MODELS OF CARE FOR OLDER PEOPLE WITH CHRONIC DISEASE: A CASE STUDY USING ALFORD'S THEORY OF STRUCTURAL INTERESTS

by

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Thesis summary

The population is ageing, and with ageing comes increased rates of chronic disease. Given the increased demand on the health system resulting from these two factors, there is an urgent need to install new models of care that better meet the needs of older people. This thesis has employed grounded theory as a method to understand how health leaders conceptualise the barriers and enablers to the implementation of new models of care. I argue that models of care are an expression of health policy and are used as an exemplar of health reform when they are established statewide.

Data was gathered from interviews with 30 health leaders in Australia, in the years, 2009-2010, with the majority working in New South Wales. As per the grounded theory method, relevant literature has been used as data to support the emergent theory.

Alford (Alford, 1972, 1975) proposed a theory about structural interest groups to explain why health reform is difficult to achieve. His three structural interest groups consist of ‘Professional Monopolists’, ‘Corporate Rationalists’, and ‘Equal Health Advocates’. ‘Professional Monopolists’ are made up of doctors, and their training institutions and professional associations. ‘Corporate Rationalists’ are the funders of healthcare, namely government. ‘Equal Health Advocates’ are the community who seek accessible, efficient, effective, safe, consistent, and high-quality healthcare.

Alford postulated that ‘Professional Monopolists’ held structural power because the healthcare system was designed in a manner that naturally protects their interests. That said, ‘Corporate Rationalists’ and ‘Equal Health Advocates’ can form temporary coalitions to challenge the ‘Professional Monopolists’ to achieve reform. However, these coalitions have generally been short-lived, have required extraordinary effort, and have resulted in compromise. Other authors have demonstrated the relevance of Alford’s theory in the United Kingdom (Harrison, 1999; North & Peckham, 2001), South Korea (Cho, 2000), and Australia (Duckett, 1984).

Alford’s theory was chosen from a number of potential theorists because it had the strongest resonance with the themes that emerged from the respondents, and hence, was consistent with allowing theory to emerge from the ground up. Alternative theorists,

including Pawson, Bacchi, Tuohy, and Braithwaite were all considered before selecting Alford.

The data demonstrated evidence supporting the existence of, and interactions between, all three structural interest groups in Australia. The data also provided examples of ‘Professional Monopolists’ blocking efforts associated with health reform; most notably in blocking ‘Health Care Homes’. In this thesis, two case studies are used to demonstrate when coalitions of structural interests were formed to achieve reform (statewide establishment of ‘Hospital in the Home’), or to stymie reform (Nurse Practitioners). Drawing on the case studies, I argue that there was evidence of a fourth structural interest group, who I call the ‘Professional Advocates’, who were doctors who led change based on evidence-based medicine and best practice. I postulate their unique ability to work with, and persuade, the dominant interest group, the ‘Professional Monopolists’, as one of the keys to achieving reform that meet the needs of older people with chronic conditions.

Declaration

I certify that this thesis:

1. does not incorporate without acknowledgement any material previously submitted for a degree or diploma in any university; and
2. to the best of my knowledge and belief, does not contain any material previously published or written by another person except where due reference is made in the text.

Angela Littleford

16th April 2020

Glossary

AARCS	Acute to Aged Related Care Services
ACAT	Aged Care Assessment Teams
ACC	Ambulatory Care in the Community
ACD	Advance Care Directive
ACH	Acute Care at Home
ACP	Advance Care Plan
ADLs	Activities of Daily Living
AHPRA	Australian Health Professionals Regulation Agency
AHS	Area Health Service
AIHW	Australian Institute of Health and Welfare
APAC	Acute Post Acute Care
ASET	Aged Services Emergency Team
CACP	Community Aged Care Package
CAPAC	Community Acute Post Acute Care
CDMP	Chronic Disease Management Plan
CHSP	Community Home Support Program
COAG	Council of Australian Governments
ComPack	Community Packages of Care
CSRP	Clinical Service Redesign Program
DRG	Diagnosis Related Group
EACH	Extended Aged Care at Home
EACH-D	Extended Aged Care at Home - Dementia
EDD	Estimated Date of Discharge
EPC	Enhanced Primary Care

