days of the release of the Provincial Health Plan (PHP) 2013-2018. Given the date of its release, it seems reasonable to assume that it was a response to PHP2013, discussed previously. The opening sentences of *CARE FIRST* describe its purpose: "The Provincial Plan was released in September, but we learned at the announcement that it was more of a 'management philosophy.' Doctors are detail-focused. We think health care needs a little less philosophy and a lot more specifics" (p. 1).

CARE FIRST is a 20-page text, with four themes and nine distinct sections, divided into 21 subsections. It is the NBMS's solution to the issue of health care system sustainability. To put the timing of this document into perspective, it was released one year after the release of the PHC Framework and during the time when a sub-group of the PHC Steering Committee (PHCSC) was working on the "*Operational Guidelines for Family Health Teams"* in collaboration with the NBMS.

According to the NBMS, *CARE FIRST* is an expansion "on our original ideas with specific, actionable steps" (p. 1). The reference to "original ideas" dates back to a written submission, provided by the NBMS, to government in 2012. In preparation for the new PHP, the Department of Health, under the leadership of Minister Dubé, held provincial consultation sessions, facilitated by the New Brunswick Health Council

(NBHC) around the theme, Rebuilding Health Care Together. Stakeholders, like professional associations, were also invited to provide written submissions (NBHC, 2012). *CARE FIRST*—released in response to the call for written submissions—highlights four themes: *Moving From a Sick Care System to a Healthcare System*; *Listen to the Frontline for Advice on the Bottom Line*; *See Wait Times as a Symptom, Not the Problem*; and *Reducing the Size of New Brunswick* (p. 2-14). Under each theme is a series of recommended actions in conjunction with a commentary about what is working well and what needs to improve.

(ii) In terms of the *analytic framework*, the assumptions underlying *CARE FIRST* as presented in the *text* are characterized by a PC discourse presented through a primary medical care lens. PHC discourse is notably absent. The problems are represented to include, fragmentation in the PC system, poor engagement of doctors on the frontline and lack of opportunities for them to provide advice to health administrators, wait times for PC, long term care and surgery, an aging population, and the general poor health of citizens.

Under theme #1, *Moving From a Sick Care System to a Healthcare System*, *CARE FIRST* notes that for non-urgent medical issues, most people define PC as "non-urgent medical care" and "the first point of contact in the health system" (p. 2). The document then refutes recent suggestions for improving health care, characterizing these suggestions as having been made by unidentified others, before proposing solutions for moving from sick care to health care: "Some groups have said that if only they could prescribe advanced medications and be paid more, our problem would be solved. Some

have said doctors should just work harder. Others propose limiting the number of sick people" (p. 2).

CARE FIRST proposes three solutions to renew "our system of primary care" (p. 2): "Create teams of primary care professionals across the province who work together; use electronic medical records to help these teams communicate; and end the bureaucratic prohibition on allowing doctors to practice where patients need them" (p. 2). Two of the solutions are a reiteration of those proposed in the PHC Framework except that the NBMS *CARE FIRST* document substitutes PC for PHC. The third solution proposed is intended to end the practice of Medicare billing numbers, a tool implemented in 1992 following the ML Report (discussed in Chapter 4), designed to encourage physicians to practice in rural communities and allow government some control over the costs associated with fee-for-service billings. Under the description of PC teams, *CARE FIRST* describes doctors as "experts in medical care" (p. 2) and states, "Sometimes, patients who need a flu shot or their blood pressure checked, don't need an expert, they need someone who is well trained to do specific tasks" (p. 2).

This depiction of other (potential) PC team members as non-experts and task-specifically "trained" is an endorsement of the hegemony of physicians, essentially referring to a family practice office nurse as "technically trained" and working for rather than with a physician, in a medically normalized office practice. Medical hegemony persists as *CARE FIRST* outlines the composition of the PC team: "people that provide patient care with various skill sets working together, so they understand each other's work and what everyone can do safely" (p. 2). The reference to safety is one that is used

consistently by the medical profession to legitimate claims that the roles of non-physician providers require medical supervision (Cashin et al., 2009, p. 125).

CARE FIRST Theme #2, *Listen to the Frontline for Advice on the Bottom Line*, begins with the following statement: "Walk into a hospital in New Brunswick and we bet you'll see someone with a clipboard walking around and making notes, and a number of people in suits, not scrubs" (p. 6). Although this medically-based discourse appears pejorative, it is used to make the point that the system is overburdened with administrators who professionally are "engineers, accountants, lawyers" (p. 6) and not physicians. The three ways that *CARE FIRST* proposes improved frontline input are to, "support the work of doctors in lowering their costs to the system, allow frontline professionals to offer advice to the highest levels of the Regional Health Authorities, and engage frontline professionals in strategic, system-level discussions about sustainability" (p. 6). According to *CARE FIRST*, "doctors are working hard to find out how they impact the costs of the system" (p. 6). The medical discourse that ensues focuses on a campaign, led by the Canadian Medical Association, called *Choosing Wisely Canada*, which states that physicians are "partnering with patients to make decisions that are supported by evidence, not duplicative of other tests and procedures already received, free from harm and truly necessary" (p. 6). The suggestion that patients influence the ordering of unnecessary procedures and tests is a patient-blaming discourse. There is no reference to the cost of fee-for-service remuneration and the extreme variability in practice, e.g., diagnostics ordered, medications prescribed, patients admitted to hospital, referrals to specialists, between PC physicians.

CARE FIRST also advocates for increased physician representation on the Boards of the New Brunswick Health Council, RHAs, and FacilicorpNB. After examining the membership of these Boards and finding them "sparse" in physician representation, the document proclaims, "Instead of trying desperately to keep doctors away from decision-makers, many provinces are making efforts to include them. Let's be honest; doctors tell it like it is. We are often direct and use tough medicine" (p. 7). There is no mention throughout this section of the then recent activity to engage physicians in efforts with government for PHC reform through the PHCSC, the PHC Summit, the PHC Framework, or the collaborative work occurring in the writing of the Operational Guidelines for Family Health Teams.

CARE FIRST Theme #3, *See Wait Times as a Symptom, Not the Problem,* addresses waiting in emergency rooms, waiting in hospitals for long-term-care beds and surgical wait times. According to the NBMS, these waits occur because of infrastructure issues, e.g., not enough hospital or long-term-care beds: "What we all need to realize is that systemic problems that underlie all of these interactions with the health system are really what need to be tackled" (p. 10). NBMS's three solutions to tackle these systemic issues are to, "align people and processes more effectively, provide seniors and their families with better options for their care in the community, and reward hospitals for both care they provide and its quality" (p. 10). As Lewis (2005) explains, "According to organized medicine, system failings are always someone else's fault. Nothing apparently, is attributable to physicians retaining control over their individual wait lists and refusing to standardize criteria for assessing and prioritizing patients" (p. 275).

The *CARE FIRST* neoliberal discourse that follows recommends hospitals adopt "management theories" like "Lean Six Sigma" (p.10), and leverage information technology to send patients for surgery to other jurisdictions in the province, e.g., from Saint John to Campbellton. *CARE FIRST* calls for a central registry for urgent and non-urgent referrals, "with the right staff to provide timely access to specialists" and that "government partner with professionals to develop a roadmap to regionalization, not centralisation" (p. 11). In response to "providing seniors and their families with better care in the community" (p. 10), *CARE FIRST* says, "We need simplicity" (p. 11), and recommends "building more nursing homes, cooperation across bureaucratic lines, elimination of unnecessary bureaucratic processes, creating a new, community-based long-term-care navigator" and the development of "guidelines and policies to make our hospitals and healthcare facilities more navigable and age-friendly" (p. 11). These recommendations, ironically, would locate PC firmly within important aspects of a PHC context, although this is not addressed.

CARE FIRST Theme #4, *Reducing the Size of New Brunswick*, refers to obesity and unhealthy living among New Brunswickers. According to *CARE FIRST*, "no one is working on a massive scale to improve the health of our population" (p. 14), and claims that by "focusing on making hospitals more effective, we're ignoring what happens outside of their walls. This is a classic example of missing the forest for the trees" (p. 14). The document further endorses doctors' efforts around promoting healthy living: "Doctors have stepped up in many ways, but we need a focus on healthy living from all partners, especially those outside the health system" (p. 14). According to *CARE FIRST*, the three areas that require focus to improve population health are, "healthier schools and

workplaces, developing more health-conscious families and providing help and education through our communities and province" (p. 14). *CARE FIRST* recommends that "Schools should be places where values are practiced" (p. 14) citing first the positive changes that have been made in the past around the substitution of nutritious food for school fund-raising projects and eliminating unhealthy food from vending machines. *CARE FIRST* also states, "There is more that could be done; there are still too many schools serving hot dogs and fries" (p. 14), and that "doctors refute the notion that schools, and teachers are in charge of fostering healthy behaviours" (p. 15). Nonetheless, strong recommendations are made around implementing "active classrooms," schools as "community hubs," mandatory physical education and family studies which "would help youth understand how to cook foods not found wrapped in plastic" (p. 15). The document also has advice for parents, families, and employers: "Eating while watching TV, drinking sugar-sweetened beverages between meals and skipping breakfast have been associated with an increased risk of obesity in children" (p. 15). Parents are encouraged to include role modelling, following Canada's Food Guide for children, less TV and "eating as a family unit at home" (p. 15). These recommendations, while consistent with current nutritional guidelines, also are consistent with a professional gaze informed by normalizing socio-economic assumptions about family life with children—i.e., as it occurs in upper middle class, two parent, nuclear family households where there is housing and food security, and also where income security is based on the full-time adult employment of one parent– whether or not youth are cooking food. Employers are also warned of the risks to their organizations where obese employees are concerned: "Obese workers have more frequent and lengthier work absences" (p. 15). Employers are encouraged to reduce and

prevent obesity in the workplace, which *CARE FIRST* states would result in "higher productivity and better job performance" (p. 15). Although the authors claim, "No one is working on a massive scale to improve the health of our population" (p. 14), credit is nevertheless extended in the document to the NB government's investment in the "NB Wellness Strategy, the provincial Healthy Eating and Physical Activity Coalition, Public Health's Nutrition Framework for Action, the provincial Anti-Poverty Strategy and the new Department of Healthy and Inclusive Communities" (p. 16). The document is silent about how these important efforts are part of a larger framework that systematically addresses health equity through action on the social determinants of health.

The conclusion of *CARE FIRST* highlights the tools that doctors have to affect sustainability of the health care system: "We have stethoscopes. We have otoscopes. We have penlights, and prescription pads, and blood pressure cuffs. But we have no magic wands to wave against the historical reasons why not to do something" (p. 18). Here, the document missed an opportunity to address some of the most serious threats to health care sustainability, including payments to physicians (Lewis, 2013). While the document briefly mentions the campaign, *Choosing Wisely*, an initiative about limiting diagnostic tests and procedures that are not based on best evidence, no responsibility for steadily increasing costs is attributed to physician remuneration models and practice patterns. According to Lewis (2013), under current practices, "The only way to permanently de-escalate health care spending is to do less with less. Collective agreements with physicians encourage them to practice more medicine, at greater cost. The only way to contain health care spending is to change the deals we make with doctors" (p. 1).

In terms of the *discursive practice* level of analysis, the processes related to production and consumption of health care services in *CARE FIRST* highlight medical privilege and the related *value assumptions* as described by Fairclough (1992). Value assumptions may indicate ideological underpinnings, defining what is desirable, valuable, necessary, crucial, and satisfactory within the discourse of, in this case, health care sustainability (Ravn, Frederiksen, & Beedholm, 2016). What is deemed valuable and necessary within the text is consistently related to access to medical care provided by a physician. Other health care providers are criticized and minimized: "We cannot have people who aren't experts trying to do things that doctors do" (p. 2). Pervasive power ideology and patriarchal discourse is present in these statements and also inherent throughout the text as reflected in the following statements: "Doctors are detail-focused" (p. 1); "Doctors are experts in medical care" (p. 2); "Doctors have been pushing for changes to access the primary care system for nine years" (p. 2); "Doctors must be involved in system change for it to occur" (p. 8); "Doctors tell it like it is" (p. 7); and "Doctors see the impacts of unhealthy living every day" (p. 14).

Although *CARE FIRST* advocates for team-based care, the document is physician-centric and includes some implicit critique of other team members. Paradoxically, in the context of advocating for better support and assistance for physicians, it states: "Doctors need to share the load" (p. 2); "for patients, [team care] should be better access to care, linked to your family doctor" (p. 2); "for the system [team-based care] means happier health professionals" (p. 2); "physicians should be encouraged to practice with other providers; (but) change is difficult and requires time" (p. 3); "publicly commit to only changing scopes of practice in the context of team-based care--not duplicating existing

services at twice the cost" (p. 4); and finally "set a target date for when pharmacists will be required to follow doctors' lead and adopt a similar system to ensure fewer medication errors and adverse events" (p. 5). These statements suggest that physicians must be arbiters in determining when, if, and how regulatory changes occur in the scope of practice among other health professions. In this, the discourse is focused on retaining medical hegemony and protecting physicians' control of PC. The emphasis is not on PHC.

There is then a noticeable and ongoing absence of intertextuality between *CARE FIRST* and the policy level commitment in NB to an articulated PHC Framework. One of the recommendations of the PHC Framework is briefly referred to under the section, C*reate Teams of Primary Care Professionals:* "The Government of New Brunswick realized this last year. They announced a new shift in how they think about primary care and we applauded their efforts" (p. 2). The use of "Government of New Brunswick" rather than the PHCSC or the Department of Health and insertion of the term "their," distances the NBMS from this work and their active participation in it. Additionally, there are a number of negative references to government employees within the document. For example, *Care First* refers to most government processes as "bureaucratic" and government employees as "bureaucrats," evident in statements such as, "end the bureaucratic prohibition on allowing doctors to practice where patients need them" (p. 2), "the government continues to go with the idea that bureaucrats know best when it comes to attaching patients to doctors" (p. 3), and "examine interactions between the Department of Social Development and the Department of Health to eliminate unnecessary bureaucratic processes" (p. 11).

Another example of how medically hegemonic PC discourse is predominant in the *CARE FIRST* document is found in its discussion of evolution from sick care in New Brunswick to include population health and health promotion interventions. These examples include immunization and prevention advice, addressing obesity, or adopting healthy lifestyle practices, as these relate to the medical diagnosis and medical treatment of illness. *CARE FIRST* is silent about/evades a comprehensive, intersectoral approach to promoting or enhancing health through policy and program redesign focused on the social determinants of health and health equity (Lewis & Edwards, 2004). Intersecting PHC and PC discourse of "first point of contact with the health system" (p. 2) is present, but discourses consistent with PHC, anchored in a PHC philosophy and less medically or disease focused, are not evident in the text. Intertextuality is medically oriented as *CARE FIRST* draws on other texts, primarily from previous NBMS publications, productions from the College of Family Physicians of Canada, political platforms from Nova Scotia, and physician-focused publications from Ontario and the New Brunswick Health Council.

Discursive practices as highlighted in Chapter 2 have a role in maintaining the social world, including those considered instrumental in creating unequal power relations between social groups. These are understood as "ideological practices" (Fairclough, 1992, p. 67). According to Raphael (2009), "the operation of economic and political systems and their resultant social and health inequalities come to be justified by the ideological structures, the dominant discourses or ideas in society that explain these phenomena" (p. 148). At the *social practice* level, *CARE FIRST* is an example of discourse reflecting medical hegemony and privilege. It promotes the role of physicians

as experts in and of the health system. Although, at the beginning of the text, there is a statement about transformative changes, "Be warned, though; our proposed changes aren't easy. They require transformative change" (p. 1), the hegemonic position of physicians within the system is maintained throughout the text. The changes articulated are about change for the other actors in the system, including patients and prospective patients.

CARE FIRST is aligned with hospitals and attempts to regain status and oversight through membership on governing boards, and to "end the ban on frontline professionals serving in leadership roles as part of the Regional Health Authority boards" (p. 8). *CARE FIRST* recommends that decision-makers "employ words and actions designed to build respect and partnership with physicians" (p. 8) and, conversely, targets perceived competitors and uncooperative organizations. For example, FacilicorpNB is targeted for its role in the development of the provincial electronic medical record (EMR) and *CARE FIRST* calls on the Government of New Brunswick twice in the text to re-evaluate CHCs: "We asked government to share cost information involved in care with professionals to inform us on how our clinical choices affect healthcare spending and explain how FacilicorpNB's decisions were cost-effective" (p. 7); "At the same time as we update our thinking around team-based care, we should re-evaluate the original Community Health Centres to ensure they are still cost-effective" (p. 3).

CARE FIRST aligns with hospitals, including the Extra-Mural Program, all of which, only permit physicians to have admitting privileges to its programs and services, e.g., "Reward hospitals for both the care they provide and its quality" (p. 10), and "Expand the reach of New Brunswick's incredible Extra Mural Hospital program to

ensure seniors are supported safely and happily in their homes" (p. 12). Elsewhere, *CARE FIRST* recommends expanding the reach of the "incredible Extra Mural *Hospital*" [emphasis added] (p. 12). The New Brunswick Extra Mural *Program* [emphasis added] (EMP) has not been referred to as a "hospital" since the devolution of that structural arrangement in 1992. And at the time this document emerged, in 2013, only physicians were privileged to admit patients to the Extra Mural Program.

The final section of *CARE FIRST, Reducing the Size of New Brunswick*, is also characterized overwhelmingly by discourses of medical privilege and power. There is no reference to the importance of achieving health equity in NB or the importance of focusing on the structural origins of social determinants of health. The document lectures teachers and parents alike about the need for healthy eating and physical activity. It recommends that educators and parents practice the values of healthy living and model healthy behaviors, "Schools should be places where values are practiced, and New Brunswick was once a leader in helping parents develop healthy children" [sic] (p. 14). There is no reference to food insecurity, poverty, precarious housing, or different types of working poor families, like single-parent households or shift work realities that challenge families who may prefer to "eat as a family unit at home" (p. 15). Instead *CARE FIRST* takes up a paternalistic, individualistic, middle class discourse now recognized as reflecting economic white privilege and position. Naïve examples of this include: "Parents need to monitor the consumption of sugar-sweetened beverages and screen time" (p. 17); "Communities can create community gardens, which enable both nutrition for families of many economic circumstances and promote nutrition-related education" (p. 17). The dominant discourses within this section leave unexamined the province's

social and economic conditions and the resulting social and health inequalities, emphasizing privileged views of individualism versus social responsibility, and accepting the legitimacy of "market forces" versus focusing on social justice (Raphael, 2009).

(iii) The *problem* presented in the premise of *CARE FIRST* is the sustainability of the New Brunswick health care system. The document is the NBMS' response to the Alward government's release of the Provincial Health Plan (PHP), *Rebuilding Health Care Together 2013-2018, A Blueprint for Sustainability*. The focus of government activity in the year leading up to the release of the PHP was consultation with New Brunswickers around the sustainability of the health care system. *CARE FIRST* asserts that sustainability is not a new topic of concern among physicians: "Doctors declared last year, long before [sustainability] was a popular topic of conversation. Our health care system does indeed face a sustainability challenge" (p. 1). *CARE FIRST* exploits the societal governing position and influence extended to physicians, including the unchallenged power they hold in establishing health care policy and their control in setting conditions around physician remuneration.

CARE FIRST leverages this hegemony, to challenge or discipline the authority and prospective policy influence of others, namely pharmacists, nurse practitioners, health policy leaders, government employees, hospital administrators, and CHCs. It capitalizes on the medical profession's perceived status as an exclusive expert knowledge holder to promote recommendations that would further solidify that status and prevent role erosion of medical power and position. Examples within the text include: "End the bureaucratic prohibition on allowing doctors to practice where patients need them" (p. 2); "Double the proposed number of Family Health Teams" (p. 4); "Now that Family Health

Teams will be the dominant model of team-based care, review Community Health Centres for their cost-effectiveness" (p. 4); "Support physicians currently using an EMR to be able to move to the provincially-funded system within the next year" (p. 4); "The province should fund the EMR program by itself" (p. 5); "With the stroke of a pen, end the bureaucracy's control over where doctors practice" (p. 5); and "Support the efforts of doctors to apply the lessons of *Choosing Wisely* in their practices" (p. 8).

Important silences also exist in the *CARE FIRST* document, including an absence of analysis that would focus on the cost of accepted practices for physician remuneration. In the publication, *Chronic Condition*, Globe and Mail columnist and public-policy analyst Jeffrey Simpson explores options around health care sustainability in Canada. He suggests that RHAs oversee paying physicians, to whom they would be responsible:

> The idea that physicians should be paid by a separate entity--a provincial health care plan, which they bill for their remuneration--leads to moral hazard, lack of accountability for outcomes, bifurcated and confusing administration within hospitals and absence of clear lines of authority. (p. 531)

None of these options are explored in *CARE FIRST*. Rather the document focuses on several non-physician related measures, stating that substantial savings could be realized by the "use of electronic medical records - $6 million in savings" (p. 5); "*Choosing Wisely* - $60 million in savings" (p. 9); "reducing wait times by 25% - annual gains of $65 million" (p. 13); and "bringing our level of obesity down to the Canadian average would reduce hospital beds by 10% - $52 million annually" (p. 17). Lewis and Sullivan (2013) note that in evading the issue of physicians' employment status and remuneration,

"Governments and doctors unwilling to depart from the historical path doom the system to a sorry combination of poor performance and eternally rising costs" (p. 3).

(iv) In terms of *discourse direction*, as defined in in Chapter 3 based on Bacchi, (2014, 2016) and Foucault (1973, 1977, 1998) an *emerging* discourse in *CARE FIRST* is the reference to those who work at the "frontline," e.g., "allow frontline professionals to offer advice to the highest levels of the Regional Health Authorities" (p. 7); and "engage frontline professionals in strategic, system-level discussions about sustainability" (p. 8). The term "frontline" is used broadly in the health care system to refer to on-the-ground experiences and interactions of health care providers at the point of direct patient contact. Hanlon et al. (2019) noted in their research on PHC reform that informants "invoked this term to describe aspects of power and authority operating through the reform" (p. 55). In that study, the lack of involvement of the frontline was interpreted by physicians as a "top down" approach to reform and that physicians, in particular, positioned themselves as "holders of intimate knowledge about their patients" (p. 57). For health care administrators in the same study, the term frontline signified "well-entrenched routines and practices that will be difficult to change" (p. 57). Given *CARE FIRST's* emphasis on the hegemony of medical providers (physicians), an important question for the NBMS is the extent to which the "frontline" advice to administrators from other professions (e.g., nurses, pharmacists, occupational therapists) would be understood as a respectful and interdisciplinary approach to health system reform.

