NETWORKS AND SOCIAL CAPITAL: A RELATIONAL APPROACH TO PRIMARY HEALTHCARE REFORM

KEY MESSAGES

- Some of the most interesting ideas can be offered by people who are on the periphery of a network.

- Using knowledge brokers to share information between specialist groups or networks should be encouraged, as should using opinion leaders to influence others when adopting new knowledge.

- Alberta has had some success in reforming primary healthcare by giving doctors incentives to form alliances with other physicians and to work with provincial authorities to build primary care networks.

This is a summary of an article written by Catherine Scott and Anne Hofmeyer

One of the proposed strategies for improving healthcare delivery is to encourage health professionals to work together as a team. Creating networks among health services decision makers and professionals can support this strategy and make a significant difference in primary healthcare reform. However, to date, there has been only limited adoption of the network approach. One explanation for this poor uptake is that few people have a clear understanding of networks and how they work, say Catherine Scott and Anne Hofmeyer, authors of a 2007 paper entitled Networks and social capital: a relational approach to primary healthcare reform. The paper offers insights into the literature to help move along the adoption of the network approach.

Key concepts for successful networks

According to the authors, three key concepts show how networks can help guide knowledge exchange and renewal within the health system. First, the "strength of weak ties" concept illustrates the significant value of informal contacts and acquaintances. Research shows that new information is more likely to flow into a network through weaker ties – members who are somewhat on the periphery of the network and not strongly connected to the other members. To take advantage of the strength of weak ties, workplaces should encourage employees to make contact with people outside of their usual sphere of professional contacts when looking for answers to health-related challenges.
Second, the distance between specialist medical teams and units can be bridged with the help of the “cross-cutting ties” concept. This concept highlights the ability of an individual, sometimes called a knowledge broker, to act as a go-between and help spread information among normally isolated networks. This approach is particularly effective when the brokers already have credibility within the different networks.

The third concept, called “structural equivalence or status,” refers to playing up similarities between peers, particularly when it comes to relationships to other network members. Within a group of peers in a network – for example, a group of physicians and nurses – there are often trusted opinion leaders who can play a crucial role in communicating new ideas and new practices. These opinion leaders can potentially speed up the communication and acceptance of new ideas within their peer group and between different networks.

Common misconceptions about networks

There are six common misconceptions about networks, say the authors of this paper. They argue that “networks” are not the same as “organizations” as some may believe; that networks can have hierarchies within them; that not everyone in a network may, in fact, know they are participating in a network; that networks have centralized power structures; that networks aren’t controlled and regulated by members; and that individuals can participate in many networks at the same time.

Network success in Alberta

At the time the paper was published in 2007, the Trilateral Master Agreement between the Alberta Medical Association, Alberta Health and Wellness and Alberta’s nine regional health authorities were using networks as part of the overall strategy to reform primary healthcare. Alberta’s physicians were given incentives to form alliances and work with regional health authorities to develop primary care networks. Physicians’ practices remained autonomous under the alliances, but they combined patient records as they worked together on initiatives such as caring for patients with no regular physician, providing urgent care and promoting healthy lifestyles. At the time, more than 18 networks were under development or were up and running.

Bibliographic Reference(s)


*This summary is an interpretation and is not necessarily endorsed by the author(s) of the work cited.*