GP	General Practitioner
GRACE	Geriatric Rapid Acute Care of the Elderly
GREAT	Geriatric Rapid Evaluation and Treatment Service
HaCC	Home and Community Care
HRG	HealthCare Resource Group
HITH	Hospital in the Home
HWA	Health Workforce Australia
IADLs	Independent Activities of Daily Living
IHPA	Independent Hospital Pricing Authority
KPIs	Key Performance Indicators
LHD	Local Health District
LOS	Length of Stay
MAU	Medical Assessment Unit
MBS	Medicare Benefit Schedule
MCO	Managed Care Organisation (in the United States)
NHS	National Health Service (in the United Kingdom)
NP	Nurse Practitioner
NSW	New South Wales
OM	Oriental Medicine (in South Korea)
PAC	Post Acute Care
PbR	Payment by Results (in the United Kingdom)
PBS	Pharmaceutical Benefits Scheme
PCT	Primary Care Trust (in the United Kingdom)
RAC	Residential Aged Care
RACF	Residential Aged Care Facility

SAC	Severity Assessment Classification
SAP	Sustainable Access Program
TCP	Transitional Care Program
UK	United Kingdom

Acknowledgements

Dedicated to all those who work tirelessly to improve the lives of older people.

To my dear friends, colleagues, and mentors who have endlessly supported this journey; notably Vale Associate Professor Debbie Kralik and Vale Daniel Comerford.

I want to acknowledge the people who contributed to this study in chronological order. First, thank you to my first two supervisors at the University of Sydney, School of Medicine. Professor Stephen Leeder, your enthusiasm for my research project was inspiring and you opened many metaphorical and literal doors for me, and I am sincerely grateful. Thank you to Dr. Jim Gillespie who read much of my early work and sought to guide me towards a theoretical home for this research. Your early insights into my study were invaluable and greatly appreciated.

Sincere thanks to all the health leaders who took the time to be interviewed for this research. In your busy schedules, making time to speak to me was enormously appreciated and I am indebted to you for your generosity and honesty in sharing your views.

To my professional mentor in the art and science of qualitative research using NVivo software, sincere thanks go to Associate Professor Linda Sweet – you are a great teacher and unknown to me at the time, you were the catalyst that allowed this research to be finished. Associate Professor Sweet was responsible for finding my supervisory team at Flinders University, and without this milestone, this research would not have been completed.

My sincerest heartfelt thanks go to Professor Eileen Willis and Dr. Pauline Hill. I cannot adequately express how thankful I am for the countless hours devoted to guiding my research journey. Our stimulating conversations about the health system that occurred monthly, fortnightly, and then weekly throughout this research journey have taught me so much. Your wisdom, humour, and grace has been both enlightening and humbling.

Professor Willis, I must sincerely thank you for reading so much of my work and tirelessly making suggestions; the breadth and depth of your knowledge is astounding, and I have learnt so much about writing and research from you.

To my friends and family who have been unwavering in their support of my research; in particular, my dear friend Dolores who has had intense faith in my ability to complete this study, and our lifelong friends, Correna and Ben. My two beautiful daughters who were teenagers when I began and are now young adults, Maddi and Lucy, thank you for your love, patience, and understanding for the many days and nights that I have been locked away in my study. As you are both now at university, I know you understand the value and importance of learning, and I hope if I have taught you anything, it is that it is never too late to learn something new.

To my partner, best friend, IT expert, and greatest fan, David, love and gratitude for the many hours you have spent ensuring my data is both secure and backed up. You never doubted that I would finish what I started, and for that, I am so thankful.

My research journey

I recognise the delay that has occurred between the collection of the respondent's views and the writing of this thesis. My research journey has been complicated by an interstate move, significant health issues for myself and my family, and changes in my supervisory team. I have also worked full-time throughout my candidature. I will briefly describe the complications that led to these delays.