Another surprising emergence in *CARE FIRST* is the recommendation by NBMS to re-evaluate the original Community Health Centres to ensure their cost-effectiveness. With this discourse, NBMS, a powerful actor in New Brunswick health care, planted

seeds of doubt about the costs of CHCs with a government that was searching for cost savings and efficiency. This is an example of how a strategic evasion of the discourse of PHC within organized medicine can influence health care reform. At an important policy moment, when CHCs could be used in the context of PHC to address the social determinants of health and achieve health equity, *CARE FIRST* suggested that CHC's cost-effectiveness should be re-evaluated. This suggestion was made strategically in the same section of text containing recommendations for how to strengthen and further protect medically oriented PC.

Similar to other texts analyzed in this period, converging discourses found in *CARE FIRST* include the convergence of PC and neoliberal discourses in suggestions of finding efficiencies – in an effort to ensure sustainability of the health care system. Efficiencies are recommended within the implementation of a provincial EMR, limiting diagnostic tests and routine procedures (*Choose Wisely*) and reducing wait times. These all converge as recommendations that will improve the sustainability of medically oriented primary care.

Another converging discourse is contained in the recommendation for the expansion of teams of PC professionals. This neoliberal cost-efficient recommendation is convergent with sustaining medically oriented PC, and it also contains an element of divergence when it refers to doctors working together in teams. For some readers, this may imply a recommendation for supporting inter-professional teams. The emphasis, however, is on the grouping of *physicians* together in teams versus traditional medical practice models of sole-practitioners. There is silence/no endorsement of *multidisciplinary* PHC teams as described in the PHC Framework.

On another physician-centric note, many of the texts reviewed in this dissertation (beginning with the ML Report, discussed in Chapter 4), diverge from or reject hospital centric discourse. Those texts would have been more consistent with WHO (2008) guidance about PHC as a supportive context for PC. In contrast, *CARE FIRST* is unique in containing convergences between the need to expand medically oriented PC and hospital expansion. Examples of this include discussion of incentives for hospitals to "drive behavior" and to develop "an Activity-Based Payment system." (p. 12).

There are a multitude of diverging discourses in the *CARE FIRST* document, as demonstrated by overall movement away from previous discussions of PHC and also by an emphasis on the hegemony of bio-medically oriented PC. Although the term PC is used throughout this document, the dominant discourse is more accurately described as aligned with "*physician oriented* primary care" than with PC. Discourses of PHC are absent, the term "primary health care" is not actually used, and there is no reference to the PHC Framework recommendations of patient-centered care, community health needs assessments, CHCs, or PHC teams. *CARE FIRST* also diverges from PHC discourse focused on health equity and addressing the social determinants of health, which is particularly apparent in the section focused on healthy living and disease prevention, "*Reducing the Size of New Brunswick"* (p. 14). In the context of present-day concerns about structural origins of health inequity, this veiled reference to obesity among individuals feels disrespectful —with no acknowledgement of the social determinants of health and subsequent health disparities that reinforce and further contribute to food insecurity and obesity. *CARE FIRST* is also devoid of reference to other key elements of

PHC discourse, such as community-based care, intersectoral collaboration, patients as partners, and multidisciplinary team-based care.

While the document evaded any PHC discourse, it also narrowed the discourse of PC, choosing to focus on medically controlled PC. In so doing, *CARE FIRST* succeeded in bringing to fruition many of its recommendations. Key among these included fee-for-service "billing numbers" being discontinued in New Brunswick (an outcome that resulted in the perpetuation of fee-for-service billing and allowed freedom of mobility for physicians to practice anywhere within the province with minimal restrictions). Other recommendations that were adopted resulted in multidisciplinary teams (Family Health Teams) not being adopted, replaced instead with teams of physicians, called *Family Medicine New Brunswick*. The significance of these particular details is the continued support for this type of physician-centric-remuneration, with minimal control by government. Fee-for-service remuneration does not support/pay physicians to collaborate with other health care professionals except other physicians. Although *Family Health Teams* are referenced in the *Care First* document and were then understood broadly among other stakeholders as *multidisciplinary* teams, the end result was significantly different than what was envisioned and understood. In contrast, the groupings of physicians as teams and the terms surrounding their assembly and operation were struck during a closed process of the *Fee-For-Service Master Contract* negotiation between the Department of Health and the NBMS. These terms also included implementation of a provincial EMR, cost-shared between government and physicians, and implemented to support these physician teams. This new concept, *Family Medicine New Brunswick*, and

the terms of these new entities, promoted as a "plan to modernize family medicine in New Brunswick," became public in an NBMS press release in 2016 (NBMS, 2016).

Document 10: *Position Statement – Primary Health Care* (NANB, 2014)

The NANB *Position Statement - Primary Health Care*, hereafter referred to as PS, was revised and released in 2014, a year after the PHP2013 and NBMS *CARE FIRST* documents, discussed previously. A position statement is a text that usually advocates for an issue important to the issuer, in this case, the profession of nursing. It describes one side of, or viewpoint about, an arguable issue and provides the background and rationale to support a given viewpoint or position. Speaking to the common international practice of articulating position statements in the profession of nursing, the American Nursing Association (2021) notes that position statements can be about nursing practice, health policy or social concerns impacting patients and their families. Position statements "guide the profession, amplify the views of nursing, and educate consumers and decision makers" (para. 1).

In terms of context, during most of 2013 leading up to its position statement, NANB had been active as part of a working group, the Operations Services Committee (OSC). The OSC was created in 2013 as a working group of the Primary Health Care Steering Committee and it was comprised of members from multidisciplinary professions and members of the public. The work of the OSC was to develop operational guidelines for Family Health Teams. The work of the OSC coincided with the release of both the PHP2013 and the NBMS *CARE FIRST* documents. But the work of the OSC was not referenced in either document.

These contextual details about the concurrent influence of OSC activity are important, in terms of understanding when the discourse of PHC began to shift, eventually becoming significantly diminished in texts addressing health care reform. In retrospect, the mandate of the OSC, to develop operational guidelines for physician-dominated "Family Health Teams," can be seen as a complex, definitive and contradictory moment, where significant commitments to WHO foundational elements of PHC reform were compromised.

(i) The *purpose* and *historical significance* of the PS are important because NANB was taking a position in response to several concurrent and evolving public policy oriented events related to PHC. First, in reference to the OSC, there had never been a similar multidisciplinary group of health care practitioners and public citizens (representing patient groups) assembled to consider the operations and accountability of *a primary health care model of delivery*. The strategy of convening "providers with patients *as partners"* had been discussed in the PHC Framework (2012), and the OSC was the first example of launching that strategy. The OSC had a one-year mandate to complete their work and report back to the Primary Health Care Steering Committee. The OSC was co-chaired by a representative from the Department of Health and a PC physician, appointed by the NBMS. The committee was explicitly mandated to develop operational guidelines for the implementation of *Family Health Teams* and an accompanying accountability framework to measure team outcomes. The OSC completed its mandate in January 2014. The PHC Steering Committee reviewed and approved the final draft of the *Operational Guidelines for Family Health Teams* document in January

2014 and struck a new sub-committee, the PHC Implementation Committee, of which NANB was also a member.

The Implementation Committee was mandated to approve applications from family physicians for the establishment of Family Health Teams, in the absence of an established Primary Health Care Network as described in the PHC Framework (2012). In May 2014, with the *Operational Guidelines for Family Health Teams* complete, the application process for Family Health Teams was launched.

In September of that same year (2014) a new Liberal government, under the leadership of Premier Brian Gallant was elected. It is possible that the publication of the PS document was a strategic release from NANB to remind stakeholders and decision makers about the principles of PHC. Given the newly elected government, it would be reasonable to expect that the motivation for this position statement was to educate and advise decision makers within the new Cabinet about the context of, and NANB's position on, PHC reform.

The PS document had been originally developed and released in 1993 and intermittently reviewed in 1996, 2002, 2008, and 2014 (p. 4). This was consistent with the then-common practice for updating position statements. The five-page document begins with a description of NANB's position on PHC, defines and addresses differences between PC and PHC, highlights PHC in New Brunswick, and concludes with eight recommendations for the Government of New Brunswick.

(ii) In terms of the *analytic framework*, the NANB PS *text* states the Association's position on PHC as follows: "NANB believes that a healthcare delivery system grounded in the principles of PHC will provide all New Brunswickers access to universal,

comprehensive, accessible, portable, publically administrated healthcare that is efficient, effective and sustainable" (p. 1).

The use of the five principles of Medicare in the PS is consistent with WHO principles of PHC. The use of the words "efficient, effective and sustainable" (p. 1) is a tactical inclusion that signifies NANB's commitment to publicly funded healthcare and the principles recently articulated in PHP2013 as "efficient, effective and sustainable" (p. 1). The second sentence of the PS speaks to the role of nursing: "NANB believes that registered nurses (RNs) and nurse practitioners (NPs) have a key role in collaborating with other stakeholders to develop, deliver and maintain such a system" (p. 1). Inclusion of the concept of nurses in a collaborating role, exemplifies NANB's commitment to and belief in a multidisciplinary team concept of primary health care provision.

The PS section *Definition Primary Health Care and Primary Care* (p. 1) begins with a recounting of the ambiguity between discourses of PC and PHC: "Confusion exists between the care delivery models of PHC and PC. The terms are often used interchangeably in the media, by government officials and health care providers" (p. 1). The PS differentiates between the two models and, using the WHO (2008) definition, states that PHC involves:

> Education for the identification and prevention/control of prevailing health challenges; proper food supplies and nutrition; adequate supply of safe water and basic sanitation; maternal and child care, including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases using

> appropriate technology; promotion of mental, emotional and spiritual health; and provision of essential drugs. (p. 2)

The PS defines PC as "illness oriented with emphasis on medical diagnosis, treatment and follow-up and is currently predominately provided by family physicians" (p. 2), and states PC is "one of the elements necessary in a broader framework of PHC services" (p. 2).

Within the section *PHC and New Brunswick* (p. 2), the PS states, "There has been a disjointed application of PHC principles in the province" and "the New Brunswick government has been exploring the concept of PHC for almost a decade" (p. 2). The PS details the previous 10 years of government exploration, beginning with the creation of the PHCSC in 2005, the discussion paper on *Improving Access and Delivery of Primary Health Care Services in New Brunswick* (2010), the PHC Summit (2011), and ending with the release of the *Primary Health Care Framework* in 2012. The PS states, "It is time the government made a firm commitment to PHC; the current fee-for-service structure was developed when there was an abundance of resources" (p. 3). The PS urges government to consider funding models that "facilitate collaborative team approaches to care allowing individual health care professionals to work to their full scope of practice" (p. 3) and "In order for a health care system based on PHC to be effective and efficient the government must make a commitment to full implementation and not choose pieces that fit into the existing antiquated system" (p. 3). The PS acknowledges that difficult decisions need to be made, emphasizing, "Research has shown significant improvements in the health status of a population and cost efficiency when the principles of PHC and the determinants of health are considered in health care delivery" (p. 3).

The final section of the PS provides eight recommendations to government as follows:

1. Decisions about the governance, funding and delivery of health care services must focus on healthy public policy considerations and are responsive to the needs and expectations of individuals, communities and populations.
2. Health care elements must be integrated across the full continuum of care (provided by a collaborative team of health professionals and support (staff), ensuring individuals, communities, and populations have timely access to the most appropriate health care provider—when, and where they need it.
3. Public policy must focus on ensuring equity, social justice and access to the broader determinants of health.
4. NB's PHC delivery model must build on the Government's primary health care framework by creating a variety of PHC collaborative team delivery methods that meet the needs of local community such as: Ontario's Family Health Team, Saskatchewan's Mobile Health bus, Ontario's Nurse Practitioner (NP) lead clinics, and British Columbia's RN led street health teams.
5. Health service delivery models, interventions and practices are informed by multiple sources of evidence and validated best practice.
6. Health record must be integrated across health systems and ideally the Electronic Health record should be implemented in all PHC health care teams.
7. Registered nurses and nurse practitioners must be utilized in PHC settings to their full scope of practice.

8. Rigorous monitoring and evaluation processes must be in place to measure the impact of PHC teams and the quality and safety of the service and inform continuous improvement. (pp. 3-4)

The recommendations deal with governance, public policy, evidence-based decision making, integration, and monitoring. These recommendations mirror those made by the WHO (2008) with the inclusion of PHC discourse of integration, community-based care, ensuring equity and social justice. The first recommendation, which references the Canadian Nursing Association, addresses national policy issues about governance, funding and delivery of health care services. Consistent with previous documents (i.e., NANB, 1998; NBNU, 1995) the PS emphasizes team-based care and timely access to the right provider. Specifically, the PS advocates for PHC models utilizing best practices nationally and designed to meet the identified needs of communities.

The recommendations conclude with an appeal for a full scope of practice for nurses, both registered nurses and nurse practitioners. The footnotes include a comprehensive description of NPs, identifying them as "autonomous health professionals" and explaining how they intervene: "[Nurse Practitioners] integrate their in-depth knowledge of advanced nursing practice and theory, health management, health promotion and disease/injury prevention, and other relevant biomedical and psychological theories to provide comprehensive health services" (p. 4). While there is no reference to PHC in this definition, this may be because for all nurse practitioners registered in NB that meaning is assumed/latent: NPs are prepared and registered to provide PHC advanced practice nursing.

At the *discursive practice* level, the PS firmly articulates NANB's position on PHC. Discursive practices are sources of information that are valued and legitimized by specific organizations and, through texts, social control and social domination are exercised, negotiated and resisted (Fairclough, 2005). According to Lewis (2010), "Nursing's combination of numbers, reputation and reach should translate into power and influence over how healthcare is financed, organized and delivered" (p. 116). Given that NANB was extremely well informed about the characteristics of PHC, had actively participated in advocacy of PHC reform, and had engaged in partnership with decision makers and other health care professional associations for close to ten years, it is reasonable to suggest that there may have been disillusionment, discouragement, distrust, or discord with government about where the process landed with respect to a Provincial service delivery model that emphasized physicians' practice in *Family Health Teams.*

This discord is evident in the following excerpts from the PS: "The New Brunswick government has chosen to focus PHC reform on the creation of Family Health Teams" (p. 2), "The province continues to fund an antiquated system" (p. 3), and "The government must make a commitment to full (PHC) implementation and not choose pieces that can fit into the existing system" (p. 3). The revision and release of the PS is an attempt to advocate for a different policy direction specifically to refocus reform efforts on PHC, in response to the government's emphasis on FHTs. *Intertextuality* and i*nterdiscursivity* in the PS occur with the inclusion of direct reference to PHC discourse and in relation to the government led process of PHC reform:

> The New Brunswick government has been exploring the concept for almost a decade. The creation of the Primary Health Care Steering Committee (PHCSC) in

> 2005, with the mandate of improving access and delivery of healthcare to New Brunswickers, resulted six years later in the release of a discussion paper, *Improving Access and Delivery of Primary Health Care Services in New Brunswick.* Informed by feedback given on this discussion paper and a PHC summit held with key stakeholders, the PHCSC developed and released the Primary Health Care Framework in August of 2012. (p. 2)

Interdiscursivity is realized in the PS by urging government to act on its own policy framework and by replicating finite examples of that discourse found in the PHP2013: "NB's PHC delivery model must build on the Government's primary health care framework" (p. 4) and "the Electronic Health Record should be implemented in all PHC teams" (p. 4).

As expected in a document dedicated to PHC, PHC discourse dominates the PS. The text addresses the ambiguity and confusion between the discourses of PC and PHC: "Confusion exists between the care delivery models of PHC and Primary Care.…these two approaches to care differ in how they define health and in the conceptualization of the underlying source of the problem and the strategies to bring about solutions" (p. 1). The PS defines PC as "being illness oriented with emphasis on medical diagnosis, treatment and follow-up and is currently predominately provided by family physicians" (p. 2). Importantly, the PS positions PC within a framework of PHC, stating PC "is but one of the elements necessary in a broader framework of primary health care services" (p. 2). The PS uses the WHO (2008) definition of PHC services in conjunction with the Premier's Health Quality Council's (2002) definition of "individual and community focused healthcare that is integrated, accessible and sustainable" (p. 1).

The *social practice* level of analysis links the PS text to the broader social practice of medical dominance and hegemony in the health care system. Given the release of the PHP2013 and its circumvention of PHC, along with the effects of the NBMS's response, also in light of the recent election of a new Liberal government, the release of the NANB's PS on primary health care was timely and intentionally strategic for the profession. The incoming Liberal platform (2014) promised "a network of CHCs [community health centres] with better access to health professionals in non-emergency situations" (p. 26), as well as "improving access to primary care by maximizing the use of health professionals such as nurse practitioners, advanced care paramedics, pharmacists and midwives, ensuring that all professionals are functioning at their full scope of training and practice" (p. 26). Against this backdrop, the most tangible promise of the Liberal government with respect to PC was "giving all New Brunswickers access to a family doctor by adding 50 net new general practitioners by 2018 (p. 26). It is not clear if these commitments were ever realized. Physician recruitment remains a political priority in 2021 (CBC, 2021) and there are currently 44, 226 people in New Brunswick waiting for a primary care provider (CBC, 2021).

The use of the term PC rather than PHC in the Liberal platform to describe providers like nurse practitioners and midwives and models of care like CHCs, again demonstrates the interchangeability of PC and PHC discourses and the ambiguity that is perpetuated in government oriented policy documents. Although these providers and delivery models do provide PC, it was the position of NANB that those providers, their practices and delivery models should be explicitly grounded by a framework of PHC.

The PS was an opportunity to refocus health care reform on the merits of PHC and the role of nurses within PHC, especially NPs. As per Lewis (2010), "Political space is finite and there will always be a fight for higher ground" (p. 117). If the PS's purpose was to advocate for "health care delivery grounded in the principles of PHC" (p. 1) by informing decision makers and others, the examples of PHC models mentioned in it did not reference the CHCs of New Brunswick or provide discussion of concrete models of PHC service delivery already existing within New Brunswick. Specific models mentioned were from other jurisdictions, where significant progress had been made in addressing PHC in advanced practice nursing. Many of the recommendations were based on the accurate representation of the WHO PHC framework and, consistent with being a position statement, there were minimal concrete, actionable recommendations. The role of the nurse practitioner was added as a footnote to the PS. Although the PS defined nurse practitioners as "autonomous health professionals" (p. 4), an explicit direct link was not made between their role and a health care system grounded in the principles of PHC. This may have been due to the presumption among primary health care nurse practitioners that it was unnecessary to restate their disciplinary expertise in communications intended primarily for nurses.

(iii) The *problem* articulated in the PS is two-fold: existing confusion between care delivery models of PHC and PC and the decision by government to pursue FHTs as the vehicle of PHC reform. A silent and salient problem is the persistent focus of government policy documents on prioritizing medical resources to populate traditional medical models with sole-bio-medically oriented physicians along with a family practice nurse or groupings of family physicians and call them primary health care delivery. As

per the PS, discussed previously, nurse practitioners were integrated in NB as PHC professionals in 2002, but have been and continue to be underutilized and underrepresented in reform efforts of PHC. The model of FHTs as promoted by government, privileged physicians, and included nurses in the traditional role of family practice office nurses. All attempts, through the Operational Steering Committee, to include NPs in the FHT model at the time were additionally thwarted by the perpetuation of existing remuneration models (fee-for-service) or by the privileged voice of physicians.

The NANB's PS, which includes a recommendation to consider other models, like "NP led clinics" (p. 4), was articulated as an attempt to refocus reform efforts. According to Lewis (2010), "Organized medicine is winning all the turf battles (while) nursing seethes in silence, only rarely venturing a timid rejoinder and never mounting a sustained battle for the public mind" (p. 117). It's not clear that nurses in New Brunswick have "seethed in silence," and the PS does acknowledge that some structural change has occurred: "Provincial legislation has changed and opened the door to new providers (such as NPs) and expanded scopes of practice for existing providers (such as pharmacists)" (p. 3). However, the PS also states that, "to date, optimizing the competencies of all professionals is not a reality" (p. 3) and suggests that "NANB [has] a key role in collaborating with other stakeholders to develop, deliver and maintain such a system" (p. 1).

A question arises from examination of the PS in this context: How could the NANB effectively represent the voice of NPs forcefully enough in policy level advocacy, given NANB's restricted regulatory function as defined by the NB Nurses Act of 1984

(updated 2002), NANB is required by law to devote its efforts to regulation of the profession, not professional advocacy. I have had experiences, in closed door meetings with representatives from the nurse practitioner group, where government officials asked NPs if they had considered "breaking away" from the NANB. New Brunswick's NPs, subsequently, did form a "separate" group under the NANB umbrella to advocate more intentionally, lobby, and represent the voice of advanced practice nurses. Importantly in this same period, across several Canadian provinces, these and other kinds of initiatives have intersected with the restructuring of nurses' associations. In this period, associations like NANB, which were created originally to address regulatory functions, have been reorganized as regulatory Colleges. This has been accompanied by the parallel creation/reorganization of provincial nurses' associations with new mandates focused on policy-level professional advocacy (e.g., the Registered Nurses Associations of Ontario, British Columbia, Alberta, Manitoba, NFL). This kind of reorganization has made it possible for professional advocacy to be addressed by nurses' associations—without challenging the resources of regulatory colleges who are focused on their legislative mandate.

Given these contextual realities, a full uptake of policy level advocacy for advanced practice nursing and PHC in NB was structurally complicated for NANB. DiCenso et al. (2007) acknowledge this situation, arguing for different forms of advocacy and suggesting that the implementation of the NP role has been "sporadic and dependent on the changing political agendas shaping the health system as well as the powerful physician influence in a physician-centered primary health care delivery system" (p. 113).

(iv) Concerning *discourse directions* and emerging discourses in the PS, the document points to other jurisdictions and the introduction of other models of PHC delivery such as "Saskatchewan's Mobile Health bus, Ontario's Nurse Practitioner lead clinics and British Columbia's RN led street health teams" (p. 4). These are examples of community based models of nursing practice, including NP practice that are consistent with PHC. They had emerged in provinces where strong advocacy for PHC-NP roles had occurred. Another emerging discourse in the PS is the introduction of the term "support staff" (p. 3) to the collaborative team of health professionals. However, given the brief scale of the PS, details about who these support staff are (e.g., community outreach staff) and how they are integrated in collaborative teams is absent from the document. PHC discourse of "ensuring equity, social justice and access to the broader determinants of health" within public policy is another emerging yet consistent discourse that re-affirms NANB's alignment with WHO (2008) principles of PHC and the importance of including these principles within a (health) public policy framework.