I commenced study part-time at the University of Sydney in semester 2, 2008 with Professor Stephen Leeder and Dr. Jim Gillespie as my supervisors. The interviews were conducted in 2009-2010. I moved my family from New South Wales to South Australia in July 2009 and continued to travel to Sydney to meet with my supervisors, but primarily Dr. Gillespie. Professor Leeder retired during this period and Associate Professor Debbie Kralik became one of my supervisors in August 2011. Sadly, Deb became extremely unwell, so I suspended my studies in semester 2, 2014.

The data used in this thesis was transcribed in 2010. The analysis process using NVivo stretched from 2011 to 2013. During this period, I wrote and presented sections from my findings, experiences, and my learning, as follows:

Littleford, A. & Slinn, A. (2010) Working within the community. In Kralik, D., & Van Loon, A. Eds (2010). Community Nursing in Australia. John Wiley & Sons, Australia.

Kralik, D. & Littleford, A. (2010). Hospital avoidance for older people through integrated community care. Australasian Journal on Ageing. 29, 21.

Littleford, A. & Kralik, D. (2010). Making a difference through integrated community care for older people. Journal of Nursing and Healthcare of Chronic Illness.

Wade, V., Littleford, A. & Kralik, D. (2011). Home Medication Management by Videophone: Translation from Pilot Project to Integrated Service in Communications in Medical and Care Compunetics, Springer-Verlag Berlin, Heidelberg.

I also presented parts of my initial analysis at a range of conferences:

Littleford, A. (2010) Reading between the lines: best practices of policy through interpretation. (invited paper) Government Policy Conference, Canberra, Australia.

Kralik, D. & Littleford, A. (2010). Integrated Community Care for Older People, ACSA Community Care Forum, Adelaide, Australia.

Littleford, A. (2011). Innovation in Health Care: Solutions for Australia's Ageing Population, Global Health Innovation Conference, Yale University, USA.

Littleford, A. (2011). Innovation in Health Care: Solutions for Australia's Ageing Population, The South Australian Division of the Australian Association of Gerontology, National Wine Centre, Adelaide, South Australia.

Littleford, A. (2011). Innovative Solutions for Australia's Ageing Population, Ninth Asia/Oceania Regional Congress of Gerontology and Geriatrics, Melbourne, Australia.

In late 2012, I suffered one of two significant life-threatening events that took me years to recover from. The first was osteomyelitis, and the second ultimately led to a fusion of two vertebrae in my cervical spine. After Associate Professor Kralik's death, my own health issues lead me to withdraw from my studies in November 2016.

However, my curiosity about healthcare reform continued and I made contact with Associate Professor Linda Sweet at Flinders University in late 2017. I had met Associate Professor Sweet when I attended an NVivo workshop in 2011 and had sought her instruction over the years in the advanced use of NVivo. Associate Professor Sweet found me my current supervisory team, and I recommenced work in semester one, 2018. The long theoretical journey I took over the course of these years is outlined in the methods chapter. As a consequence, this study looks back to the 2009-2010 period, and presents an account of what was occurring at that time, noting that the theoretical insights reflect that period.

CHAPTER ONE: INTRODUCTION TO THE THESIS

This chapter provides the context of this research which was conducted in 2009/2010, before stating the research questions. The chapter briefly describes the major sections of the thesis and touches, by way of introduction, on some of the themes that emerged from the data. **In summary, the research sought to understand why the health system is so resistant to change or ‘reform’. The research question focused on the highly topical issue of older people with increased rates of chronic disease. I argue that increased rates of hospitalisation represent the system’s failure to change to meet their needs. To examine system inertia, I examined models of care from the major areas of healthcare in Australia, that is General Practice (or primary care) and the acute hospital sector**. I assert that models of care are an expression of health policy (as they dictate the way health care is delivered). Attempts to introduce new models of care are met with resistance. Understanding why this is so, is important if future health reform is to be achieved. I also argue that in 2009-2010, increasing rates of chronic disease among the ageing population put a strain on the acute hospital sector, not only in New South Wales Health (NSW Department of Health, 2010; Smyth, 2009), but also federally, as evidenced in the Health and Hospital Care Reform Commission Report (Commonwealth of Australia, 2009) – this assertion is expanded upon in Chapter Two.