Converging discourses involve combinations of elements related to health care sustainability, chronic disease management and an aging population are present in the PS,

> Statistics on the health status of New Brunswickers are overwhelming: seven in ten have been diagnosed with at least one chronic disease, more than one in every three New Brunswick children, ages two to seventeen, are considered overweight or obese and New Brunswick ranks second in Canadian provinces with the percentage of its population over the age of sixty-five. (p. 2)

Other converging discourses include elements of effective PC in the context of PHC: "funding models to facilitate collaborative team approaches to care," "optimizing the

competencies of all health care professionals," "implementation of electronic health records to all PHC teams," and "rigorous monitoring and evaluation processes to measure impact, quality and safety of the service" (pp. 3-4).

Diverging discourses in the PS are those that move away from prevailing NB PC discourse, identifying specifics of what PHC involves, such as "education around prevention and control of prevailing health challenges, proper food supplies and nutrition, adequate supply of safe water and basic sanitation, maternal and child care, including family planning, and promotion of mental, emotional and spiritual health" (pp.1-2). These PHC discourses are not used interchangeably with the discourse of PC, and they diverge from PC discourses described in previous documents.

The PS presented NANB's position on PHC and PHC reform. It defines and addresses differences between discourses of PC and PHC, highlights the timeline of PHC reform in New Brunswick, and concludes with eight recommendations for the Government of New Brunswick. The dominant discourse is that of PHC with recommended innovative models for enhancing the nursing role in the delivery of PHC in the province.

Document 11: *Better Access to Primary Health Care – New Brunswickers Deserve It* (NPNB, 2019)

The *Better Access to Primary Health Care - New Brunswickers Deserve It*, is a promotional document (hereafter referred to as PD) produced by Nurse Practitioners New Brunswick (NPNB). PD is a four-page text that describes the training, role and priorities of NPs.

(i) The PD is *historically significant* as it builds on the work of the PHC Steering Committee, especially the *Primary Health Care Framework* (2012), and challenges the traditional fee-for-service medical models of PC. Like the NANB's PS document, discussed previously, PD comes at a social/political time in the province when health care reform is focused on health care sustainability, reducing health care costs through "enhancement" of the PHC system. Although it is widely accepted in international settings and policy-related documents by this time that improved access to PHC reduces overall costs to the system and improves health outcomes, the ambiguity and ambivalence between PC and PHC persists in NB government-related and NBMS documents, found for example, in PHC Framework (2012), PHP (2013), and CARE FIRST (2013). The challenge for NPs at this time (2019), is that the model chosen for PHC reform, Family Health Teams (FHT), is one dedicated to preserving the hegemony of physicians and medical practice.

(ii) PD is a promotional document—internally disseminated at the time to RN members of NANB. The text explicates the role of NPs in the health care system. As such, it appears that its most important intended audience were RNs as members of NANB. One purpose of this document was then to clarify the role of PHC NPs for RNs who may not have been familiar with PHC as a field of advanced practice. The document explains the role of NP's as providing a specific kind of PC, one centered in the specialized field of PHC advanced practice nursing. The PD provides an explanation of what an NP does, details their training and skills in PHC, provides a description of PC, details barriers to NP practice, and concludes with four priorities to improve PHC through greater engagement of NPs. For RNs unfamiliar with the NP role, the PD

describes an NP (generically) as “an advance practice nurse who has completed a master’s level university degree and has advanced knowledge and clinical expertise to diagnose, treat and manage disease or illness” (p. 1).

The PD describes skills of NPs as prescribing medications, ordering and interpreting laboratory and diagnostic tests and “referring to specialists when needed” (p. 1). These are all clinical skills that are required in the field of PHC Advanced Practice Nursing. These clinical skills allow NPs to address health disparities and inequities among vulnerable populations. They do this by assessing, diagnosing, and treating the health/illness challenges of individuals, while also explicitly addressing social determinants of health that lead to health inequity in the community among marginalized populations. These skills are acquired in PHC nursing as a specific field of advanced practice nursing. They are not interchangeable with the skills of family practice physicians.

The PD refers to PHC broadly in describing NP practice. The PD was likely intended as a text to clarify this kind of advanced practice nursing as a form of community based PC to an audience of RNs. In light of discussing this different kind of PC, the document further clarifies the unique role NPs have in blending nursing knowledge and biomedical fields of knowledge. NPs’ work is described as “comprehensive clinical care that blends the practice of medicine with the practice of nursing” (p. 1). Importantly, this statement does not indicate that physicians and NPs are interchangeable.

Using WHO’s definition of PC, the PD document describes PC as “usually delivered in communities and is the first place people go when they have health

concerns" (p. 1). Channeling the NANB PS definition of PHC, the PD goes on to describe what is included in the provision of PC among PHC NPs:

> PC [among PHC NPs] includes routine care, care for acute and complex health problems, mental health care, maternity and childcare, psychosocial services, home care, health promotion and disease prevention, periodic health exams (i.e. PAP tests), managing chronic illness and end-of-life care. (p. 1)

The following PD section presents challenges to NP practice. It refers to chronic struggles around access to PHC and promotes PC providers like NPs as a solution: "Our government has recognized the importance of improving access to primary healthcare; yet government continues to be unsuccessful in fully integrating the Nurse Practitioner role in the province [resulting in the] underutilization of this valuable primary care provider" (p. 2). The PD cites data about New Brunswick's population emphasizing the need for a broader population health approach: "New Brunswick has the highest rates of chronic disease such as COPD, diabetes and hypertension in Canada" (p. 2). It also goes into some detail in discussing access to a primary care provider; "Sixty-two thousand (62,000) New Brunswickers are either without a primary care provider or unable to access their current provider" (p. 2); and "Several New Brunswickers have had multiple providers due to frequent migration of physicians in and out of the province" (p. 2).

The final paragraph of this PD section speaks to the inadequacy of current funding models: "There are Nurse Practitioners who are willing and able to provide competent and patient-centered primary care who are underutilized because of lack of current funding models" (p. 2). Current funding models, according to the PD, limit optimal use of NPs: "the existing funding model has Nurse Practitioners working in

established regional health facilities like health centres, clinics, and hospitals" (p. 2). The argument that the PD makes for alternate funding models relates to where PHC is delivered: "Given that primary health care is delivered outside of the regional health authorities [the current funding model] does not allow NPs to work in the most vulnerable and difficult to recruit communities in our province [or in] private practice or within family health teams" (p. 2).

In this complex statement PD begins by arguing that PHC (when it exists) occurs in many diverse venues, contexts, sites, and practices (far beyond medically oriented spaces)—as defined by the WHO. This would also be the situation in NB, if PHC were fully enacted. In other words, in that reality, PHC would not be limited to or occurring only in association with RHAs. It would occur, for example, in services that are currently funded by other branches of government—as well as in non-health care related venues, some funded by other governmental or non-governmental entities (e.g., schools, long term care facilities, assisted living, correctional facilities, shelters, specialty clinics, community health centres, wellness centres, pharmacy outreach, rehab settings, public housing settings, food pantries, employment services, occupational rehab, corporate settings). This conceptualization of PHC is consistent with the WHO definition in part because it is community focused, and it addresses the social determinants of health in order to achieve health equity among historically marginalized populations. But importantly, the PD is arguing that a weakness in the current model for PHC in NB is found in the existing NP funding model. That model restrains the deployment of NPs, confining NPs mostly to existing structures of medically oriented primary care.

In challenging the current funding model for NP's, the PD is specifically pointing to the practice of funding NP positions through the RHAs. Since RHAs do not robustly fund services that occur outside of their authority, there are weakened prospects for achieving PHC through the practice of NPs. As long as NPs are funded in the way they are by RHAs—they are not deployed to many practice contexts where they could effectively address PHC. In contrast to the process for creating physician positions, NP positions have historically been funded based on approval of proposals submitted to the RHA senior leadership (i.e., VP, CEO level) to work in RHA-sponsored and funded programs. And RHAs can view the activity of PHC NP practice as not being concordant with the prevailing practices of (medically hegemonic) primary care. The PD is correctly pointing to the contradiction that while RHAs have responsibility for the majority of health care delivered to citizens, that care defines primary care as a service provided by physicians. And given the definition of PHC, this funding arrangement is untenable for supporting NPs in the delivery of PHC.

It may also be argued that in the current healthcare system, primary (medical) care is delivered by physicians, technically outside of the RHAs, in that the RHAs have no authority over physician practice other than granting privileges to use hospital services including admitting patients. That arrangement is not available for NPs who are salaried—employed in positions offered by the RHAs to provide specific services in the RHA. NP's have also not lobbied to practice in a fee-for-service arrangement—resembling the remuneration model of medicine. So, there are no opportunities for NPs to work in a fee-for-service-type practice and bill Medicare as physicians do. And with this restriction, the document correctly argues that the funding model for NP positions limits

the delivery of PHC in NB. In this analysis, the document correctly points to what is experienced as a structural conundrum.

The final section of the PD text details "Nurse Practitioners of New Brunswick's four priorities to improve primary health care" (p. 3). The priorities are: "Improve primary care access in New Brunswick, primary health care reform, senior care, and mental health and addiction" (p. 3-4). Under the "improve primary care access" priority, NPs advocate for employment for all newly graduated NPs in PHC and a "multipronged funding model" (p. 3) that allows for their employment within or outside of the RHA structure. The PD calls for more educational seats at universities, the development of "inter-professional collaborative care practices that include Nurse Practitioners in communities with the greatest needs," and a demand to "fill longstanding temporary and *permanent* family medicine vacancies with Nurse Practitioners" (p. 2).

The PD Priority #2, *Primary Health Care Reform* (p. 3), calls for the establishment of "an inter-professional working group that includes Nurse Practitioners to make recommendations regarding primary health care reform," and for the province to "boldly move forward with inter-professional collaborative care models that include Nurse Practitioners" (p. 3). Other recommendations under this priority include, "establishing a provincial Nurse Practitioner advisory group, allow all primary care providers proportionate access to provincial health care dollars, move away from volume-only benchmarking, establish an accountability framework for primary health care and develop a universal prescription drug program" (p. 3). These recommendations continue the pattern in the text of focusing on how PHC NP's can collaborate with others to strengthen primary care in the context of a stronger provincial commitment to PHC.

The third priority, *Senior Care* speaks to supporting seniors in their communities by "increasing care in their communities and their homes" (p. 4), increasing the number of NPs employed in nursing homes as NPs have been "shown to reduce emergency room visits, transfers between facilities, and admissions to hospitals" (p. 4). The final recommendation under *Senior Care* is to include NPs "in strategic planning for aging-care initiatives" (p. 4). The final priority highlighted and titled as, *Mental Health and Addiction,* advocates for more involvement by NPs: "Improve access to mental health and addictions services in New Brunswick by employing Nurse Practitioners who would collaborate with psychiatrists and other mental health team members to address primary care needs" (p. 4). This priority also includes a recommendation to: [Update the] Mental Health Act authorizing Nurse Practitioners to sign relevant involuntary hospitalization forms (Form 1)" (p. 4). As with the other priorities, the *Mental Health and Addiction* priority ends with a plea to include NPs in future health care planning, and to "create an interdisciplinary addiction task force that includes Nurse Practitioners with the goal of developing a strategy to support primary care providers who are assisting patients in discontinuing prescription narcotics" (p. 4).

At the *discursive practice* level, the PD affirms NANB's position on PHC but with an explicit focus on NP practice as a way to make PC *consistent* with PHC. Through this text, the NPNB are negotiating a shift in PC focus away from exclusive reference to physicians—toward inclusion of PHC-NPs as a legitimate and valued PC provider. In collaboration with the NANB Position Statement on PHC, the NPNB PD is promoting the role of NPs in the context of PHC through focused attention on the discipline. The predominant difference between the NANB definition and the one presented in the PD, is

the specificity in the PD definition of advanced practice. This definition includes tasks previously assumed by many RNs to be uniquely practiced by physicians. Parts of the PD definition could also be viewed by those unfamiliar with the role of PHC NPs as describing the work of a physician, so the clarity provided, that NPs do not work under the direction of a physician, is strategic.

The PD also recommends greater involvement from NPs in health care planning and similarly recommends the inclusion of NPs in PHC reform. Although an NP was included as a member of both the PHCSC and the OSC, the ratio of primary care physicians to NPs was disparate (favoring the representation of physicians) on both of these decision-making committees. It is not clear from document analysis whether the involvement of one NP on each committee resulted in tokenized engagement, largely over-ridden by the hegemony of input from physicians.

While the PD text does not reference any NP involvement in previous health care reform, it does focus on the future by challenging the existing system's approach to NPs: "Our government has recognized the importance of improving access to primary health care [but] … the current system is not working for many New Brunswickers [and]… the government continues to be unsuccessful in fully integrating the Nurse Practitioner role in the province" (p. 1). As a result of these perceived barriers, the PD recommends *new* decision-making policy structures and calls on the Government of New Brunswick to: "establish an interprofessional working group that includes Nurse Practitioners to make recommendations regarding primary health care reform" (p. 3); "establish a provincial Nurse Practitioner advisory group, which includes a Nurse Practitioner to ensure effective utilization of the role" (p. 3); "establish an accountability framework for primary health

care that is administered by an external primary health care experienced group who lacks conflict of interest" (p. 3); "include Nurse Practitioners in strategic planning for aging-care initiatives" (p. 4); and "create an interdisciplinary addiction task force that includes Nurse Practitioners " (p. 4). In these recommendations, NPs are arguing/insisting to be included in policy decisions that impact their on-going practice and professional viability. Although NPs have been "at the table" where reform was debated, e.g., the PHC Steering Committee, they are often outnumbered by a four to one ratio by physicians (TOR PHCSC, 2012).

Intertextuality and interdiscursivity occur in the PD with references to the definition of PHC, discussions of health care sustainability, the relationship between health promotion and disease prevention and, specifically, the reduction of health care costs: "[The] utilization of Nurse Practitioners having expertise in health promotion and disease prevention would significantly reduce healthcare costs" (p. 2); and "Many are forced to seek their basic healthcare needs in less suitable and more expensive walk-in clinics and emergency rooms" (p. 2). Congruent with the PS document, Family Health Teams are referenced in the PD as an untenable PC model for NPs: "The current funding structure does not allow Nurse Practitioners to work in private practice or within family health teams" (p. 2).

Notable here in terms of *discursive practice*, is how the NPNB is responding by appropriating and accurately using the discourse of PHC to represent PHC policy reform. These areas of PHC reform have long included the role of nurses in providing community based PC, community based and residential senior care, as well as mental health and

addictions intervention. This may not have been understood within the wider context of government and medicine in NB.

In terms of the *social practice* level of analysis, the PD does take up PC discourse, familiar to NPs and to other actors involved in health care reform. The PC discourse explicitly positions the role of NPs as primary care providers *in the context of PHC*. It also anticipates some audiences who may not be familiar with the role of NP's in policy making environments. It defines NP practice by using terms for assessment, diagnosis and clinical therapeutics that are shared with physicians, both functioning as primary care providers—like "diagnose, treat, manage disease, prescribe medications, order diagnostic tests and refer to specialists" (p. 1). The PD challenges the broader social practice of bio-medical dominance and hegemony in the health care system by providing clarity about NP's autonomous practice and relationship with physicians: "NPs do not work under the direction of a physician but work in collaboration with physicians" (p. 1).

As previously noted, the PD takes issue with what is perceived to be a contradiction in government funding. These challenges may reflect growing skepticism among NPs in 2019 about persistent policy failures to embrace PHC in NB health care reform. Among some readers, the PD may be incorrectly viewed as endorsing a fee-for-service private practice model for, though it never proposes this position, and though the NANB PS (2014) earlier describes that as an "antiquated system" (p. 3).

In 2019, the PD suggests that NPs be deployed in wider contexts of PC, so that they may provide PHC. However, it is important to emphasize that the text does *not* argue that NPs themselves should be paid according to a fee-for-service model. Rather the PD explanation for taking a position about funding is based on a long standing and

unresolved contradiction in hiring practices: “The current funding structure does not allow Nurse Practitioners to work in private practice or within family health teams” (p. 2), which leaves NPs with limited and unsustainable employment options. As previously discussed, the PD is clear in its challenge of existing funding models, insisting that something must change. The thinking from NPs may have been that until a different funding mechanism is created for NPs to practice in PHC, they are being left behind.

In comparison to the PS (2014), the PD demonstrates, in its brief text, comparative silence in offering “visionary” suggestions for how NPs might creatively innovate in order to offer PHC in NB. Given the NP’s experience of peaks of hopeful reform followed by prolonged stagnation in failure to achieve tangible health care reform, there is no uptake in the PD regarding new or different models of PHC like those highlighted in the PS (2014), e.g., “Saskatchewan’s Mobile Health bus, Ontario’s Nurse Practitioner (NP) lead clinics, and British Columbia’s RN led street health teams” (p. 4). The absence of this kind of optimistic visioning in the document may be read to emphasize that the planning and health policy process in NB needs to include a bona fide inclusion of NP voices and real evidence of that influence, rather than their continued involvement in propping up medically dominated PC, with its untenable challenges.

In its major emphasis, the PD promotes and conveys the relevance of NP practice. In a recommendation in *Priority One*, PD strategically recommends to “employ Nurse Practitioners to fill longstanding temporary and permanent family medicine physician vacancies—both fee-for-service and salaried positions” (p. 2). (Again, this is not equated with arguing for NP’s to be hired via a fee-for-service model.) In this part of the text and in other aspects of the document, PD clearly conveys the message that NPs are fully

qualified (and as qualified as physicians) to provide PC. At a visual level, the photograph on the cover of the PD shows the torso of a person wearing a white lab coat holding a stethoscope. It would be easy to identify this image as being either a physician or a NP, among those familiar with the NP role.

Additionally, there is no mention in the PD of community health centres (CHC), the closest institutionalized example of a PHC delivery model in the province. This omission is somewhat puzzling. It may be understood as either short-sighted or strategically informed by NP's recognizing that CHCs and PHC were not being supported under a Conservative government. The PD's silence about CHCs may also suggest significant growing skepticism among NPs about how likely it is to expect real provincial PHC changes, especially in the province's CHCs. If so, NPs silence about CHCs raises an important strategic message, pointing toward previously missed opportunities, where there had been NP support for CHCs in real dialogue with health policy leaders.

Like the NANB PS document, the NPNB PD was an opportunity for NPs to be seen as positive contributors to PHC reform. The position articulated in the PD included focusing on PC embedded within the principles of PHC and to highlight the unique role of NPs within this space. While the document did address this, for some outside of nursing, it may have added more confusion and ambiguity. For example, among some readers unfamiliar with the profession of nursing, the text can be understood incorrectly as suggesting that NPs and primary care physicians are interchangeable. At the broader level of social practice involving health policy work however, the PD may more productively be understood as insisting that NPs cannot justifiably be left behind in the ongoing failure to reform health care according to the vision of PHC. On this reading, the

failure to fully integrate PHC NPs in NB will ensure complicity by all stakeholders in perpetuating medical hegemony and deferring the achievement of PHC.

(iii) The *problem* as presented by the PD involves a lack of integration of NPs and incompatible funding models: "Government continues to be unsuccessful in fully integrating the Nurse Practitioner role in the province" (p. 2), and NPs are "underutilized because of the lack of current funding models" (p. 2). Given stalled progress in the province on PHC reform and failure to adequately fund the full integration of NPs in PHC, the PD document understandably uses PC discourse. It uses PC discourse to promote the Advanced Practice NP role and to support NPs in finding their place in some different, more sustainable model of PC in the context of PHC.

After 19 years of trying, NPs are continuing to acknowledge that their practice is PHC advanced practice nursing. However, they appear to have embraced PC discourse in this document, perhaps because there doesn't seem to be another policy-influential discourse circulating in the health arena in NB or in the RHAs where most/nearly all of the NPs are able to practice. The logic of this direction in the PD could be that if PHC is not recognized or tolerated as a discourse, which is required to secure employment opportunities and use their advanced practice nursing skills, it appears that it is necessary to take up the dominant discourse of PC. Devlin, Braithwaite, and Plazas (2017) speak about the power dynamics involved in this reality, and they describe the "tension between medical and nursing disciplines especially within PHC reform" as being related to "knowledge appropriation and power," which requires a "negotiation of jurisdiction" (p. 111).

The NPNB PD document is generally collaborative, promoting PC practice (while being critical of the power display involved in defining Family Health Teams). The PD is also focused on critiquing the existing funding models, because these negatively affect NP employment and, as a result, negatively impact collaboration with family doctors: "Some physicians in New Brunswick are struggling to meet demands of large practices and are seeking opportunities to participate in collaborative team based models of care" (p. 2). This statement, that points to a willingness among NPs to collaborate with family doctors, is followed by "adopt a multipronged funding model that supports the employment of Nurse Practitioners, within or outside, the regional health authorities" (p. 3) and "move away from a volume-only benchmarking system to one that measures patient health outcomes" (p. 3). These critiques reflect frustration with the funding model that has not been addressed in structural reform. It also expresses criticism of how these structural impasses threaten the sustainability of PHC as NP's are prepared to provide it.

As per Devlin et al. (2017), "attempting to establish a role that would overlap the skills and knowledge of medicine, a profession sitting at the top of the hierarchy in the healthcare system, is not an easy task" (p. 112). Interprofessional and intra-professional collaboration is a crucial element of PHC reform. Communication, role definition and role understanding are critical elements of NP integration at systems levels in the province, which would include communicating with RNs, as well as with MDs in the province. It may be that the PD emerged during a time when RNs themselves were not convinced that health care reform would successfully achieve the goals of PHC. Having approached NP integration in the province by early agreement to fit into established funding models, the attention/horizon/imagination of the nursing profession could have

initially been focused on the unique role of NPs within a health promotion/disease preventative framework. This idea, of a health promotion NP horizon, is especially relevant for PHC NPs who are registered to practice and who work with marginalized populations. Yet, within the PD document, addressed as it is at least in part to RNs, that horizon is not strongly emphasized, and there are minimal concrete examples given that promote different models for PHC, like NP-led clinics or CHCs. This may again reflect NP skepticism given the effects of a previous Conservative government, and/or NANB recognition of stalled provincial progress on the agenda to reform NB health care toward PHC.

(iv) *Emerging discourses* in the PD are prevalent PC discourses that promote NPs as alternative providers in PC, prepared in advanced practice nursing with skills that combine nursing and bio-medical knowledge (e.g., pathophysiology and pharmacology). This PC discourse describes NP practice as "comprehensive clinical care that blends the practice of medicine with the practice of nursing" (p. 1). Another slightly different emerging discourse is one that characterizes PHC as occurring beyond and outside of the RHAs. This discourse holds the potential for those who understand the PHC NP role to re-envision PHC. It reminds those who recognize PHC that NPs have the capacity to reduce health inequity through their practices in diverse venues. Although the PD describes NPs as primary care providers who are able to "increase access to primary healthcare for New Brunswickers" (p. 2), "primary healthcare" is not defined in the document. This silence may have been based on skepticism or uncertainty among NPs about the likelihood of achieving PHC reform in NB.

Another emerging discourse is related to potential struggles between primary care family physicians and NPs. This emerging discourse appears in a recommendation to "allow all primary care providers proportionate access to provincial health care dollars" (p. 3). This can be understood as a struggle for participatory parity, supporting NPs by extending "proportionate access" to them for funded positions. It is also a call for structural support, for different funding formulae to support multidisciplinary team based PC, different than medically dominant PC, again calling for PC that is explicitly associated with PHC. Other related emerging discourses in the PD document include access to "a universal, comprehensive, evidence-based and sustainable prescription drug program" (p. 3), and "developing a strategy to support primary care providers who are assisting patients in discontinuing prescription narcotics" (p. 3).

Converging discourses of health care sustainability related to chronic disease and an aging population are present in the PD. These are positioned around the impact of NP practice as a response to these policy issues: "Increase the use of Nurse Practitioners employed in nursing home facilities" (p. 4), and "Improve access to mental health and addiction services in New Brunswick by employing Nurse Practitioners" (p. 4). Similar converging discourses related to the management of chronic illness and/or health care sustainability include: "Develop inter-professional collaborative care practices that include Nurse Practitioners in communities with the greatest need," "Boldly move forward with inter-professional collaborative care models that include Nurse Practitioners," and "Establish an accountability framework for primary health care" (pp. 3-4).

In the PD there is a divergence of the discourse of PHC from what was described

in the NANB PS (2014) of "ensuring equity, social justice and access to the broader determinants of health" (p. 3). While referencing or drawing on the WHO definition of PHC, the PD depicts PHC more vaguely, as a context within which PC should be operating. These references to discourses of PHC in the PD are mostly devoid of explicit emphasis on the social determinants of health or health equity. This comparative weakening of PHC discourse is accompanied by heavy emphasis on PC discourse, deploying NPs who can effectively replace permanently unfilled positions for family practice physicians, especially in rural communities. The pattern of converging and diverging references to PC and PHC discourses is consistent, as these discourses have been used to describe NP practice in the context of PHC reform in NB. Convergences and divergences in the use of discourses of PC and PHC have been consistent within the majority of texts so far examined.

Document 12: ***New Brunswick Nurse Practitioners Supporting Access to Health Care for All New Brunswickers Infographic*** **(NPNB, 2019)**

The Infographic, *Supporting Access to Health Care for All New Brunswickers*, hereafter referred to as IG, is a promotional, one-page document produced by the Nurse Practitioner interest group of New Brunswick (NPNB) as an accompaniment to their *Better Access to Primary Health Care* PD document, discussed above. In 2019, NPNB separated from an earlier version of Advanced Practice Nurses New Brunswick (APNB)—specifically separating NPs from CNS in NB, while remaining affiliated with NANB.

In relation to describing the text, infographics are a creation of contemporary journalism. The NPNB IG is a good example of the infographic genre, which is defined

as a visual representation of information and data that combines elements of text, image, data and diagram as an effective tool to present data and explain complex issues (Velho, 2009).

(i) In terms *of historical context and significance*, the IG was developed by members of the NPNB as a forward-facing document to accompany the PD. It provides a one-page snapshot of NP practice at a time when an increasing number of graduating NPs were concerned about being unable to find employment in new or previously established NP positions in New Brunswick. This was due mostly to the restricted number of new positions available in the RHAs. PHC reform efforts in NB at that time were focused on the development of FHTs. As previously discussed, FHT was a model that privileged family physicians and was anticipated to be funded by the fee-for-service remuneration model, which does not provide salaries for NPs in collaborative practice (PCCPP, 2007). Like the NANB PS, discussed earlier, the IG comes at a social/political time in the province when health care reform is focused on neoliberal health care sustainability (under a Conservative government), also reducing health care costs through enhancement of the hospital based biomedically oriented PC system. By this time, it is widely accepted among policy analysts and health experts that improved access to PHC reduces overall costs to the system and improves health outcomes (PHC Framework, 2012; PHP, 2013; PS, 2014). In contrast to this emphasis on PHC, the challenge for NPs at this moment, is that the model chosen for PHC reform in NB, i.e., funding Family Health Teams, is one dedicated to physicians and to protecting medically oriented primary care.

(ii) The IG is an infographic *text* dedicated to NPs and NP practice. Its format coincides with a textual genre that is typically used to "build brand awareness" (Velho,

2009f). The information contained in the IG is a repetition of educational requirements and scope of practice for NPs as contained in the PD, discussed previously. The IG reinforces the collaborative relationship between NPs and physicians, and states: "NPs do not work under the direction of a physician but work in collaboration with physicians" (para. 2). The most prominently displayed feature of the IG is the number of NPs in NB (130), visually associated with the image of an advanced practice nurse—accompanied by an image of a stethoscope, with a related stated satisfaction rate: "88% of New Brunswickers rate their NP's service as 8-10 out of 10" (paras. 1 & 4). Underneath this prominent text is a grey map of New Brunswick overlaid with white script listing locations where NPs work: "family practices, nursing homes, emergency rooms, health centres, correctional facilities, Canadian Forces, universities, schools, specialty clinics such as methadone, diabetes, mental health/addiction, and sexual health clinics as well as private business" (para. 5). Adjacent to the map is script describing licensing and liability insurance requirements: "NPs must complete annual licensing requirements administered by the Nurses Association of New Brunswick. NPs must carry liability insurance administered by the Canadian Nurses Protective Society" (para. 6). Underneath this section is a paragraph describing legislative changes to enable NP practice: "The Nurses Act was amended in July 2002 to enable the practice of nurse practitioners in New Brunswick" (para. 8). This section is accompanied by medical and advanced practice nursing insignia, followed by the final section, at the bottom of the page, containing an image of a cardiogram line also commonly associated with acute care and also with adult and acute care advanced practice nursing. The bottom section script is in larger font than the middle section and is capitalized. It states, "Nurse Practitioners of New Brunswick

continue to work with the Department of Health, Nurses Association, and the New Brunswick Nurses Union to better utilize NPs and improve access to primary care for New Brunswickers" (para. 9). In representing the role of PHC NP's, the IG reflects the NP vision of primary care, still in the context of primary health care.

The final section of the IG is a dark section along the left side of the page that defines NPs as:

> NB Nurse Practitioners (NPs) are advanced practice nurses who are educated to a master's level with a focus in primary health care. They have knowledge, skills and ability to take care of the physical, emotional, mental and social aspects of their patients' health needs. (para. 1)

Embedded in this statement is an emphasis on NPs as advanced practice nurses and primary care providers in NB who have advanced training in PHC. This advanced training is represented in the IG as a resource that should be leveraged in models of health care reform. In a context previously more focused on PHC, this preparation to address PHC would have included a focus on reducing inequities and addressing the social determinants of health.

The bottom section of the IG, under the above paragraph, contains a list of health services that NPs can offer:

> NPs CAN: assess, diagnose and treat health issues, order medical imaging, bloodwork, and specialized tests, perform minor procedures, prescribe medical and psychosocial treatments, prescribe medications and write orders to be carried out by other healthcare providers (e.g. dietary order, oxygen therapy, physical therapy, etc.), complete health and extended\benefits forms, work autonomously

> with health care teams in acute, primary and residential settings, refer to specialists, admit and follow patients in the Extra Mural program. (para. 7)

This section about what "NPs Can" do is accompanied by the symbol of an advanced practice nursing bag with a cross on it. The images depicted in the IG are recognizable symbols related to medical practice, advanced practice nursing, and also commonly associated with other health-related services (allied health first responders, EMT, RT).

At the *discursive practice* level, the IG promotes factual information about NPs, their numbers in the province, education and licensing requirements in an effort to provide compelling information to solicit public support. This effort responds to decades of now stagnated health policy reform in New Brunswick, responding to stalled progress in an agenda that could locate PC within the framework of primary health care. Like the PD, the IG shows more divergence toward the discourse of PC, with less emphasis on the discourse of PHC, though that is still the field of advanced practice that NPs registered in NB provide. With both the PD and IG texts, the NPNB are emphasizing PC as they attempt to attain/retain a stake in the power struggle of health care reform.

Provincial attempts to establish PHC over time had mostly used the discourse of PC to systematically privilege physicians in models of care. Through the texts of the PD and IG, NPNB are now also invoking PC discourse to construct themselves within the defined provincial parameters of PC reform and sustainability. The use of descriptive and regulatory text like "advanced practice nurses who are educated to a masters's level with a focus in primary health care" (para. 1), positions NPs as a crucial health professional, well qualified to advance and influence a political agenda of healthcare reform. By listing all of the activities that an NP can do, the NPNB are also accurately representing

themselves as legitimate PC actors, with less emphasis on their practice within a PHC framework. The emphasis on not working "under the direction of a physician" (para. 1) but in "collaboration with physicians and other healthcare team members such as dietitians, nurses, pharmacists, and many others" (para. 3), represents and conveys the identity of NPs as collaborators. (This is a requirement of advanced practice.) The explanation that NPs are legitimized through legislation and regulated by that legislation, that they must complete annual licensing requirements and carry liability insurance, dispels the perpetuated myth of ultimate doctor liability (Cashin et al., 2009).

The final section of the IG describes NPs as collaborators in the progression of health care reform and improvement: "[NPNB] continues to work with the Department of Health, Nurses Association of New Brunswick, and the New Brunswick Nurses Union to better utilize NPs and improve access to primary care for New Brunswickers" (para. 9). By including this section in the IG, NPs are reinforcing their advocacy role in health policy reform, especially as it relates to the integration and expansion of the NP role and reform centered on PHC. The text again suggests that because NPs are primary care providers in NB who have advanced training in, they should be leveraged in models of health care reform.

Intertextuality and *interdiscursivity* occur between the PD and IG text by highlighting NPs educational requirements, their relationship with physicians, and the collaborative nature of their work. The final paragraph, referencing NPs continued work with the Department of Health, NANB, and NBNU to integrate NP practice and improve PC access, demonstrates a mobilization of discursive resources in NPs' continuing commitment to be actively involved in health care reform. This assertion of a

commitment to be and stay involved/relevant in policy level challenges related to health care reform is important, even though their agency (NPNB) is constrained by larger discursive structures like NBMS and the direction of PHC reform.

At the *social practice* level of analysis, the IG highlights factual information about NPs, which represents, reminds, and reinforces their location within the political discourse of healthcare reform. It appears that the intended audience for this text is membership of NANB as well as the general public, with reference to the rating of NPs: "88% of New Brunswickers rate their NP's service as 8-10 out of 10" (para. 4) and listing specific functions like "assess, diagnose, treat health issues, order medical imaging, bloodwork, and specialized tests, perform minor procedures, prescribe medications and write orders, refer to specialists" (para. 7).

These ratings of public satisfaction with NPs may not be known by RNs in generalist practice. Among most other New Brunswickers, the itemized clinical tasks sound similar to what a family physician would do. Many New Brunswickers and some RNs, however, may not know that in contrast to PC physicians, NPs are educated and practice to achieve the outcomes of PHC. For this reason, the minimal use of the term "primary health care" in the text has relevance for more than one audience. For those citizens without a primary care provider, knowing this information would solicit inquiries and apply pressure to decision makers to increase numbers of NPs in the province. This availability of an additional resource for PC would be even more important given the fact that after 17 years of their established practice and legal legitimacy, there was at the time a sustainable and strong workforce of "130 NPs in New Brunswick" (para. 2). Like the PD, discussed previously, the IG challenges the broader social practice of medical

dominance and hegemony in the health care system by affirming the autonomous practice of NPs and their relationship to physicians. The IG informs the public that NPs are "educated to master's level with a focus in primary health care," and that they are positioned to "improve access to primary care for New Brunswickers" (para. 9).

The IG further represents the role of NPs as partners with physicians for PC rather than emphasizing their unique role. In contrast, Devlin et al. (2018) challenge NPs to embrace their "precious point of view" acquired from "reflecting on the needs of society" and being available to offer "primary care to the marginalized" (p. 114). It is from this vantage point that NPs can justifiably speak as the best positioned PC provider to act on the social determinants of health and health inequities and to support social justice (Devlin et al., 2018).

(iii) The *problem* addressed in the IG is primarily a lack of understanding among the public, among health policy analysts, experts, politicians, and even among some RNs about NP education, training, scope of practice, leadership, and NP's collaborative relationship with physicians. It is a truism of communication theory that a focus on what information is valued will influence how it is accessed and used (Hardy, 2001). Given this, the ultimate target audience for the IG appears to be the general public or the citizens of New Brunswick, especially those without a family physician or with poor access to their family physician. In also reaching RNs, the IG broadens the capacity to disseminate this message widely in NB.

Public support and public advocacy can lead to social change (Cohen, 2011). By providing information, i.e., a greater understanding about NPs and their role in providing access to health care, NPNB is ultimately enlisting the public's assistance to advocate for

a more substantive role in healthcare reform. The IG promotes the role of NPs by providing concrete examples of their potential interventions, highlighting their status as autonomous, advanced practice nurses, and listing the various environments where NPs could/would be employed, which is a political strategy (Fairclough, 1992). Lewis (2010), recommends that nurses enhance their political advocacy: "Nursing's combination of numbers, reputation and reach should translate into power and influence over how healthcare is financed, organized and delivered" (p. 116).

The implementation of the NP role in NB has been complex, careful, challenging, and dependent on the changing political agendas shaping health care reform in addition to the powerful and previous well-established physician-centric PC delivery system in NB and Canada (DiCenso et al., 2014). IG addresses the problems of misunderstanding and misinformation about the role of the NP and promotes a collaborative, albeit presently separately funded, and competitive relationship with physicians.

(iv) *Emerging discourses* in the IG are consistent with the emphasis on PC discourses of the PD, but muted, given the lack of space available to capture ideas. NPs are characterized as being trained in PHC but are promoted as being able to improve access to PC. Locations conducive to NP practice like "correctional facilities, specialty clinics, as well as private businesses" (para. 5), contribute to emergent discourses about NP service delivery occurring "outside of the regional health authorities" (PD, 2019, p. 2). Other emerging profession growth discourses are the numbers of NPs in the province, 130 at the time, and satisfaction rates of NPs, "88% rate their NP's service as 8-10 out of 10" (para. 4). *Converging discourses* of collaborative care and better access to PC are noted. *Divergent discourses* (consistent with PD), are the diminished/divesting/absence

of discourses of PHC, for example the silence about "ensuring equity, social justice and access to the broader determinants of health" (NANB PS, 2014, p. 3).

The NBNP documents *Better Access to Primary HealthCare* (2019) and accompanying Infographic (2019), explain and promote the training, role and licensing requirements of NPs. Four priorities for improving PHC are presented and a few myths about NPs, e.g., their relationship with physicians, are dispelled.

Summary

This concludes the analysis and examination of the six documents pertaining to PHC reform spanning a time period of seven years, from 2012 to 2019. The chapter examined how the discourses of PC and PHC are represented in GNB health policy documents and professional nursing and medical documents. In detailing consistencies/continuities, contradictions/ discontinuities, intersections, and gaps in PHC and PC discourses as reflected in these documents, I explored how the discourses of PC and PHC in GNB health policy documents and professional discipline documents contributed to or interrupted PHC reform in NB. I also examined how this history is connected to and reflects the integration of primary health care NPs in NB.

The trajectory of PHC reform that these seven years represent encompassed a pinnacle of PHC optimism with the release of the PHC Framework (2012), followed by a steep descent away from the discourse of PHC, to a predominance of neoliberal influenced discourse of PC, beginning with the PHP (2013). The PHC Framework (2012) and the PHP (2013) highlight the disconnect between PHC discourses and the Government of New Brunswick's neoliberal commitments to cost containment and performance excellence, along with individual responsibility for health, improved

accountability, and rationalization of health services. In comparison, the discipline specific documents from the professions of nursing and medicine differently privilege the discourse of PHC or neoliberal arguments for improved access to medically oriented PC.

Beginning with the government enabled *PHC Framework* (2012), this period was historically significant because it represented the culmination of approximately nine years of work by the Primary Health Care Steering Committee, and it represented the final concrete initiative of this collaboratively-focused time period described in Chapter 4. Specifically, the PHC Framework took up the ideas introduced in the ML Report, endorsed them, built on them and provided more operational detail to encourage implementation, i.e., Family Health Teams. Although some of the recommendations contained in the PHC Framework reflected the discourse of PHC, the model chosen for development, the Family Health Team (FHT), appeared to be a model that privileges physicians in PC. The provincial health plan (PHP 2013), *Rebuilding Health Care Together 2013-2018*, despite being published only one year after the *PHC Framework* (2012), and originating from the same government department (i.e., Department of Health), was effectively silent on PHC. Neoliberal discourses of financial sustainability, enhanced accountability, performance measures and performance excellence dominated the plan. In contrast to the *PHC Framework*, the 2013 PHP was focused primarily on the acute care hospital system with minimal attention to transformative changes within the broader system existing outside the walls of hospitals.

The NBMS's response to the Government's PHP (2013), *Fixing New Brunswick's Healthcare System* (2013), attempted to reassert the physician-dominated, medical model of PC into the vision of health care reform and refute the proposed emphasis on

accountability prevalent in the PHP (2013). The predominant discourse of medically-oriented PC prevalent in both the PHP (2013) and the *CARE FIRST* documents was more aligned with the discourse of neoliberal health care reform and cost containment through investment in the medical model of care delivery than PHC and its associated discourse of health equity and the social determinants of health.

The NANB *Position Statement* (PS, 2014) was a response to both government-produced texts, the *PHC Framework* (2012) and the PHP (2013). As an organization representing primary health care providers, NANB tried to refocus the reform discourse on the principles of PHC articulated by the WHO (2008). In the PS document, NANB addressed the ambiguity perpetuated by media and government texts related to the interchangeable use of PHC and PC discourses and reaffirmed the importance of a health care system grounded in the principles of PHC, namely the assurance of equity, social justice and access to the broader determinants of health. The final two discipline produced texts, developed by the NPNB, *Better Access to Primary Health Care* (2019) and *Supporting Access to Health Care for all New Brunswickers* (2019), detailed the work of NPs as APNs trained as primary health care providers. Both of these documents from NBNP were significant because they accurately represented NPs as legitimate PC actors within PHC frameworks of practice including the collaborative and team-focused orientation of their practice.

Over the seven years examined in Chapter 5, a predominant pattern emerged of neoliberal discourse continuously intersecting with or becoming aligned with PC, and less so with PHC. This interdiscursivity between the discourses of neoliberalism, PC, and PHC is demonstrated in several ways. In the period 2012–2019, interdiscursivity

occurred in some of the documents, consisting of mixed references to all three discourses (neoliberalism, PC, and less frequently PHC). The PHC Framework and the PHP (2013) referred to elements of population health, chronic disease prevention/management and health promotion through healthy living. But these analyses were frequently articulated in the context of controlling the high costs of hospital-based care, implementing community-based and less costly, PHC, and increasing access to PHC (PHC Framework, 2012). In these years, PHC discourse and its elements of health equity, social justice, and addressing the social determinants of health became less obvious and less explicit, especially in government and medical documents, than in the period 1989-2011, discussed in Chapter 4. Interdiscursivity between PC and neoliberal discourses occurred most noticeably in the years 2012-2019, with frequent calls for "better access to primary (medical) care" (NBMS, 2013; PHP, 2013), countered by limited reference to improved access to PHC in the PHC Framework (2012) and NANB PS (2014). These examples of rising PC discourse were also evident in the NBMS document, together preserving medical hegemony in PC.

During these same years, there is evidence in some government and nursing documents of using PHC discourse to address health care reform (NANB PS, 2014; PHC Framework, 2012). These instances of explicit PHC discourse demonstrate intertextuality, where some government and nursing texts took up PHC discourse consistent with the WHO (2003, 2008). The increase in numbers and integration of PHC NPs in this period coincided with the text that specifically addressed a framework for PHC (NANB, 2014) and the NPNB (2019) texts promoted NP practice as a way to make PC consistent with PHC. Through these texts, the NPNB negotiated a shift in PC focus

away from exclusive reference to physicians toward inclusion of primary health care-NPs as a legitimate and valued primary care provider. This and the NANB PS (2014) linked the social determinants of health and community-based models of care to health equity, describing improved access to PHC. The documents demonstrate a peak presence of PHC discourse in the period (2007-2012), with the diminishment of PHC discourse in the period (2013-2019). This may have been attributed to a rise in the neoliberal discourse of health care sustainability prominent in the PHP2013 and minimal demonstrative models of PHC (teams) in the province or a reluctant acceptance of the predominance of PC discourse given the implementation of medically hegemonic health care teams (i.e., Family Medicine New Brunswick), (NPNB, 2019).

This completes the analysis of the 12 selected government and discipline-specific texts. The period of focus in Chapter 5, 2012–2019, generally demonstrated continuity with the discourse of PC and discontinuity and diminishment of PHC discourse. The optimism for PHC reform, experienced during the introduction of NPs in 2003 and the implementation period of these PHC providers from 2004–2012 was replaced with neoliberal discourses of clinical sustainability, performance measurement and fiscal responsibility. Chapter 6 provides a synopsis of these results and conclusions related to the discontinuity of PHC discourse.

Chapter 6

Summary and Discussion

Inspired and influenced by critical discourse analysis, specifically the work of Carol Bacchi and Norman Fairclough, this doctoral thesis has traced the trajectory of discourses associated with health care policy and PHC health care reform in New Brunswick from 1989 to 2019.