This chapter also outlines the context of the study, my own specific engagement in healthcare reform, the organisation of healthcare in Australia, and an overview of the major policy directives at the time the research was completed. The final section provides an overview of the thesis argument.

Research questions

The research question for this thesis asks why the health system is so resistant to change, or ‘reform’ as it is often described. The research question was narrowed to the highly topical issue of older people with increasing rates of chronic disease. The inability of the system to change to meet their needs was narrowed to focus on models of care. Models of care were taken from across the fields of General Practice (or primary care) and in hospitals. I assert that models of care are an expression of health policy. My initial research was positioned within grounded theory; however, for reasons I will later outline, no emergent theory presented itself. This provided an opportunity for me to contrast my major themes with those of other authors and theorists. Ultimately, I contrasted my findings with Alford's formal theory of structural interests and three further research questions were established. This is also consistent with the Grounded Theory method whereby a researcher can draw on other substantive theories to elucidate a theory from their findings. As Glaser and Strauss (1965) stated

> *… substantive theory may help in formulating formal theory. It may also contribute to the formulation of new formal theory grounded on careful comparative research … Consequently, if one wishes to develop a systematic formal theory (or general) theory of awareness contexts, he must analyse data from many substantive areas* (In Glaser (2007) p. 97).

Therefore, I used my findings, significant reports from the period of the research (namely the Health and Hospital Reform Commission Report, Productivity Commission reports, and Annual Reports from NSW Health), and compared them with Alford's theory of structural interests, as outlined in his work on ideological interest groups and barriers to health reform (Alford, 1975). The three research questions I posed were:

1. ***Does Alford's theory explain why reform within the Australian healthcare system is difficult to achieve?***
2. ***Was there evidence of Alford's three structural interest groups in the themes that emerged from respondents?***
3. ***Did these interest groups behave in a manner consistent with what Alford described?***

In addition to answering these three questions, I postulated that a fourth structural interest group emerged in the Australian healthcare system, which I called the 'Professional Advocates'. Importantly, while there may be a variety of other theories that have been used to explain resistance to health reform, the arguments presented in this thesis emerged from the views of the 30 senior health leaders (respondents) interviewed for this thesis.

To examine the impact of the models of care identified by the respondents, I also used the relevant literature to understand the impact as well as the reach these models of care have had on the health system. My use of grounded theory is expanded upon in Chapter Five, the methodology and methods chapter; and, it is important to highlight, in grounded theory, literature can be drawn from relevant periods related to topics that emerge from the data (Heath, 2006; Rolfe, 2006). Chapter Five also contains a brief summary of other author's that could have been used to understand my emerging themes; instead of the use of Alford's theory; my justification for using Alford is also contained within this chapter.

As stated in the final report of the Health and Hospital Reform Commission, A Healthier Future For All Australians (National Health and Hospitals Reform Commission, 2009):

> *The provision of an affordable and accessible health system is vital for a fair and just Australia.*
>
> *Our country must act now to ensure our health system can cope with the demands of the future.* ***Demand for health services is increasing as our population is ageing and more people are living with chronic disease*** [emphasis added] (p. 3).

My research questions were critical to work through in order to understand why the cycles of investigations, reviews, inquiries, and recommendations to improve the health system have ultimately failed. To demonstrate this point, consider a brief chronology of inquiries in Australia this century. In 2005, the Productivity Commission released its report into the requirements of the health workforce (Australian Government Productivity Commission, 2005). In 2008, a major Inquiry into the New South Wales hospital system was released (Garling, 2008) and one of the largest reviews of the Australian healthcare system led by the Rudd Government was completed in 2009 (Commonwealth of Australia, 2009). I expand upon each of these inquiries in Chapter Two, but for now, make the point that Australia mirrors Alford's examination of the New York Health system in the 1970s, that is, a system under constant review where little change or reform is actually achieved as a result of these reviews.