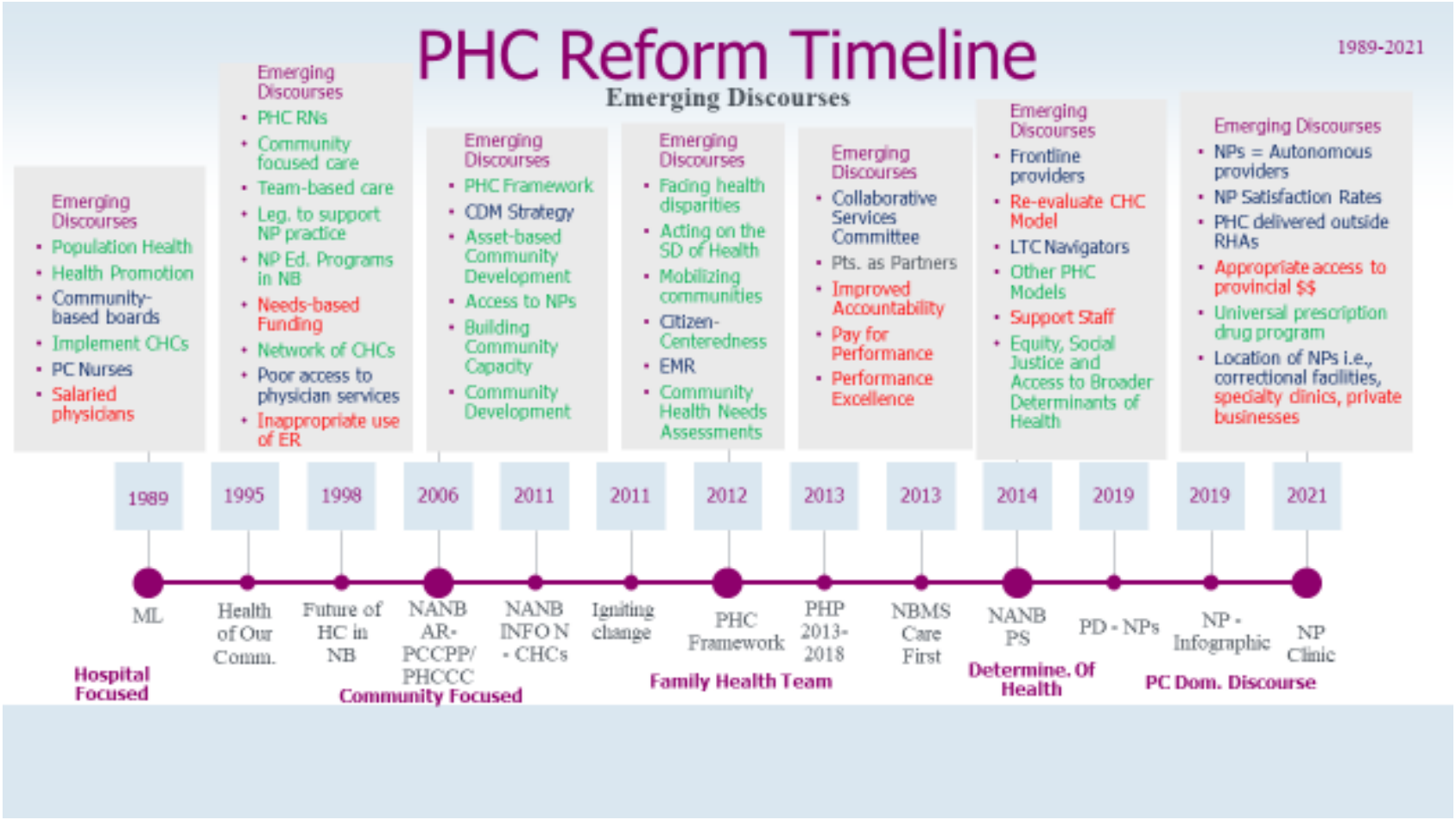
I organize this chapter into the following sections: (a) a summary of the findings in light of the timeline of health care reform discourse in New Brunswick; (b) a statement about why the focus of this study and its findings have significance; (c) a reminder of the research questions; (d) interpretation of findings, where I discuss discourse direction, interdiscursivity and intertextuality, discourse threads, problem representation, power and control, governmentality, and integration of NPs; (e) discussion of implications, limitations, recommendations; and (f) an offering of final thoughts.

Summary of Findings During the Period 1989-2019

Figure 1 depicts a timeline for "Primary Healthcare Reform" in NB—as presented in my analysis of documents in Chapters 4 and 5. The figure illustrates the trajectory of health care reform discourses that emerged in various government and health professional documents between 1989 and 2019. It illustrates how emerging discourse strands or threads appeared in different documents, e.g., strands addressing community health centres, population health, PC doctors, and PHC nurses. These discourse strands in the figure illustrate how PC and PHC co-mingled, with PHC peaking in the period 2011-2012, then PHC declining in 2013. The timeline also depicts how the discourse of PC was reflected most prominently in New Brunswick health policy in 2013-2019.

Figure 1

PHC Reform Timeline



The figure contains larger circles at five intervals on the bottom of the timeline with corresponding areas of named emphasis in the documents, i.e., “Hospital Focused” – “Community Based Primary Care” – “Family Health Teams” – “Determinants of Health” – “Primary Care as Dominant Discourse”. These labels represent my analysis of broad categories of emphasis that occurred in healthcare reform discourse between 1989 and 2021. They summarize areas of emphasis contained in emerging discourse strands along the historical continuum. Taken together, they illustrate different aspects of PC vs PHC emphasis - rising or competing for emphasis over thirty years. Finally, the figure illustrates, by color coding of vertical columns, when **PC (blue)**, **PHC (green)**, and **Neoliberal (red)** discourses were strongest, equally balanced, diminishing, or disappearing. More discussion of these patterns is found below.

Significance: Why the Discursive and Social Practices of Healthcare Reform Matter

I have long been interested in understanding why intense efforts federally and provincially to reform health care toward PHC were largely unrealized and resulted in only minor adjustments to the New Brunswick health care landscape. Provincially, health care reform has been a priority item for subsequent governments beginning in 1987 with the McKenna liberal government who initiated the first document of my analysis, the ML Report (1989). PHC is named specifically as having a reform focus beginning in 2000 with the federally-initiated Primary Health Care Transition Fund (PHCTF), 2000-2006 (Health Canada, 2007). This federal policy direction, ensured through a strategic $800-million dollar investment nationally, called for improvements to PHC as a crucial element of health services renewal (PHCTF, 2000-2006). Over the six-year period the PHCTF supported provinces and territories in their efforts to introduce new approaches to

PHC delivery. New Brunswick, under this fund, received $15 million which was primarily directed toward establishing Community Health Centres (CHCs) and implementing collaborative practice models for PC delivery with family physicians working with nurse practitioners (NPs) (GNB, 2012). The discursive and social practices of healthcare reform mattered in these areas of federally-initiated reform. PHC reform outcomes were aligned to the significant funding expected by federal contributions.

As a Department of Health Policy Advisor, I was introduced to the discourses of PHC during this time when CHCs were the focus of reform efforts. Later, in 2013, as Director of Primary Health Care and later, Executive Director of Community Health Services, the political focus had shifted to the PC system and the role of primary care providers (physicians and nurse practitioners). I believe now, in retrospect, that it is fair to surmise, that I, along with my colleagues on the Primary Health Care Steering Committee, did not fully understand how to position PC within the broader discourse of PHC. This misunderstanding of the discursive and social practices of reform translated into missed opportunities for PHC team models focused on health equity and the social determinants of health. Given this missed opportunity, I was compelled to examine the trajectory of PHC reform in the province of New Brunswick through the lens of critical discourse analysis (CDA). This methodology was selected because it holds promise for identifying discursive practices, problem definitions, power relations in social practices, governmentality, and other influences that shape government policy direction (Bacchi, 2012c, 2016; Fairclough, 1993, 2001, 2005).

Research Questions

In this study I examined how the discourses of PC and PHC are represented in three Government of New Brunswick health policy documents and nine nursing and medical policy-related documents. The research questions addressed changes in the presence of these discourses as reflected in selected government and disciplinary health policy related documents between the years 1989 and 2019. The specific research questions and a summary of the findings are as follows:

1. **How are the discourses of primary care (PC) and primary health care (PHC) reflected in New Brunswick health policy post Canada Health Act (CHA, 1984)?**

   The presence of PHC diminished steadily in the government policy texts in that it was more prevalent in the earlier document (1989) then in the later documents (2012-2013). Generally, government health policy took up PC and neoliberal discourses to argue for improved access to PC at a lower cost, with effects that attenuated the presence and influence of PHC.

2. **How are the discourses of PC and PHC represented in New Brunswick health discipline-specific document, specifically nursing and medicine, post Canada Health Act (CHA, 1984)?**

   PHC was rarely (if ever) present in the medical text where primary (medical) care was the most prevalent discourse. This pattern is in contrast to the nursing texts where there was sustained use of PHC discourse over the 30 years examined.

3. **What are some examples of consistencies/continuities, contradictions/discontinuities, intersections, and gaps in PHC and PC**

discourses as reflected in the selected provincial health policy and professional discipline documents?

During the time period 1989-2013 PHC discourse diminished steadily in the government policy texts and was absent in the medical text. There was more consistency in the uptake of PC and neoliberal discourse in the government and medical texts. This pattern is in contrast to the nursing texts where there was more continuity, demonstrated in sustained use of PHC over the 30 years examined. In relation to government texts, use of PHC appeared most strongly at the beginning of this timeline. During the years 2012-2013, government and health discipline texts included some consistent elements of PHC, e.g., universal access, teamwork and interdisciplinary collaboration in PC, community participation, a PC focus on broader population health, and linking PC to continuity of care from prevention to chronic care. While including these elements of PHC, most references to PHC in government and medical documents were largely silent about health equity or the social determinants of health which was contradictory to nursing texts where this discourse was peripherally referred to but was generally a gap in all documents examined.

4. **How are the discourses of PC and PHC represented in the Government of New Brunswick health policy documents and in professional discipline documents specifically in relation to the introduction of Nurse Practitioners (NPs) in New Brunswick?**

The nursing texts consistently referred to the introduction of NPs and, once introduced, the promotion and maintenance of the NP role. There was minimal reference to NPs in the government and medical texts.

Interpretation of Findings

In critically analyzing the 12 selected documents, I focused on the consistencies/continuities, divergence/discontinuities, intertextuality, interdiscursivity/intersections, and gaps in PC and PHC discourses. Historically over a timeline of thirty years, the health professions/discipline documents were developed to either influence government policy documents or in response to them. The documents reveal how health care reform was being represented by government and health professions using PHC and PC interspersed with neoliberalism. Using CDA to address the research questions, I compared representations of PC and PHC in the documents and also considered how discursive patterns were associated historically with the introduction and integration of NP practice in New Brunswick. The analysis of text, discursive practice, and social practices revealed a number of critical discourse analytic elements and patterns, as discourses were woven through and developed over the 30-year time period examined.

Discourse Directions

As discussed earlier in the dissertation, discourse direction refers to directional elements of the discourse under examination, e.g., emerging, converging and diverging of PC, PHC, and neoliberal discourses. Bacchi and Bonham (2014) refers to Foucauldian genealogical examination to illustrate how political practice facilitates the emergence and direction of discourse (Bacchi & Bonham, 2014). Taking my lead from Bacchi &

Bonham, I analyzed how PC, PHC and neoliberal discourses emerged historically and were continuous over time. I also examined when the discourses converged/intersected and when there was discontinuity and divergence.

From a discourse direction perspective, the overall analyses of the 12 texts revealed emerging discourses, diverging discourses, and converging discourses. These converging or intersecting discourses included the use of neoliberal discourse in close relationship to, coextensively with or in close association with, PC. This occurred for instance in the government-produced PHP (2013) and the NBMS *Care First* (2013). There was clear evidence of how government health policy took up PC and neoliberal discourses to argue for improved access to PC at a lower cost, with effects that attenuated the presence and influence of PHC. Over time, as illustrated in Figure 1, the presence of PHC diminished steadily in the government policy texts and was rarely (if ever) present in the medical text. This pattern is in contrast to the nursing texts where there was more continuity, demonstrated in sustained use of PHC over the 30 years examined. In relation to government texts, use of PHC appeared most strongly at the beginning of this timeline. It was attenuated over time in the government policy texts by a hybrid neoliberal-PC discourse that emphasizes PC. During the years 2012-2013, government texts nominally included some elements of PHC, e.g., universal access, teamwork and interdisciplinary collaboration in PC, community participation, a PC focus on broader population health, and linking PC to prevention, acute care and chronic care across all components of the health system (PHC Framework, 2012; PHP, 2013). While including these elements of PHC, most references to PHC in government documents were largely silent about health equity or the social determinants of health.

The analysis also revealed how different discourse threads were variously emphasized, minimized or absent in respective documents, making clear how dominant discourses emerged in each text examined. The dominant discourse of each text was dependent on the discursive positioning of each entity (i.e., government, NANB, NBNU, NPNB, NBMS). For example, government texts, although advocating for reform, also subscribed to fiscal responsibility and value for money discourse. Nursing texts, NANB, NBNU and NPNB, promoted PHC reform but also broader scopes of practice and greater responsibility for the profession of nursing. The NBMS text, although somewhat aligned with government reform direction around interdisciplinary PC teams, promoted continued authority and privileged positions for physicians.

Interdiscursivity and Intertextuality. Over the time period examined, a predominant pattern emerged of neoliberal discourse intersecting with PC and/or PHC discourses. As discussed in Chapter 3, interdiscursivity is defined as the aspect of a discourse that relates it to other discourses (Fairclough, 2001; Wodak, 2001). Interdiscursivity in relation to PC and PHC was demonstrated in several ways. In the period 1989-2019, a "hybridized" interdiscursivity occurred in the government documents (ML, 1989; PHP, 2013) and the nursing documents (NANB, 1998, 2014; NBNU, 1995), consisting of references to all three discourses (neoliberalism, PC, and PHC). Early nursing documents (NANB, 1998; NBNU, 1995) referred to PHC elements of population health, disease prevention and health promotion. But these analyses were frequently articulated in the context of controlling the high costs of hospital-based care, implementing community-based PC, and increasing access to PC. In these early years, before the establishment of PHC NP practice, PHC discourse and its elements of health

equity, social justice, and the social determinants of health were less obvious, nascent, emerging, or less explicit in health disciplinary as well as in government documents. Interdiscursivity between PC and neoliberal discourses was also noticeably emphasized in the government documents and the NBMS *Care First* text, with frequent calls for better access to PC (ML Report, 1989; NBMS, 2012; PHP, 2013). During these same years, there is also evidence in the government documents (ML Report, 1989; PHC Framework, 2012; PHP, 2013) and the nursing documents (NANB, 1998; NBNU, 1995; NANB, 2014) that followed, of using PHC discourse to address health care reform. These instances of explicit PHC discourse in government and in nursing demonstrate intertextuality consistent with the WHO renewed PHC strategy, *Health for All in the 21st Century* (WHO, 1997). NBMS documents in this period did not associate PHC with NB efforts for health care reform. Instead NBMS documents demonstrated strong interdiscursivity and intertextuality between the neoliberalism of Lean Six Sigma, a methodology borrowed from business and industry to improve organizational performance, such as eliminating waste and duplication, and stronger PC.

The noticeable implementation (in 2003) of regional health authority (RHA) funded positions for practicing primary health care NPs in NB, was due in part to the additional provincial funding from the Primary Health Care Transition Fund (PHCTF) 2000-2006 and occurred in the later part of the 1989-2011 period. The presence of primary health care NPs in 2011 was reflected in professional documents (Barry & Saunders, 2011; Davies, 2011; NANB, 2014). Having achieved some beginning level of provincial integration into existing systems, professional nursing texts in this period demonstrated the prominent influence of PHC in discussion of PHC-NPs. This emphasis

on PHC appeared in continuity with an early, originating text that specifically addressed a framework for PHC (NANB, 1998). This pattern in the later nursing texts did explicitly link some of the social determinants of health and community-based models of PHC to health equity, describing improved access to PHC – not improved access to PC.

The interchangeability of PC and PHC and persistent perpetuation of ambiguity between the two discourses is most prevalent in the government-produced texts in the period 2012-2019 with PC discourse being more consistently referenced. In contrast, a regularly referenced PHC discourse was the dominant discourse of the nursing texts (NANB, NBNU, NPNB), whereas PC was the dominant discourse of the NBMS text.

Discourse Threads: Continuities and Discontinuities. This analysis of continuities and discontinuities demonstrates complex intersections between PC, PHC, neoliberalism and various other discourse threads occurring over the 30 years examined. Bacchi (2012 c.) refers to "common threads and analytic tensions" in the study of problematizations (p. 3). She notes the "condensations of thinking" that are revealed through what she describes as poststructural policy analysis (Bacchi, 2015, p. 4).

As per Bacchi (2012 c., 2015, 2016), the analysis of Chapters 4 and 5 revealed several discourse threads pulled through each of the documents demonstrating both continuity and discontinuity in meanings over the 30-year period. These discourse threads include: (a) neoliberal discourses about health care sustainability and greater accountability within the system, (b) PC discourses emphasizing the reorganization of PC in the existing healthcare system, (c) reform discourses that critically address medical hegemony and promote multi/interdisciplinary team practice, and (d) PHC discourses that emphasize population health and to some degree social determinants of health.

Neoliberal discourses of health care sustainability and greater accountability are two complimentary discourse strands that were woven through both the government and discipline produced documents. These were most prominent in the government-commissioned texts. Beginning with the ML Report (1989), neoliberal discourses of health care sustainability, fiscal responsibility, and greater accountability were prevalent. The ML Report focused on enhanced accountability by developing system targets and priorities that could be "measured, evaluated and implemented" (p. 110). This discourse thread was also present in the PHC Framework (2012) and the PHP (2013). The PHC Framework (2012) spoke to the development of an accountability framework with "performance indicators and clinical outcomes" (p. 20), and the PHP (2013) called for more accountability in the system by patients/clients, health care providers, and administrators of the system. The NANB (1998) document also recommended implementation of a workload measurement system and the NBNP document, *Better Access to Primary Care* (2019) recommended the development of a PHC accountability framework administered by a third party to avoid "conflicts of interest" (p. 3).

Another discourse thread evident in the early ML Report (1989) flagged the power and influence of physicians as gatekeepers to the health care system as one of the sources of systemic financial strain, fueled by unfettered demand with little accountability to and stewardship over publically funded facilities and services. Similarly, the NANB and NBNU texts took up this discourse thread by presenting PHC as an option for cost sensitive improvement in health care: "increasingly, health services research indicates that better primary health care can markedly improve health and reduce the need for institutional and physicians' services" (NBNU 1995, p. 3).

A related discourse thread placed emphasis on the critique of bio-medical hegemony. The NANB (1998) challenged medical hegemony by introducing an "integrated health delivery system" with nurses in "advanced practice roles" and "the creation of the Nurse Practitioner role" (pp. 1-2). Both the NANB and NBNU documents referenced the challenges with the preponderate medical model of care supported by fee-for-service remuneration. The PHC Framework (2012) responded to medical hegemony by introducing shared responsibility for PHC care delivery and included a recommendation for multidisciplinary models of care. In contrast, the PHP (2013) addressed medical hegemony by promoting the neoliberal discourse of improved systemic accountability and increased numbers of multidisciplinary PHC teams with reassurances that there were enough health human resources in the system. The later nursing documents, NANB (2014) and NPNB (2019), both referenced the challenges with the stand-alone, family physician model of care supported by fee-for-service remuneration.

The interprofessional reorganization of the health care delivery system with more services delivered through multi/interdisciplinary, collaborative teams of health care providers was another reform discourse thread taken up in the texts. The ML Report (1989) spoke to a reorganization or rebalancing of the system. The PHC Framework (2012), defined the desired state of PC being delivered within a framework of PHC, with an engaged and involved community by an interdisciplinary family health team. The PHP (2013) mentioned shifting the focus from hospital care to more preventative interventions and better access to PHC through the use of multidisciplinary teams. The NBNU and NANB documents, also promoted alternative models of PHC [including early references

to Community Health Centers (CHC)] and addressed the limitations of a medically dominated, sole-provider, model of care delivery. Collaborative team approaches to care were a consistent theme in the nursing texts. NBMS however proposed team-based care restricted to teams of physicians with other potential team members assuming traditional, subservient roles. In contrast to the nursing texts, CHC models of care were not promoted by the NBMS and historically have not been supported by organized medicine (Jones, 2019; Lomas, 1985).

Over time however, explicit references to CHCs became less prominent as a component of health care reform, when compared to earlier texts. Strong references to CHCs also disappeared from nursing texts, as in the last NPNB texts, *Better Access to Primary Health Care* (2019) and *Supporting Access to Health Care for all New Brunswickers* (2019). In its text, the NBMS (2013) called for reconfiguring PC within the existing system, promoted PC medical teams and concurrently called for a somewhat threatening review of the cost effectiveness of CHCs. The NBMS also promoted the elimination of billing numbers which could trigger unfettered control of fee-for-serve remuneration.

Discourse related to population health is a final discourse thread woven through the 12 texts. Early in the timeline (1989-2006), references to "population health" were emerging in government and nursing documents (ML, 1989; NANB, 1998, 2006; NBNU, 1995). Beyond 2006, there was continuity in ongoing mention of population health in the government texts and the nursing texts. The PHC Framework, PHP 2013, NANB (2014) and NPNB (2019) all recognized and addressed how focusing on narrow systems of medical diagnosis and treatment would not produce a high level of overall population

health. Population health discourse in these texts was frequently aligned in neoliberal ways with healthy living discourses, especially in the PHC Framework (2012), PHP (2013) and NBMS CF (2013). Although some elements of population health discourse included varying references to achieving health equity, there was less consistent mention of the social determinants of health. The social determinants of health as foundational for addressing health equity were mentioned in a limited capacity in ML (1989), NBNU (1995), PHC Framework (2012) and the PHP (2013). In both of the nursing texts, NANB (1998) and NANB (2004), the connection of the social determinants of health to health equity is explored more robustly. Whereas biological, behavioral, or social factors influencing health were identified in the NBNU DP (1995), the NANB PB (1998) focused on promoting the health of specific populations, like women, children, youth, and seniors. By comparison, in the NBMS (2013) document, population health interdiscursivity occurred in neoliberal "healthy living" discourses, placing responsibility on individuals for their choices in relation to health. This was in contrast to social justice discourse identifying the need to address structural components of PHC and health promotion among those living with chronic illness, income, and food insecurity in the nursing texts (Barry & Saunders, 2011; NANB, 1998; NANB, 2014; NPNB, 2019).