The evidence to support the claim that the health system is resistant to reform is the increasing number of older people presenting to Emergency Departments in New South Wales in 2009/2010, the long waits they endured within Emergency Departments, and the extended lengths of stay they had once hospitalised. Evidence is provided throughout this thesis that supports these claims, but by way of introduction, the Department of Health 2008/2009 Annual Report (NSW Department of Health, 2009) stated that the NSW health system was under ever-increasing demand due *"… to a growing and ageing population with increasingly complex and chronic conditions*" (p. 2). The ageing population is identified to be an issue because advanced age and the proportion of older people in the community "*… is significant, because older age groups need considerably more health care than the general population*" (NSW Department of Health, 2009, p. 280).

In the 2009/2010 Annual Report (NSW Department of Health, 2010) the impact of the ageing population was further highlighted:

> *As individuals get older, their likelihood of deteriorating health status increases and their subsequent utilization of health resources generally increases.* ***Persons aged 65 and over tend to be higher users of the public health system than most other age groups, so the larger this segment of the population becomes, the more demand it creates.*** *NSW has a higher proportion of its population aged 65 and over than the national average, at 13.9% compared to 13.2% nationally. Recent population trends show that this age group is increasing as a proportion of the total population in Australia* …" [emphasis added] (p. 35).

The 2009/2010 New South Wales Health Annual Report separated out older people's use of inpatient hospital beds from adult beds for the first time, further reflecting the Department's attention on age-related bed occupancy (NSW Department of Health, 2010). The annual report stated a "*Separate reporting category for Older People. These* *were reported together within the Adult category in previous reports*" (NSW Department of Health, 2010, p. 284).

Dr. Tim Smyth, who was the Deputy Director-General of the Health System Quality, Performance, and Innovation Division, stated that hospitalised older people have a longer length of stay than their younger counterparts (Smyth, 2009). In 2009, it was reported by NSW Health that the average length of stay in hospital was 4 days, but for people aged over 75 years, it increased to 9 days (Smyth, 2009, p. 6).

A decade later, the focus on healthcare and the increased costs associated with increased demand had not changed. In 2019, in the lead-up to the federal election, health was a hot topic in the media and in the election campaign. The Financial Review summarised the key issues of the election which included healthcare (McIlroy, 2019). The Labor Party planned to establish a permanent health reform commission *"… designed to break the cycle of boom and bust of funding and changing policy priorities*" (McIlroy, 2019), while the Coalition observed that funding for services at public hospitals had increased from $13.3B in 2013-14 to $23.4B in 2020-21, a massive 76% increase with new hospital agreements and the expansion of the Pharmaceutical Benefits Scheme (McIlroy, 2019). The observations and commitments of both parties have reflected the urgent need for sustained reform to improve the health system both in terms of its fiscal efficiency as well as the quality of services to patients. It has also demonstrated that previous reviews, inquiries, and reforms have been unsuccessful.

Personal significance

This research has personal significance for me. Between 2005 and 2007, I worked in the Clinical Service Redesign Program (CSRP) within NSW Health. This program was led by Professor Katherine McGrath who was the previous Chief Executive Officer of the Hunter New England Area Health Service (HNE AHS). Professor McGrath led the "Maggie" program (HNE AHS), which was named after a patient, "Maggie", who experienced poor outcomes while in hospital. This patient's experience was documented and then used to inform a systematic change process that was aimed at identifying the root causes of sub-standard care and the potential solutions to remedy and prevent the recurrence of such an experience.