According to Raphael and Bryant (2000), "population health is firmly rooted in the epidemiological tradition" (p. 9), and "lacks an explicit values base, neglects political and sociological issues and neglects how health determinants are created and maintained by powerful economic and social forces" (p. 9). In contrast, *health promotion* identifies the roles that "societal structures and public policy play in shaping the health of populations in general and the most vulnerable in particular" (Raphael, 2008, p. 483). As

a discourse, population health is not always synonymous with PHC discourse and is often more aligned with neoliberal interpretations of individual accountability for health promotion in PC discourse. It frequently has also been associated with neoliberal visions for movement to more "community-based" services. Given these dimensions of population health discourse, services grounded in the epidemiology of population health increasingly have not taken up the need for action on social determinants of health, health promotion, or wider questions of health equity and social justice in liberal market economies (Raphael, 2008, p. 487). Yet these questions are central to PHC.

As an example, population health discourse frequently contains references to "healthy living" while also evading questions of income inequality, structural racism, housing and food insecurity, and other health determinants. In NB, population health discourses were incorporated in government, medical, and in some nursing texts as a health reform discourse. In references to population health, *healthy living* was especially prominent in government and medical texts. In nursing texts, population health was generally associated with "chronic disease management," "preventative care," "health promotion," and "disease prevention" (Barry & Saunders, 2011; NANB, 1998, 2014; NPNB, 2019). In government and nursing texts the uses of population health discourse were linked to a focus on children and youth, seniors, Indigenous populations and, in some cases, gender focused care (NANB, 1998; NPNB, 2019; PHC Framework, 2012; PHP, 2013). In general, however, these documents, like those from the NBMS, were mostly silent about value commitments to address structural sources of health inequity. Although silent about value commitments, Thompson (2014) has explored how "nurses have practiced for social justice, integrating various discourses into complex folk

paradigms and professional ethics that address social justice and equity in health care" (p. E17).

It is of course possible that all these population health terms in early documents represented neoliberal intersections of PC and PHC discourses—while not intending to replicate negative consequences of neoliberal cost-effective reform. But it is also worth noting that lacking an explicit commitment to health equity and structural transformation of various forms of oppression, the discourse of population health too often conveys neoliberal assumptions which perpetuate health inequity (Raphael, 2008, 2009).

At the time of the ML Report (1989), government policy was focused on maximizing population health status within a climate of fiscal restraint. The PHC Framework (2012) took up this discourse focusing on an aging population and the rise of chronic disease at a time of growing strain in Canada's liberal market economy. In that context, some policy makers likely genuinely believed that "a health-system focused on primary health care is more likely to produce better health outcomes and greater patient satisfaction, all at a lower cost" (PHC Framework, 2012, p. 10). The PHP (2013) continued this population health discourse as the key to fiscal sustainability, by citing "population health challenges" (p. 7). These challenges were explained as follows:

> The major causes of illness and death in developed countries like Canada are chronic diseases. Management of these diseases is a costly and often life-long process…we could do a better job of looking after our personal health. (pp. 7-8)

In contrast to these neoliberal interpretations of each autonomous individual being ultimately responsible for their own health, within the early nursing texts, population health discourses ranged from specifying biological, behavioral or socio-economic

factors that determine health status, to population specificity by "focusing on the most vulnerable" (NBNU, 1995, p. 5). Similarly, the NANB spoke to a focus on specific vulnerable populations such as "women, children and youth and the elderly" (NANB DP 1998, pp. 16-18). In contrast, discourses of healthy living were more prevalent in NBMS CF (2013). During the timeline from 1989-2019, the strongest advocacy for PHC being most aligned with action on the social determinants of health and health equity came in explicit language from the nursing profession in NANB (2014): "It is time the government made a firm commitment to PHC. Public policy must focus on ensuring equity, social justice and access to the broader determinants of health" (p. 3).

Problem Representation

Bacchi's (2016) poststructural policy analysis, specifically her *What's the Problem Represented to be?* approach, used in the analysis of selected documents in Chapters 4 and 5, was useful in shedding light on assumptions embedded in New Brunswick health policy documents. In particular, Bacchi's focus on knowledge practices and power relations revealed how meaning is made and why some discourses are acted upon and some are not. She notes that policy issues tend to be "represented in ways that mystify power relations and often create individuals responsible for their own 'failures', drawing attention away from the structures that create unequal outcomes" (Bacchi, 2000, p. 46). Bacchi (2016) speaks to policy problems being socially constructed and representative of continuities across policy formulations. In this study, continuities and discontinuities were revealed in the use of PHC and PC discourse to determine how problems are represented in policy documents. In the analysis of the 12 documents, continuities that existed across statements of policy problems included calls for changes

to the current health care system because of its orientation to the hegemony of a bio-medical, illness, curative model, centered around hospital care and offering an uncoordinated, unintegrated fee-for-service delivery model (ML Report, 1998; NANB, 1998; NBNU, 1995). These and other problem representations all reflected neoliberal explanations of "the problem." Using neoliberal discourse over thirty years, government health policy and professional documents alternatively described a system that is unsustainable due to: (a) failed cost containment; (b) ineffective delivery of PC; (c) rising chronic disease and/or population health related issues (ML Report, 1998; NANB, 1998; NBMS, 2013; NBNU, 1995); or (d) growing public debt, as noted in the ML Report (1989), PHC Framework (2012) and the PHP (2013).

Another continuity in "problematization" (Bacchi, 2012, p. 1) in the texts is the idea that individuals are responsible for their own health failings. Bacchi describes this concept, congruent with neoliberal thinking, as "responsibilisation" (p. 5). This discourse emphasizes individual responsibility and independence in decision-making. It has emerged as an influential discourse in criminal justice, addictions, and population health discourse. The ML Report (1989), the PHP (2013), as well as NBMS (2013), feature this governing victim blaming discourse. In contrast, the nursing texts do not subscribe to a responsibilisation discourse.

An additional continuity involves the contribution of nurses to positive health outcomes not being fully recognized or realized. This was identified as a problem in all of the nursing-produced documents (NANB, 1998, 2014; NBNU, 1995; NPNB, 2019). The representation of the problem in the ML Report (1989), using PC and neoliberal discourse was also to emphasize how nurses could, more cost-effectively address

inadequate access to PC. This was in contrast to the nursing documents that emphasized PHC as a broadly based "policy direction" (NANB, 1998, p. 3) along with the removal of funding barriers impeding advanced practice nursing (NPNB, 2019). Similar to the government texts, the NBMS used PC and neoliberal discourse to define the problem of access to health care, as a problem of access to family physicians, citing billing numbers as the barrier. In contrast to this NBMS definition of the problem, PHC discourse was used in the NANB PS (2014) and the NPNB PD document (2019) to problematize stalled progress on PHC reform.

The confusion, ambiguity, and inaccurate interchangeability of PC and PHC in government-produced texts was also critiqued as problematic in NANB-produced documents, which were also articulating the importance of PHC as a policy direction. All five of the nursing documents used the discourse of PHC and articulated its importance as a framework for a reformed health system (NANB 1998, 2014; NBNU, 1995; NPNB, 2019).

As part of problematization, Bacchi speaks to discursive positioning as a factor in determining how particular problem representations take shape and assume dominance, while others are silenced. According to Bacchi (2021), discursive positioning is influenced by experiences, knowledge, discourses, and practice. Discursive positioning for government, as reflected in the policy texts, was one of stewardship of the health care system and ensuring its sustainability while maintaining quality care: "Accessible, Appropriate range of services, Effective, Efficient, Equitable, Safe, Clinically Sustainable" (PHP, 2013, p. 5). The NBMS (2013) was discursively positioned to protect its own interests, warning the government of the danger in creating "two duplicative

systems that compete with each other" and ensuring that "everyone deserves timely access to a family doctor" (p. 3). Finally, nursing positioning involved advocacy for systematic changes that prioritized social justice in health through PHC, allowing full scope of practice for primary health care NPs and multidisciplinary teams of collaborative providers for citizens (NANB, 2014).

In addition to the problem representations and discourse threads woven through the government and discipline specific texts discussed above, broad themes or propositions for reform were revealed in the documents. The texts and their respective discourse threads alternately emphasized the need to interrupt the existing arrangements of power and control and/or to assert influence over health care reform via government policy direction. These two broad concepts—power and control, and governmentality—influenced the reform process and had a role in the introduction and ongoing practice of advanced practice nursing embodied in nurse practitioners (NP).

Power and Control

Transformation in any organization requires a shared purpose amongst all of the actors involved, attention to the discursive positioning of these actors in the reform process, and strong, resilient leadership (Hanlon et al., 2019). The analysis of texts in Chapters 4 and 5 highlights the ongoing discursive struggle between discourses of PC and PHC as a framework for health care reform. The ambiguity and confusion between the two discourses persisted throughout the 30 years examined, with the eventual dominance of PC and the silencing of PHC as a framework for health care reform in New Brunswick as reflected in the PHP (2013) and NBMS *Care First*, 2013. The WHO

(2003), originators of the discussion about PHC, acknowledged the confusion that has existed in the definition of PHC since 1978, stating:

> no uniform, universally applicable definition of primary health care exists. Ambiguities were present in the Alma-Ata document, in which the concept was discussed as both a level of care and an overall approach to health policy and service provision. (p. 103)

The PHC discourse of social justice and health equity aligned with the WHO renewed strategy, *Health for All in the 21st Century* (WHO, 1997). In this document WHO acknowledged some of the failures of the original policy document, stating "decision-making in the health care sector is still dominated by professional interests that favour curative medicine over preventative and promotive public health" (p. 10).

During the period being analyzed here, health policy scholars began to comment on ambiguities, confusion, inconsistencies, divergence, and contradictions in the ways the two discourses of PC and PHC were being used. That literature suggests that elements common to/addressed by both PC and PHC discourses include: "1. First Contact Care, 2. Accessibility, 3. Comprehensiveness, and 4. Coordination of Care" (Muldoon, Hogg, & Levitt, 2006, p. 410). Where PHC discourses diverge from PC include the following from two WHO documents describing PHC:

> 1. principles of equity, 2. universal access, 3. community participation, 4. intersectoral approaches, 5. focus on broader population health issues, 6. reflecting and reinforcing public health functions, 7. creating conditions for effective provision of services to poor and excluded groups, 8. organizing integrated and seamless care, 9. linking prevention, acute care and chronic care

> across all components of the health system and 10. continuously evaluating and striving to improve performance. (WHO, 2003, p. 103)
>
> Promotion of health systems that contribute to health, equity and social justice, service-delivery reforms that re-organize health services around people's needs and expectation, so as to make them more socially relevant, public policy reforms that secure healthier communities and leadership reforms that promote negotiation--based leadership versus command and control. (WHO, 2008, p. 18)

In addition to these analyses, other health policy scholars have argued that PC is generally understood as family-doctor type services provided to individuals (Hutchinson, 2008; Starfield, 1998). For advocates of PHC, this limited view of PC draws attention to the importance of contextualizing PC within a larger social, political, and economic framework of PHC. For these scholars, the wider context of PHC speaks more clearly to matters of health equity, in large part by addressing the social determinants of health. Given that PC discourse clearly articulates a family practice physician's role and function, the discourse of PHC may be threatening to the medical community or uncomfortable politically because of the less biomedically defined principles and role delineation. Community involvement, in particular, requires collaborative skills and relationships and the sharing of knowledge and responsibilities in non-hierarchical, community-based partnerships. These have not historically been the primary source of power and privilege for physicians.

Health care is understood as a complex entity comprising different social actors, governance structures, belief systems and values, each vying for resources and legitimacy (Hanlon et al., 2019). The medical profession has historically held a dominant and

privileged position of power within that system (Cashin et al., 2009; Coburn, 1993; Lazar et al., 2013; Lewis & Sullivan, 2013; Turner et al., 2007), influencing health policy direction and playing an intermediary role between the state and other health occupations (Coburn, 1993). Weber (2016), defines medical hegemony as both the "influence or authority over others, the social, cultural, ideological, or economic influence exerted by a dominant group and the dominance of the biomedical model and the active suppression of alternatives" (p. 1).

Gramsci's (1971) concept of hegemony, as embraced by Fairclough, "is a cultural and ideological means of perpetuating domination by securing the spontaneous consent of the subordinated' (p. 170). Using this literature, my analysis of findings presented in Chapters 4 and 5 reveals the influence of medical hegemony in the three government policy documents examined, i.e., the ML Report (1989), PHC Framework (2012), and PHP (2013), and in the NBMS *Care First* (2013) document. However, medical hegemony was not addressed the same way across these texts. The government documents regarded medical hegemony as inherently negative and a threat to health care sustainability; the NBMS, *Care First* text promoted the retention of medical hegemony through negative representation of other professions attempting to replace medical work. Despite the provincial government's efforts to erode medical hegemony through the introduction of different models of care, like CHCs and salaried PC team models, the stand alone, fee-for-service family physician office, as the dominant model of care, has prevailed.

A feminist perspective is also a consideration under the broad theme of power and control. As introduced in Chapter 3, feminist poststructuralism speaks to social realities

constructed and modified discursively depending on time, context, experience, and power (Jefferies, Goldberg, Aston, & Tomblin, 2018). A feminist poststructuralist view is focused on how discourses are socially, historically, and institutionally created and maintained, and how gender, power, and language are used to position discourses marginally or hegemonically (Macdonald, 2019; Sawicki, 1991; Weedon, 1997). Feminist poststructuralism "provides a perspective that focuses on the critique and transformation of patriarchal power relations while maintaining an understanding that multiple forms of power exist everywhere and in many contexts" (MacDonald, 2019, p. 63). Poststructural feminism allows for examination of the multiple ways in which power impacts various intersections of, for example, class, gender, and race and is a factor to be considered in this critical discourse analysis because of the gendered positionality of nursing as a profession in North America.

In *Bedside Matters: The Transformation of Canadian Nursing, 1900-1990,* MacPherson (2012) documents the history of nursing and the persisting patriarchy within healthcare. According to MacPherson,

> in the early twentieth century the male medical establishment exploited the labour and talents of skilled young women and in the later twentieth century male administrators, and legislators, along with doctors continue to deny nurses the workplace authority or financial remuneration commensurate with nurses' critical role in patient services. (pp. 8-9)

As a result of professionalization in the 20th century, nursing continues to be practiced by (predominantly white) women who now identify as middle-class professionals. Alternatively, medicine has been traditionally understood as an upper-middle class

(predominantly white) profession dominated by men. There exists a hierarchy in the health care system with the knowledge and authority of (privileged male) physicians positioned at the apex of the hierarchy and the knowledge and authority of (female) nurses (and other providers) located lower in that hierarchy (Adams & Bourgeault, 2004).

Turner et al. (2007) found that with the introduction of NPs as new and autonomous providers, policy, text and talk still reinforced subservient, traditional roles for nurses within the health care system. Similarly, in this study, the discourses of PHC, most prominent within the nursing texts (NANB, 1998, 2014; NBNU, 1995), were not taken up with the same emphasis, discursive practices or social practices as were demonstrated in the government or medical texts. Especially relevant are the ways in which PC and neoliberal discourse were the dominant discourses in the medical text (NBMS, 2013).

When considering the relationship between discourse, power and ideology, Fairclough (1995) speaks of ideological-discursive formations where actors speech is connected with the position they occupy. Physicians are powerful actors in the social practice of health care delivery and have jurisdiction over the diagnosis of illness and all of its ensuing sequela (Freidson, 1984; Moffatt, Martin, & Timmons, 2014). As a group, physicians are publicly perceived as altruistic with a monopoly over a body of knowledge inaccessible to lay people (Freidson, 1984). In the texts from the nursing profession analyzed in this study (i.e., *Discussion Paper: For the Health of our Communities,* 1995; *The Future of Health Care in New Brunswick: The Nursing Contribution,* 1998; and *Position Statement – Primary Health Care, 2014),* the dominant discourse of PHC in these documents is inter-professionally conciliatory, focused on strong alliances,

partnerships and integrated service delivery focused on the needs of people and communities. The recommendations from the nursing profession for health care reform are linked to changes in population health, higher incidences of chronic disease and the inability of the existing configuration (medically oriented, curative, and hospital-based) to meet these needs. More in line with Foucault's (1973) conceptualization of power as circular and generating resistance, nursing, as a profession, has become increasingly skilled at negotiating authority from a hierarchically lower position within the medical institution (Hallett & Fealy, 2009).

Nursing's calls for reform are aligned with the WHO's strategies for health equity and social justice realized through PHC reform (WHO, 2008). Hanlon et al. (2019) note, "to make sense of the politics of reform efforts, careful attention needs to be paid to the discursive (re)positioning of actors in the reform process" (p. 52). Two actors federally, Commissioner and former Saskatchewan premier Roy Romanow, and Senator Michael Kirby, both strong national advocates for transformation in PHC, "noted the glacial advance of primary care reform" (Lewis, 2005, p. 275). This scenario, of slow to non-existent reform from PC to PHC, has played out in New Brunswick, where, despite substantial federal investments and attempts to transform the system, the majority of PC is still delivered by family physicians in traditional PC models of care, while the more comprehensive PHC is realized in small pockets throughout the province, mainly in CHCs.

What is the reason for this resistance to PHC reform? What is the origin of this resistance? One explanation is that as a community of practice, physicians have resisted change and lobbied for the maintenance of their privileged role in proposed PHC team

models, taking up hegemonic discourse such as having physicians positioned as "head of the team," "quarterback," "most responsible," and with "ultimate responsibility for the care delivered to patients by all health professionals" (Cashin et al., 2009, p. 125). In New Brunswick, despite being involved in provincial PHC reform efforts through significant professional representation on the (Health) Ministerial Primary Health Care Steering Committee, the NBMS (2013) does not use the discourse of PHC in the document *Care First*. In contrast to the nursing texts, discourses of collaboration, negotiation, partnership, and integrated service delivery are absent in the medical text. Medical hegemony persists throughout the *Care First* (2013) document. Whereas physicians are described as "experts in medical care" (p. 2), other team members are identified as non-expert, trained in specific roles subservient to and under the direction of physicians and the practice of primary (medical) care. Other health care providers are criticized and minimized: "We cannot have people who aren't experts trying to do things that doctors do" (p. 2); "Some groups have said that if only they could prescribe advanced medications and be paid more, our problem would be solved" (p. 2). As Whitehead and Davis (2001) observe, "Privileged groups always have a vested interest in maintaining the status quo, to protect their advantage" (p. 114).

Throughout much of the 30 years examined, physicians in New Brunswick held a privileged status. They were able to retain the autonomy of an independent contractor and were free from clinical outcome measurement and accountability for the health outcomes of their patients in a complex organization that they primarily controlled (Lewis, 2005). Such "ideological practices" (Fairclough, 1992, p. 67), as revealed in the analyzed texts, played a role in maintaining discursive and social practices in the health care system

including creating unequal power relations between social groups. As evidenced in the NBMS *Care First* (2013) document, the medical profession continues to appropriate the societal trust of a governing position extended to physicians, while enforcing the subordination of the positions and influence of others, namely pharmacists, nurse practitioners, other health care professionals, government employees, and hospital administrators. Organized medicine is critical of other models of care (e.g., salaried remuneration models) where physicians work as partners/members of a multidisciplinary team, e.g., CHCs, as a loss of autonomy and independence (Jones, 2019; Lomas, 2015, NBMS, 2013). The NBMS *Care First* text capitalized on the medical profession's status as expert medical knowledge holder to promote recommendations that solidify that status and prevent further role erosion of power and position.

As highlighted previously, attempts to erode medical hegemony were present beginning in 1989 with the ML Report. The power and influence of physicians over the health care system was an area of growing concern for legislators. At the time of the ML Report, physicians were exclusively the entry point to the health care system, they controlled access to hospital programs, including diagnostic and intervention services such as specialty care, surgery, rehabilitation, and pharmaceutical treatment. The ML Report spoke to the number of physicians in Canada growing beyond the growth of the population and the problematic role physicians played as "gatekeepers" in the system (p. 32). This gatekeeper function was perceived as the cause of growing financial strain on the province.

Also, at that time, the provincial government's neoliberal discourse of cost reduction and rationalization of publically-funded services intersected with

recommendations in the ML Report that called for an increased focus on PC. At that time, PC was considered *community care*, provided outside of the expensive acute care system so less costly and even more so if care was provided by a different, less expensive, less autonomous provider (i.e., primary care nurse). Ten of the 64 recommendations made in the ML Report were dedicated to enhanced PC services including a call for primary care nurses working within a more independent role in community. This recommendation was intended both as a solution to the increased costs of providing health care by physicians and an effort to erode the monopoly of physicians over care provision both in hospital and in the community. Other solutions proposed in the ML Report included controlling the numbers of practicing physicians through Medicare billing numbers and expanding the scope of publicly funded care, which could be offered by other health professionals: "There is mounting evidence that the current emphasis on the medical model of diagnosis and treatment is not producing, and will not produce on its own, the level of population health that is possible" (p. 27).

In the period following the ML Report, a number of projects were piloted in New Brunswick to improve access, coordination, and delivery of PC via the use of other health care professionals, namely nurses. The majority of these projects reflected the prevailing political ideology at the time, i.e., that "community-based family doctors' offices are the backbone of the PC system, and it makes sense to build on that foundation" (GNB news release, 2004). One example of these projects, was the Primary Care Collaborative Practice Project (PCCPP) detailed in Chapter 4. The term "collaborative" implies collaboration but, in reality, the project maintained the existing position of nurses working in a subservient role for physicians.

The second government policy document analyzed, the PHC Framework for New Brunswick (2012), addressed power and control in the system by introducing shared responsibility for PHC care delivery with the recommendation for multidisciplinary models of care. Contrary to methods attempted in the ML Report, to control medical practice patterns and physician billing numbers, the PHC Framework invited collaboration from stakeholders including primary care physicians, registered nurses, and nurse practitioners. The group assembled to make these changes, the Primary Health Care Steering Committee (PHCSC), provided more membership for physicians at the table. The PHC practice models and ideas that flowed from the committee were refurbished examples of primary medical care. After much deliberation and debate, the family health team (FHT) model of care was recommended as the multidisciplinary model moving forward (GNB, 2012).

The recommendations of the PHC Framework (2012) represented a consensus from all members of the committee, physicians, RHA administrators and Department of Health representatives. Fairclough (2001) characterizes such texts as *negotiated texts* where the goal of text producers is to create a consensus document without a need for arguments based on other discourses. The extent to which a PHCSC vision for the *family health team* could have transformed the hegemony of bio-medically oriented primary care is an important question. Analysis of these texts suggests that the concept of family health teams functioned as a status quo negotiated text, leaving medical hegemony in place as a major focus in PC, and diminishing efforts to establish PHC collaborative models of care.

In addition to the PHC Framework's recommendation for the creation of family health teams, recommendations to "conduct community health needs assessments" and "implement corresponding Collaborative Services Committees (CSC)" (p. 14), had the potential to not only lessen the physician strangle hold on community-based PC but also to erode the power of the RHA. According to the PHC Framework (2012), the CSC, by design, was to offer a community governance model that would "manage the integration and re-profiling of RHA resources into team-based settings and determine investment needs" (p. 14). As a support for this recommendation, the PHC Framework (2012) referred to the Health Council of Canada's indication that "primary health care needs an organizational body (like a CSC) at the community level to act as an integrative force and serve as the link between government and professionals providing care" (p. 15).

As a subtext to the above recommendation, the PHCSC (2012) recommended that each CSC be "co-chaired by a physician representative and an RHA representative" (PHC Framework, 2012, p. 14). This oversight function, recommended by representatives from the RHA and physicians, reflected the power struggle between the two entities. This power struggle eventually led to regression of the ideals of the CSC, further perpetuated the ambiguity or conflation of PC and PHC, reversing the discourse back to health care systems dominated by hospitals and PC physicians and away from community focused and community led PHC with commitments to health equity.

Ultimately, family health teams were not implemented in New Brunswick. Following a round of fee-for-service contract negotiations between the Department of Health (Medicare Branch) and the New Brunswick Medical Society, the model that emerged was a voluntary model called *Family Medicine New Brunswick* (FMNB) and

included groups of physicians with enhanced funding options to provide afterhours care and roster patients to the practice. There were no expressed plans or intention to incorporate any other PC providers into the model (NBMS, 2016). There are currently nine FMNB teams in the province involving 51 family physicians (FMNB, 2021).

The final government policy document analyzed, the Provincial Health Plan (PHP) 2013-2018, continued the neoliberal discourse of cost reduction and sustainability of the system, with a strong focus on greater accountability in efforts to erode medical hegemony. It promoted the government wide *Performance Excellence Program*, implemented to change the mindset of employees and administrators to one that reduces costs and focuses on growth and continuous improvement through process optimization (GNB, 2013). Health system outcomes, measured by key performance indicators, were foundational to the Performance Excellence Program, which promoted a collaborative team-based effort to improve organizational performance by systematically removing waste and reducing variation. The neoliberal discourse of "principled decision-making, clinical sustainability, benchmarking, equitable delivery of services" (p. 14-15) in the PHP text was applied exclusively to hospital care in attempts to improve the quality of services, making them more efficient and thereby reducing costs. This methodology, applying as it did to RHA hospital employees, was not mentioned or extended to measuring or benchmarking PC services provided by physicians. As Lewis (2005) notes,

> The history of Medicare is a clash between the state's goal of equity, order and efficiency with medicine's goals of autonomy, growth and control. Doctors retain the right to remain independent contractors rather than full partners in a complex

> system, freedom from the measurement, scrutiny, and accountability of US-style managed care. (p. 276)

Although the PHP's discourse of process improvement is restricted to hospital care, the PHP (2013) also attempted to challenge medical hegemony with numbers and facts that challenge a need for more physicians: "Getting access to timely care for more routine problems or preventative check-ups, however, is a regular frustration of New Brunswickers" (p. 7); "New Brunswick had 113 general or family physicians per 100,000 people while the Canadian average was 106 per 100,000" (p. 7). It counteracts claims that the health care system needs more human resources with: "[there are] over 20,000 health professionals, mostly doctors, nurses and other allied health professionals" and "74% of health expenditures are directed to employee remuneration" (p. 7).

Missing in the policy documents are more progressive sociopolitical assumptions about how PC could be re-organized to achieve health equity, through outcomes that address the social determinants of health, a discourse more aligned with PHC. Instead, all three policy documents highlight challenges with medical hegemony and recommend strategies to change the power dynamics influencing the delivery of PC. Methods of remuneration for physicians, mostly fee-for-service, are negotiated in oblique ways with provincial governments. These practices continue to dictate patterns in physician-dominated delivery of PC, serving as a deterrent to the ideals and discourse of PHC. According to Lewis and Sullivan (2013),

> The perverse incentives that privilege piecemeal problem-solving over holistic care, prescriptions over conversations and procedural specialists over generalists

> must be erased. So, too must the mechanisms that get in the way of an efficient division of labour between doctors and other providers. (p. 2)

Until physician remuneration models are balanced against and include the integration of interdisciplinary teamwork, PHC will remain elusive. Bio-medically oriented PC will continue to be the dominant perspective rather than a model of community-oriented care focused on health equity. Lewis and Sullivan (2013) predict that "governments and doctors unwilling to depart from the historical path doom the system to a sorry combination of poor performance and eternally rising costs" (p. 2).

Governmentality in Health Care

The concept of governmentality in health care (Foucault, 1997; Miller & Rose, 2008), as explained in Chapter 3, allows for a more equal relationship between the "experts" or knowledge holders and policy makers. According to Miller and Rose (2008), "The powers and technologies accorded to experts enabled them to establish enclosures within which their authority could not be challenged, effectively insulating experts from external political attempts to govern them and their decisions and actions" (p. 212). Those considered to be experts in health care, and those whose authority is difficult to challenge, are regulated health care providers and administrators (Hanlon et al., 2019). It should be noted here that, in Canada, provincial legislation determines and defines the legal responsibility for professions to self-regulate. As per Bacchi (2016):

> discourses, as understood in this perspective, consist of socially produced forms of knowledge that constitute *the real.* Governing takes place through the full range of public legislation, professional regulation, advanced knowledge, and

> sites involved in societal administration of the practices and theories of *experts.* (p. 8)

This understanding of governmentality also helps explain how neoliberalism influences health policy texts. In the government produced policy texts analyzed in this study, both governmentality and neoliberalism are tied to a "free market view" of health care, rather than a perspective about health as a human right and a matter of social justice. Neoliberal discourse about controlling the cost of health care persists throughout the three government policy documents analyzed in Chapters 4 and 5. The main tenets of neoliberalism applicable in this analysis and related to governmentality involve the reducing of government expenditure on social programs like income security, education and health care and the erosion of social and political commitments to the public good in favor of individualism, individual responsibility, self-reliance, and self-interest (Kirkham & Browne, 2006; Martinez & Garcia, 1997; McGregor, 2001). Within a neoliberal discourse, there is no explicated relationship between economic growth and social equity, community engagement/participation, or sustainability, all prevailing discourses in PHC (McGregor, 2001).

Governmentality is located in the discourse of fiscal responsibility. Fiscally responsive discourse of "achieving better value from the current level of funding" (p. 2) is evident throughout the government documents. According to Fairclough (1992), value assumptions may indicate ideological underpinnings, defining what is desirable, valuable, necessary, crucial, and satisfactory within the discourse of, in this case, health care sustainability (Ravn, Frederiksen, & Beedholm, 2016). As I have shown in Chapters 4 and 5, each of the government-produced documents addressed and managed the fear of

an unsustainable health care system differently, depending on the political thinking of the day. In 1989, the conditions under which New Brunswick had entered the national universal health care program were no longer evident. Federal transfers were covering approximately 40% of expenditures and costs for physician care, hospital services and pharmaceutical programs were growing at rates greater than inflation. By the time the PHC Framework was released some 24 years later, health care spending was consuming over 40% of the province's overall budget (PHC Framework, 2012). New Brunswick's economic and fiscal climate required all departments of government to find efficiencies in an effort to reduce the province's debt load. In 2012, New Brunswick's spending on health care was among the highest in Canada when expenditure was represented as a percentage of GDP (New Brunswick Health Council, 2010).

With the rising rates of chronic disease and an aging society, the federal government recognized the potential of PHC as "cost effective, low intensity care, focused on prevention/management" (PHC Framework, 2012, p. 10), and as having the potential to impact health outcomes and prevent unnecessary and costly hospitalization. As mentioned previously, the federal government's *Primary Health Care Transition Fund* (PHCTF, 2000-2006) had invested approximately $800 million nationally in an effort to improve PHC nation-wide (Health Council of Canada, 2010). The five broad categories targeted for this federal investment were new PHC initiatives:

1. to increase the proportion of the population with access to primary health care organizations which are accountable for the planned provision of comprehensive services to a defined population;

2. to increase the emphasis on health promotion, disease and injury prevention, and chronic disease management;
3. to expand 24/7 access to essential services;
4. to establish multi-disciplinary teams, so that the most appropriate care is provided by the most appropriate provider; and
5. to facilitate coordination with other health services (such as specialists and hospitals) (PHCTF 2000-2006, p. 1).

Given that most PC was delivered by fee-for-service physicians, the government emphasized the need for greater collaboration and consultation with physicians in policy development dedicated to PHC reform through initiatives like the Primary Care Collaborative Practice Project (PCCPP) and the Primary Health Care Steering Committee (PHCSC).

Parallel to these government-initiated physician engagement processes, other PC professionals were emerging and challenging the existing configuration and arrangements for service delivery in this community space. As Miller and Rose (2008) note in their studies of governmentality in the United Kingdom (UK),

> The medical monopoly over the internal working of the health apparatus began to fragment. New actors proliferated – nurses, physios, occupational therapists – and began to organize themselves into 'professional' forces claiming special skills based upon their own esoteric knowledge and training, demanding a say in the administration of health, contesting the superiority of medical expertise. (p. 76)

Although Millar and Rose (2008) speak to the progression of health system governance in the UK, this can be extrapolated to Canada which shares a similar model of a single-

payer, government system. The new administrative focus in Canada and New Brunswick was an approach to health care management presented in the government document PHP (2013), as being grounded in health economics, with far-reaching outcomes like *value for money,* and *cost-benefit analysis.* This neoliberal discourse of accountability, key performance indicators, quality improvement, efficiency and effectiveness provided tools for non-clinicians and clinician-managers to challenge the clinical authority of doctors (Millar & Rose, 2008).

The PHP (2013) is grounded in this neoliberal discourse of fiscal responsibility, measurement, accountability, and value for money. It is modeled on the government-wide *Performance Excellence* program described in Chapter 5, with outcomes to "save money and reduce waste while increasing quality of care and patient satisfaction" (PHP, 2013, p. 10). From a health care perspective, performance excellence has not only been a tool of health care administrators reporting to their political authorities but has been credited with substantial savings and reduced wait times for hospital-based services (GNB, 2014). It has however, had little to no impact on primary (medical) care, which remains an autonomous profession-regulated service.

The final element of governmentality is the neoliberal discourse of patients as consumers of health care. This discourse is evident in each of the government documents and to a lesser degree in the NBMS (2013) document: individuals as consumers of a scarce and expensive resource rather than citizens entitled to universal health care. This value, of patients being consumers, is consistent with a neoliberal political agenda (Raphael, 2008). According to Miller and Rose (2008),

> The health consumer was transformed, partly by developments in medical thought itself, from passive patient, gratefully receiving the ministrations of the medics, to a person who was to be actively engaged in the administration of health if the treatment was to be effective and prevention assured. (p. 76)

The ML report (1989) describes this patient/consumer responsibility for rising health care costs through a population health discourse: "The extent of utilization and costs of health care will be determined by the effectiveness of efforts to improve lifestyles and risk exposures" (p. 101). This discourse is concerned with people neglecting their health and engaging in unhealthy behaviors like eating unhealthy foods, smoking, being overweight, and avoiding exercise. The emphasis is also on over-reliance on the health care system: "a reliance on health care institutions such as emergency departments as a substitute for people not looking after themselves" (p. 102).

This focus on individualistic lifestyle concerns in a free market is aligned with a neoliberal approach to health policy development where issues of health equity are silent and the importance of developing health promoting public policy and strengthening citizens' ability to influence the social determinants of health are neglected (Raphael, 2008). Recommendation #7 in the ML Report speaks to personal responsibility for rising health care costs: "initiate innovative approaches to health care which are sensitive to the diverse needs of the province and which foster personal responsibility for health, the appropriate use of resources by individuals and health professions" (p. 110). The PHC Framework (2012) speaks to patients taking a more confident and active role in maintaining their health with shared decision-making between patient and provider. According to the PHC Framework, this redefined relationship between engaged patients

and the health care system results in “better use of health services and resources” (p. 23). The PHP (2013-2018) also addressed personal responsibility for health noting that everyone must take responsibility to “rebuild their personal health” (p. 22), because “New Brunswickers exceed the Canadian average in smoking rates, adult obesity rates, unhealthy alcohol use, diabetes, heart and respiratory disease” (p. 8).

This ideological discourse of individualism and personal responsibility intersects with the discourse of PC, remaining silent about the need to address structural reforms related to the social determinants of health and health equity. In this silence, the discourses have the effect of justifying the presence of social, economic, and other structural challenges (health determinants) that presumably can be controlled by the individual. According to Miller and Rose (2008), this governmentality discourse, of patients as consumers, speaks to citizens being actively enrolled in the government of health. They become “educated and persuaded to exercise a continual informed scrutiny of the health consequences of diet, lifestyle and work” (p. 76). This discourse of individualism, consumers of health services, and personal responsibility intersects with and bolsters the discourse of PC, evading the presence of social and health challenges that cannot be controlled by the individual. This tactic was used heavily throughout the PHP (2013)—a government document essentially alarming citizens about the unsustainability of the health care system and the possibility that it could not be guaranteed for the future.

This neoliberal discourse can have the effect of indoctrinating patients as proxies for making untenable decisions around health care cuts and rationalization. According to Raphael (2009), “The operation of economic and political systems and their resultant

social and health inequalities come to be justified by the ideological structures, the dominant discourses or ideas in society that explain these phenomena" (p. 148). The dominant neoliberal discourses of fiscal restraint and unsustainability of the health care system within all three of the government policy documents represent governmentality, i.e., "particular ways of governing, particular ways of seeking to shape the conduct of individuals and groups" (Miller & Rose, 2008, p. 7). They do not address the resulting social, economic, and health inequalities that are foregrounded within the discourse of PHC. They focus on individualism versus democratic communalism and emphasize market forces versus social justice (Raphael, 2009).

In contrast to the government and NBMS documents, the nursing documents (NANB, 1998, 2014; NPNB, 2019) consistently speak to a more progressive PHC middle path, inviting collaborative and supportive relationships with "individuals, families and communities to promote health to a higher level" (NANB, 1998, p. 6). They rely on the discourse of health promotion to refer to a PHC health care system that is responsive to the "needs and expectations of individuals, communities and populations" (NANB, 2014, p. 3).

Integration of Nurse Practitioners

Given the political climate of advocating reduced health care costs, sustainability of the health care system, importance of PHC as cost effective and low intensity care, and efforts to challenge medical hegemony, the introduction of NPs in New Brunswick in 2002 through legislation (*An Act Respecting Nurses and Nurse Practitioners*) ticked all of the political boxes. However, the subsequent integration of NPs into the health care system has been somewhat sluggish and consistently challenging.

Historically, on the national front, “enhanced or expanded” roles for nurses had been established in northern and isolated parts of Canada in the 19th century. The wording “enhanced” nursing practice is understood to refer to that period when nurses could provide extended PC in remote and rural areas without advanced degrees. In the period when the ML Report (1989) was being created, Canada was moving quickly to establish regulatory authority for advanced practice nursing and to establish the master’s degree as a minimum educational requirement for advanced practice nursing. Another historical account of the development of PHC providers is documented by Rachlis and Kushner (1995), in their discussion paper, *Community Health Centres: The Better Way to Health Reform.* Here Rachlis and Kushner referenced a historical time in Canada when there were many different types of caregivers: “nurses and midwives plied their trades alongside traditional medical doctors” (p. 24). In contrast to some descriptions of the role of “outpost nurses,” Rachlis and Kushner focused on how physicians exerted their power and privilege over practitioners like midwives and nurses:

> In the late nineteenth and early twentieth centuries, physicians succeeded in convincing the provincial licensing authorities that more exclusive regulation of health professionals was required to protect the public. Nurses and other professionals found that their scopes of practice were defined by the medical profession. (p. 24)

Later in the twentieth century, however, the professionalization of health care providers in North America ended this kind of medical hegemony through legislative acts that established self-regulation for nursing practice, as was the case in other health professions.

Provincially, a different role for nurses was contemplated and introduced in the ML Report (1989) and further developed in the document *For the Health of Our Communities* (NBNU, 1995). The idea of a different type of PC provider (a primary care nurse) was initially described in ways that were more consistent with improving universal access to PHC. These descriptions envisioned primary care RNs, as a way to improve "front door" access at a reduced cost than fee-for-service physicians. The concept of a primary care RN, with less autonomy than a Primary Health Care Nurse Practitioner, was introduced in the ML Report (1989) in conjunction with a proposal for CHCs. This proposed model of PC was positioned as having the "potential to improve access to health care, to enable introduction of a multi-disciplinary approach to primary care and to increase the provision of health promotion services" (p. 67). A foundational principle of CHCs was the expectation that all providers employed in the model would be salaried employees. Other cost containment possibilities envisioned for CHCs were the ability to not only improve access to PC but also to coordinate care and limit the use of emergency departments in acute care facilities. It is important to note that at the time of the ML Report and during subsequent years, professional nomenclature or established "text" referring to "primary care nurses" did not exist in the profession of nursing in Canada. The use of the term "primary care nurses" in the ML Report suggests the discursive practice of using text found within the discourse of PC to refer to nurses who might increase access to PC at a reduced cost. In subsequent decades, these nurses would be prepared at the master's level and registered in Canada as "primary health care nurse practitioners" (Staples, Ray, & Hannon, 2016, p. 3).

More structure and definition were added to the NP vision in the nursing document, *A Discussion Paper: For the Health of our Communities*, authored by the New Brunswick Nurses' Union (NBNU) in 1995. The term PHC is used throughout the document, which was significant for that time period and a divergence from the more established terminology of PC used provincially to describe services delivered outside of the traditional acute care setting. The term "enhanced," used predominately throughout this document when referencing a different role for nurses, was part of the earlier history of outpost nursing described above. During an interim period between 1999 and 2002, nurses who had earned post-graduate "certificates" to practice in "extended roles" were "grand mothered" to practice as nurse practitioners (NP). Then beginning in 2002 and beyond in NB, those NPs holding a master's degree in nursing were registered to provide advanced practice nursing, and their registration was titled (under regulatory authority) "Primary Health Care (PHC) Nurse Practitioner."

The discourse of PHC was an important part of changing the text from *enhanced* nursing practice in New Brunswick and throughout Canada to *advanced practice nursing* (APN). It was an important historical moment when the discourses of PC and PHC converged in nursing. This shift from primary care nurses to primary health care nurse practitioners with expanded roles and subsequent re-training had the potential to move the concept of PHC as a framework for reform closer to a reality in New Brunswick.

All of the documents analyzed from the nursing profession, *A Discussion Paper: For the Health of our Communities* (NBNU, 1995); *The Future of Health Care in New Brunswick: The Nursing Contribution* (NANB, 1998); *Position Statement – Primary Health Care* (NANB, 2014); *Nurse Practitioners of NB - Priorities* (NPNB, 2019); and

Nurse Practitioners of NB - Infographic (NPNB, 2019), positioned Nursing as an invested stakeholder in reducing health inequities and acting on the social determinants of health. The PHC discourse within each document demonstrates a vision for health equity in health care reform that is not self-serving: "the way actors talk about health care, and their positioning within it, exerts an influence on the material practices of health care delivery and reform" (Hanlon et al., 2019, p. 52). This discursive positioning of actors in the reform process assists in explaining the inertia related to health care reform. Attempts to "transform health care systems are prone to generate conflict between conflicting interests" (Hanlon et al., 2019, p. 52).

The NANB Position Statement (PS) on PHC clearly articulated the profession's position on supporting PHC and the role of PHC as a framework for reform: "NANB believes that a healthcare delivery system grounded in the principles of PHC will provide all New Brunswickers access to universal, comprehensive, accessible, portable, publically administrated healthcare that is efficient, effective and sustainable" (p. 1). The nursing role is articulated, through all of the texts, as one of collaboration and partnership: "NANB believes that registered nurses (RNs) and nurse practitioners (NPs) have a key role in collaborating with other stakeholders to develop, deliver and maintain such a system" (PS, 2014, p. 1). Inclusion of the concept of nurses in a collaborating role, exemplifies a commitment to and belief in a multidisciplinary team concept of PHC. Although in general, the tone of the nursing texts is conciliatory, NANB expressed misgivings about the myopic focus of government on physician-centric models: "It is time the government made a firm commitment to PHC; the current fee-for-service structure was developed when there was an abundance of resources" (PS, 2014, p. 3), and

"In order for a health care system based on PHC to be effective and efficient the government must make a commitment to full implementation and not choose pieces that fit into the existing antiquated system" (p. 3). The nursing texts examined urged government to consider funding models that facilitate collaborative team approaches to care and opportunities for health care professionals to work to their full scope of practice.

However, from the beginning in 2002, when NPs were educated, registered, and introduced as primary health care professionals, their skills were underutilized and underrepresented in reform models of PHC. From a political perspective, NANB had actively participated in PHC reform in partnership with decision makers and other health care professional associations for close to ten years. The decision of government to focus health reform efforts on physician-dominated Family Health Teams (FHT) in 2012 must have been disappointing and discouraging for NANB. A silent, but perhaps salient problem for the nursing profession was the persistent focus of government policy documents on medical resources to populate existing medical models and call them primary health care delivery.

The NANB *Position Statement* (2014) tried to refocus health care reform on the merits of PHC and the role of nurses within PHC, especially NPs. As per Lewis (2010), "political space is finite and there will always be a fight for higher ground" (p. 117). Although the NANB's purpose in the PS was to advocate for "health care delivery grounded in the principles of PHC" (p. 1), the text did not make a strong argument for necessary elements of PHC and did not make the link between a sustainable model of PHC and the autonomous role of NPs within this model. This may have reflected a complex positioning of the profession between competing forces. Those forces included

growing neoliberal provincial political rhetoric aimed at the health care system. Forces related to conservative medical and entrenched corporatized health system financial interests. Competing forces of the ongoing failure to leverage control away from physicians in providing PC to communities and specific populations. Further forces included shifts away from a progressive pride over investing in PHC to more politically conservative (victim blaming) social views about marginalized populations bearing responsibility for their own marginalization and social or health inequities.

In this context, the stakes were high for RNs to secure primary health care NP positions after completing their graduate educational programs. Precisely at this time, previously non-existent NP positions were being requested—created by Chief Nursing Officers (CNOs) in the RHAs. Specifically, new NP graduates were placed in the position of writing proposals for their own employment. NPs and their advocates were—in fact—using the discourses of PHC they had learned, to propose practice opportunities that would allow them to address the challenges of PHC, at the same time as they were positioned to be supplicants for their own employment. These positionings occurred against well entrenched neoliberal and more conservative forces of elite privilege, which were largely ineffective in transforming a health policy landscape that supported perceived cost-effective strategies of medically oriented PC. In this context, it is important to recognize the intersections of the gendered, racialized, and classed dimensions of the newly registered NPs. Noticing how a predominantly female, white, and aspiring working-to-middle class professional group took up the discourse of PHC, against huge odds—and with determination—established a foothold in practicing primary health care advanced practice nursing in a system that was ill-equipped to support PHC.

In tracking this story from a feminist poststructuralist standpoint over thirty years, it is important not to blame NPs singly or nurses in general for the stalled status of a progressive liberal vision of PHC for New Brunswick. Some have erred in offering that kind of simplistic analysis about timidity among nurses. For example, according to Lewis (2010), "organized medicine is winning all the turf battles while nursing seethes in silence, only rarely venturing a timid rejoinder and never mounting a sustained battle for the public mind" (p.117).

The increase in the numbers and organization of the NPs in New Brunswick into a formal professional interest group (NPNB), with a president and spokesperson, was a positive step of professional advocacy toward bringing attention to the role of NPs. The text prepared by the NPNB, *Better Access to Primary Health Care - New Brunswickers Deserve It* (PD, 2019), challenged the existing medical models of PC and came at a social/political time in the province when health care reform was even more acutely focused on health care sustainability and reducing health care costs through enhancement of the existing PC system. Through this text, the NPNB negotiated a shift in PC focus away from an exclusive emphasis on physicians as agents of PC to also recognize NPs as a legitimate and valued primary care provider. The text additionally explained the barriers to NP practice: "The current funding structure does not allow nurse practitioners to work in private practice or within family health teams (FMNB)" (p. 3). In the NPNB documents examined, there was an effort to change the discourse of PHC reform by not only insisting on the importance of elements of PHC, but also firmly inserting the NP role into areas of practice requiring reform, namely, PC, senior care, mental health, and addictions intervention.

NPNB challenged the broader social practice of medical dominance and hegemony in the health care system by providing clarity about NP's autonomous practice and relationship with physicians: "NPs do not work under the direction of a physician but work in collaboration with physicians" (p. 1). Devlin, Braithwaite, and Plazas (2018) describe the tension between medical and nursing disciplines especially within PHC reform as related to "knowledge appropriation and power" which requires a "negotiation of jurisdiction" (p. 111). As per Devlin et al. (2018), "attempting to establish a role that would overlap the skills and knowledge of medicine, a profession sitting at the top of the hierarchy in the healthcare system, is not an easy task (p. 112). Communication, role definition and role understanding have been critical elements of introducing the role of the NP, implementing that role, and eventually fully integrating the role into health care systems. The sweet spot for NPs is their expertise with illness management and health promotion/disease prevention, combined within a PHC framework oriented by social justice for health equity with marginalized populations. Although the discourse of PHC reform in New Brunswick has proposed the positioning of privileged physicians in new models of primary care, NPs are well positioned to work with vulnerable populations where health inequity and the social determinants of health can be mitigated. Devlin et al. (2018) challenge NPs to embrace their "precious point of view" acquired from "reflecting on the needs of society" and being available to offer "primary care to the marginalized" (p. 114). It is from this vantage point that Devlin et al. (2018) argue NPs are the best positioned primary care provider to act on the social determinants of health, health inequities, and support social justice.

Through the texts produced, the NBNP invoked purposive discursive activity to construct themselves within the parameters of PHC but also as legitimate actors within PC practice. By providing an explanation that NPs are legitimized through legislation, must complete annual licensing requirements, and carry liability insurance, NPNB attempted to dispel the perpetuated myth of ultimate doctor oversight and liability (Cashin et al., 2009). Both of the NPNB texts challenge the broader social practice of patriarchy, medical dominance and hegemony and establish NPs role within PC even though the texts diverge from an exclusive focus on the discourse of PHC.

Recent reform efforts have created NP-led PHC clinics in three urban sites/cities in the province. The purpose of these clinics is "aimed at removing New Brunswickers from the wait list for a primary care provider" (GNB News Release, 2021 p. 1). The GNB news release further announced that each NP will remove and roster 1000 patients from the "provincially managed, bilingual patient registry for New Brunswickers looking for a new **primary health-care** [emphasis added] provider, either a family doctor or nurse practitioner" (p. 1). Although NPs as providers continue to make progress in establishing new models of PC, the ambiguity of PC and PHC persists.

Implications

Canada's universal health care system and its embracing of social justice and equity principles has been a well-founded source of pride for Canadians (Jones, 2019; Martin, Miller, Quesnel-Valée, Vissandjée, & Marchildon, 2018). Canada is considered a liberal welfare regime and has historically produced public policy that favors the dominance of the marketplace as opposed to the state as the primary means of distributing economic resources amongst the population (Raphael & Bryant, 2006).

Additionally, Canada is a federal system which makes it difficult to align federal and provincial public policy around economic and social security, especially when the responsibility for funding social programs rests primarily with each province (Government of Canada, 2021; Raphael, 2012). Health care is considered one of the three pillars of social policy along with education and social welfare/income security (McGregor, 2001). Policy for all three pillars is developed provincially.

Canadian Medicare, a single-payer model financed by tax revenues, has long been dependent on a remuneration model with fees for physician services that are negotiated by each province. Although this model of remuneration has been highlighted as a barrier to interdisciplinary care and the culprit of steadily increasing health care costs (Lewis, 2010; Martin et al., 2018) it is deeply entrenched as the remuneration of choice for the majority of Canadian and New Brunswick physicians (CIHI, 2020). The lack of remuneration options more amenable to interdisciplinary practice is a barrier to PHC reform. This lack of modifiability of the current fee-for-service remuneration and the continuous struggle, by both government and the medical profession to maintain the current configuration of physician dominated PC despite changing socioeconomic forces has implications for health care reform.

With this in mind, and with respect to health policy reform in New Brunswick, the continuity of PHC discourse in nursing texts did not translate into a coherent PHC policy framework for reform in the 30 years examined. PC, delivered by fee-for-service physicians, was sustained as the predominant model of health care delivery.

According to Fairclough (1992), “invoking discourses through the creation and dissemination of text and talk can represent political strategies” (p. 67). This development

of competing political strategies occurred through the progression of New Brunswick health policy documents examined with discourses of PC and PHC being used interchangeably and ambiguously with the eventual minimizing of PHC and domination of PC. Nursing, as a profession, was more prolific in producing texts promoting PHC as a framework for reform but recommendations in those texts did not achieve traction or status within the government policy documents. In trying to understand why this occurred, Lazar et al.'s (2013) work is helpful in explaining why health-care policy reform in Canada is so difficult. According to Lazar et al. (2013) the scarcity of reform efforts in Canada is due largely to those actors who:

> had the political clout to hang on to the turf they occupied or, where they could not, they generally were able to steer the direction of the reform process to a destination that was acceptable to the interests they represented and at a pace that minimized the disruption to those interests. (p. 307)

This was how PHC reform efforts played out in New Brunswick—powerful actors controlling policy discourse and the neoliberal ideology of health care sustainability and value for money discourse dominating reform efforts. This experience has not been unique to New Brunswick. For well over a decade, according to Raphael (2009), the idea of addressing the social determinants of health as a blueprint for public policy action has stagnated because of Canada's "increasing adherence to neo-liberal policy prescriptions" (p. 158).

The introduction and implementation of the NP role in New Brunswick has been slow, at times unsteady and appearing to be stalled, and dependent on the changing political agendas shaping health care reform. In addition, it has been dependent on the

powerful, and well-established physician-centric PC delivery system, strongly entrenched provincially and across Canada (DiCenso et al., 2007). Hughes (2010) also found that gender was an obstacle that nurses faced in their attempts to influence and contribute to health policy. Her findings raise questions about the "wider impact of gender upon nurses' organizational lives as they attempt to influence healthcare and decision making at the clinical, managerial and strategic level" (p. 989). These are details that speak to the importance of addressing leadership skills among RNs and NPs—so that early experiences with perceived and real subordination to physicians may be transformed and relevant skills cultivated for clinical leadership and professional advocacy. Thompson (2014) speaks to the importance of leadership by advocating for a more "robust and democratically engaged profile in higher education" (p. E31). She contends that "by teaching for social justice in health and engaging in health equity through practice and knowledge projects, we contribute as professionals to justice and caring in our democracy" (p. E31).

Rather than confront the challenges head on, government initiatives have been more modestly focused on "work arounds" or circumventions of established medical structures. Examples of this, include circumstances where other primary care providers like NPs, midwives, pharmacists, and RNs are given more authority and scope of practice to provide services and influence health outcomes. Although I support these strategies, to provide broader scope of practice to more primary care providers and health services to citizens, they have limited capacity to provide continuity of care through the life cycle. Despite the ever-growing provincial unattached patient lists, NPs have been compelled to

advocate and lobby for the creation of positions and work opportunities even when there were long term ("permanent") vacancies in physician positions in the RHAs.

In New Brunswick, given the limited uptake of the Family Medicine New Brunswick (FMNB), lack of tangible patient outcomes, little ability to influence practice and an ever growing unattached patient wait list, it seems the recent announcement of three NP-led clinics in NB is a sign of a shift in political thinking. In the absence of progress on controlling the rising costs of fee-for-service physician remuneration, this is the kind of continued innovation is needed in the province. According to Lewis (2008) "we do not hold organized medicine to a higher standard of discourse and accountability…we have given organized medicine too much power" (p. 1).

The implications of this study are far-reaching; the discourse of PHC, committed to social justice and health equity, is critical in addressing health inequities experienced by Indigenous populations and vulnerable groups. Addressing these inequities requires coordinated action on the social determinants of health (Martin et al., 2018). The narrow funding of medically necessary services covered under Medicare requires expansion, as advocated by NANB over the 30 years of this study. Better funding for community care options including home care and assisted living as well as mental health and addictions care will be required and can be provided by other health care professions like nurses, occupational therapists, and social workers. Models of care that promote and embrace PHC teams, populated by salaried health care professionals knowledgeable about the needs of and assets in the community will be better positioned to address inequities and take action on the social determinants of health.

Limitations

Policy analysts who understand policy as discourse often have a particular agenda for change (Bacchi, 2000; Shaw & Greenhalgh, 2008). As a health professional and civil servant whose mandate was to lead health care reform in the area of primary health care, I brought a range of ideas and my own values to this study. I have spent a number of years reflecting on the reasons why alternate models of PHC were not and have not been implemented or supported by appropriate remuneration models or why the model of PC continues to exist relatively unchanged and unchallenged. My introduction to CDA and the suggestion that *social problems* are brought into being, rather than simply existing, waiting to be solved, corrected or addressed by government was an epiphany of sorts.

My focus on the selection of documents and the particular time period inevitably means that my own views and my privileged identity and life experience may well have influenced and limited potential considerations and possible explanations. In addition to specific government policy documents, as explained in Chapter 3, I focused on selected nursing and medical publications. Other primary care providers such as midwives, occupational therapists, pharmacists, and social workers have all contributed to the PHC reform literature. And though it would have been unrealistic for me to include all of these perspectives, the study is limited by their absence.

Another limitation of this study is the one-dimensional focus on texts and not on actual health care practices or interviews with policymakers and primary care providers. Additionally, the focus is on New Brunswick, which is reasonable given that health is a provincial responsibility, but this does narrow the scope and wider applicability of the findings.

Recommendations

My discussion of recommendations is based on the barriers perpetuated through discursive and social practice upheld by discourses of power and control that persisted throughout the 30 years under investigation. These discursive and social practice barriers included siloed delivery systems, minimal opportunity for team-based PHC, lack of appropriate remuneration models to support team-based PHC, and weak policy frameworks that struggled to position PC within a broader context of PHC. Marchildon (2012) reflects on his experience as a policy advisor in *Making Medicare: New Perspectives on the History of Medicare in Canada*: "As a policy advisor I have been continually fascinated by how contemporary policy problems and solutions are perceived as brand new when in fact they have circulated in one form or another in the past" (p. IX). My experience in health reform policy work mirrors Marchildon's. As has been demonstrated in this critical discourse analysis, similar solutions have been articulated across various policy documents, spanning a number of years.

My recommendations include: reducing the proportion of fee-for-service physicians practicing in PC, increasing the proportion of physicians and other providers working within a salaried remuneration model, the implementation of more progressive remuneration models and beginning the process of phasing out fee-for-service remuneration as the mainstay of PC, strengthening and expanding the CHC model of care and developing funding models that support a viable framework for addressing the social determinants of health. My recommendations are directed toward three influential groups influenced by the social practice of PHC: health care professionals, policy and program advisors, and university administrators and researchers.

With a focus on health care professionals, NP-led clinics (a new offering in New Brunswick) have the potential to improve access to PHC and address health inequities. These clinics, now available in Moncton, Fredericton and Saint John, should be replicated in various other municipalities in the province and encouraged to not only provide PHC services but to advance policy related applied PHC research in collaboration with university resources in these municipalities. Another recommendation aligned with health care professionals is a revisiting of existing CHCs in New Brunswick and augmenting their capacity to address the social determinants of health as per the model discussed by NBNU in 1995. This augmentation, including integration of public health providers, could strengthen community-capacity to act on the social determinants of health. These broader services, focused on health equity and the social determinants of health, are not currently included in the services offered within the existing CHC model of care.

From a health policy perspective, CHCs organized by an operational framework grounded in PHC have the potential to link health and social services like housing, income support, food security, employment support, and training programs in addition to addiction and mental health services. Butterfield (2017) speaks to an approach that unites nursing and public health in addressing health determinants (p. 4). Butterfield addresses how to create practice conditions that will facilitate like-minded providers to work together to "execute upstream actions" (p. 8). This partnership, in working upstream has the potential to shift the dominant discourse and foster structural change.

An exemplary model of this type of CHC exists in Fredericton. The *Fredericton Downtown Community Health Centre,* a partnership between the RHA (Horizon Health

Network) and the University of New Brunswick, is a model that could be enhanced and replicated in other centres throughout the province. This requires institutional support of community-engaged practice partnered with educational and research learning experiences that are unambiguously informed by the tenets of PHC. Whether or not provincial (corporatized) health authorities and post-secondary educational institutions would agree with these investments of resources is an important policy level question. As mentioned earlier, health services in New Brunswick have been incorporated into two regional health authorities (RHAs). These two RHAs, Horizon Health Authority and Vitalitié Health Authority, are funded globally by the Department of Health to provide health services to the citizens of New Brunswick.

With support from academic institutions like UNB, these models of care can provide experiential learning opportunities for students who will eventually become members of the interdisciplinary PHC team. This could include nurses, nurse practitioners, social workers, dieticians, midwives, occupational therapists, and physicians. This experiential learning, of future team members learning together, has the potential to actively showcase the discourse of PHC and interrupt the discourse of neoliberalism in health policy innovations. This interprofessional collaboration in health education programming focused on health equity, social justice, and the social determinants of health as expectations of interprofessional knowledge and skill for entry to practice has the potential to alter what health providers expect from health policy. Thompson (2020) speaks to this "moral terrain of social justice in nursing practice, research and education" (p. 58). Thompson (2014) also advocates for a "focus on engaging nursing education in the ethics of social justice as an organizing precept and

discourse in the preparation of professional nurses" (p. 30). I agree and would add that the ethics of social justice and health equity is an interdisciplinary organizing precept required for all of the helping professions.

Experiential group learning would foster opportunities for NPs and other primary health care providers to act on and address health inequities, to draw on their training in PHC, to challenge social and economic policies that keep people in poverty conditions including food insecurity; a lack of adequate, affordable housing; and accessible, affordable, quality child care. The development of these alternate models of PHC would facilitate opportunities for NPs and others to maximize their strengths as collaborators and facilitators and provide services beyond biomedical diagnosis and treatment to include the broader social determinants of health. With their knowledge of integrated PHC, primary health care providers can position their services to include health promotion and prevention, outreach, and community development to specific groups such as newcomers, Indigenous people, and people who are homeless or precariously housed or living with disabilities. These actions will solidify health care providers' value as PC providers working within a framework of PHC and may potentially provide clarity and value to the public understanding of the discourse of PHC.

The scarcity of studies of PHC models across Canada is another implication that presents an opportunity for recommendations to fellow researchers. Although a synthesis of initiatives funded by the *Primary Health Care Transition Fund* (PHCTF) was completed by Health Canada following the PHCTF (PHCTF, 2006), not a lot is known about the sustainability of these PHC delivery models nation-wide. Additionally, PHC reform efforts in other provinces are not consistently documented or studied. Critical

discourse analysis is a methodology well positioned to examine discourses of PHC reform in other provinces across Canada. CDA is conducive to multidisciplinary investigations and should be a required research course in graduate programs in nursing, medicine, allied health, public health, and health policy.

A final recommendation for further research is an examination of the roles of primary health care and public health providers and opportunities for closer collaboration. Given our experience with the current COVID pandemic, a closer relationship and collaboration between PHC and public health could significantly enhance the focus on health equity, social justice, and the determinants of health. A recent $10M funding announcement by the Government of Canada to increase Canada's public health research capacity by investing in seven new Applied Public Health Chairs whose "research will focus on implementing new approaches that will help address Canada's health challenges" is an opportunity to examine a renewed and strengthened relationship between PHC and public health (Government of Canada, News Release, January 19, 2022).

Concluding Thoughts

This dissertation focused on policy development and how discourses of PC and PHC were taken up in health policy related documents in New Brunswick from 1989 to 2019. CDA provided an appropriate methodology with its focus on discourse as text as well as discursive and social practices. The use of CDA enabled a critical interrogation of discourse and its role in the development of policy as well as analysis of how social problems become identified and addressed through the varied activities and values of different interest groups (Shaw & Greenhalgh, 2008). According to Shaw and

Greenhalgh (2008) “policy can be broadly conceived as the translation of political values into changes in society, with the policymaking process involving dialogue, argument and influence” (p. 2506).

The challenges we have been experiencing related to the COVID pandemic have surprisingly translated into opportunities for integrated care. Caring for individuals who have, for example, been affected by a COVID-19 outbreak in a homeless shelter has necessitated that social workers, public health and home care (Extra-Mural Program) nurses, medical officers of health, the Red Cross and not-for-profit community groups work together to provide alternative community sites where people who experience homelessness can safely self-isolate, access health care and/or rapidly transition to peer-supported housing with necessary supports during their illness. Unprecedented collaboration between government departments, RHAs and community resources have occurred by necessity.

Although too soon to understand the full impact, virtual PC, only a concept two years ago, is becoming a more frequently used platform for providing PC. The provincial electronic medical record is now available to all primary care providers and plans are in place to permit patients to book their own diagnostic tests like blood work or diagnostic imaging (GNB, 2021). This again speaks to privilege and equity as not all citizens have access to and familiarity with digital technology. The rapid advancement of change in a health care system under duress has demonstrated the art of the possible. The COVID-19 Pandemic has focused a bright light on the gaps and weaknesses of our health care system, and it is entirely possible that we will never return to the pre-COVID-19 state and structure of health care delivery.

In conclusion, this study supports previous work on PHC discourse and the implementation of nurse practitioners (Cashin et al., 2009; Hamilton & Rickards, 2018; Turner et al., 2007). It introduces new knowledge specific to New Brunswick about how the discourse of PHC evolved and was taken up in government policy documents and how this influenced the introduction of nurse practitioners in the province. The literature supports the findings of how neoliberal discourse has been aligned with prevailing PC discourse (ML, 1989; NANB, 1998, 2014; NBNU, 1995; NPNB, 2019) and privileges physician-centered delivery models. This privileging supports existing power relations, deflects attention away from worsening health inequities, and contributes to protectionism of the current delivery structures (e.g., fee-for-service family physicians). Gender was also evident as a factor that influenced professional advocacy among nurses on behalf of PHC and among nurses themselves in policy related venues. In an era now focused more acutely on gender and racial justice, health equity for LGBTQ+ people, provision of long-term care, trauma informed care for populations with a history of genocide, culturally safe health care for immigrants and refugees, and other marginalized individuals and groups, there is no doubt that the relevance of the discourse of PHC will continue to matter in New Brunswick.

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Conference Presentations:

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October 2011 – *Chronic Disease Management and Primary Health Care* – Presenter – UNB Graduate Conference, Fredericton, NB

February 2012 – NB Primary Health Care Summit - *Our Health–Our Future Integrating Change in Primary Health Care*, Chair/Moderator, Fredericton, NB

July 2012 – *Primary Health Care Framework for New Brunswick* – Presentation to the NB Executive Council, Fredericton, NB

November 2012 – *Primary Health Care Framework for New Brunswick* – Presentation to NANB Board of Directors, Fredericton, NB

May 2013 – *The New Brunswick "Test Strip" Story – Can You Get There From Here? –* Presentation – CADTH Symposium – Moving Evidence into Policy and Practice, St. John's, NL

May 2013 – *Primary Health Care Transformation* – Sweden Healthcare Executive Study Tour, Presenter/Participant, Stockholm, Sweden

April 2014 – *Primary Health Care Framework and Community Health Centres*- REACH Annual Conference, Horizon Health Network, Keynote Address, Moncton, NB

September 2014 – *Community Coordinator Role – Family Health Teams*- Presentation to Horizon Health Network Senior Management Group, Miramichi, NB

June 2015 – *NB Family Health Team Model*- Presentation, Primary Healthcare Partnership Forum (PRIFOR), St. John's NL

May 2022 – *The Representation of Primary Care and Primary Health Care in New Brunswick Health Policy: A Critical Discourse Analysis* – Dissertation defense presentation, Fredericton NB