The success of the “Maggie” program led the NSW Government to fund the Access Block Improvement Program in 2004 (Masso, Robert, McCarthy, & Eagar, 2010). A total of 10 hospitals were chosen to use the Clinical Service Redesign Program (CSRP) methodology to improve the performance of their Emergency Departments. The philosophy of the first “Maggie” program informed the methodology that was used by the Clinical Service Redesign Program. The 10 hospitals that successfully improved their Key Performance Indicators (KPIs) lead the then Health Minister and later Premier, Morris Iemma, to fund the CSRP program for three years (2006-2009). The principles of how the CSRP operated were:

1. NSW Health, Performance Improvement Branch, set Key Performance Indicators for each Area Health Service to achieve.
2. The KPIs were in the Area Health Service (AHS) agreements with NSW Health and were monitored monthly.
3. Each Area Health Service was given a budget to undertake the CSRP projects.
4. The Area Health Service was funded to partner with an external consultant to work on their project.
5. The improvement cycle was generally 12 weeks, and was informed by Business Process Re-engineering methods. The first phase was an investigation of the problem, the second was solution design and solution planning, and then followed the implementation. The expected outcome was that each project would achieve the KPIs set in the implementation phase while being informed by those set by NSW Health (O'Connell, Ben-Tovim, McCaughan, Szwarcbord, & McGrath, 2008).

In the first year of operation, the CSRP tackled state-wide projects, setting KPIs for each Area Health Service to improve access and performance of emergency departments, elective surgery waiting lists, and mental health in-patient services. In the final year of the program, three KPIs were set ***to improve the experience and outcomes of older people when accessing healthcare.*** By this phase of the program, a significant number of patient journeys had been collected, and the NSW Health CSRP team could see the challenges for older people with chronic diseases, who often appeared as outliers within acute wards (Ben-Tovim., Dougherty., O’Connell., & McGrath., 2008). The ageing of the population also heralded significant concern for both the state and Federal Governments, as with increasing age, comes increased in-patient separations, more bed days, and increased complexity. Of the approximately 9.3 million in-patient separations in Australia in 2011-2012, 39 per cent were for people aged over 65 years who accounted for 48 per cent of total hospital bed days (Australian Institute of Health and Welfare, 2013, p. 119). O'Connell et al. (2008) reported at the time that older people used 50 per cent of hospital bed days in New South Wales and noted that older people, due to their chronic and complex health issues, had a longer length of stay (LOS).

A further strategy of the Clinical Services Redesign Program was to capture successful models of care (which were defined by allowing a facility to reach its set Key Performance Indicators, or KPIs). For example, Westmead Hospital was able to achieve the Emergency Department KPIs through the establishment of the OPERA model of care. OPERA was written up as a Model of Care document by NSW Health and shared with clinical leaders and managers across the NSW Health System. The plan was to capture the model of care so it could be transplanted into other settings with the intention that it would achieve similar results. The models of care captured by CSRP became programs in themselves. My job was to capture these models of care and publish them on the Australian Resource Centre for Health Innovations (ARCHI) website (they can now be found at:
https://www.aci.health.nsw.gov.au/resources/models-of-care).
The models of care included an implementation guide to encourage other Area Health Services to install the models. Area Health Services were able to implement these new models of care using ‘new’ funds from the Sustainable Access Program (SAP) included in their Area Health Service Agreements with NSW Health. In exchange, they had to meet the stated Key Performance Indicators (KPIs) in the SAP agreement. These KPIs will now be described.

During the Access Block Improvement program and with the CSRP projects that targeted Emergency Department (ED) performance, there were emerging issues with older people being assessed as Triage Category 4 or 5 and spending long periods within the Emergency Department (MacLellan, Cregan, McCaughan, O'Connell, & McGrath, 2008). Triage Category 4 and 5 generally means the patient could have been treated within the community by their primary care health professional, usually their General Practitioner (GP). It was recognised that there needed to be changes to the Emergency Department model of care to provide a better response for these patients (Shanley, Sutherland, Tumeth, Stott, & Whitmore, 2009). In the final year, the KPIs aimed to decrease total bed days for people aged over 65 years with cardiac and respiratory chronic diseases, and an increase in referrals to secondary prevention and rehabilitation programs for cardiac and respiratory disease and zero SAC 1 (SAC stands for Severity Assessment Code) patient falls within the acute setting (Smyth, 2009). A SAC 1, for example, would be when a patient falls and dies as a result of such a fall.

In my 30 years of experience in the health sector, this was the first time that systematic change processes, learnt primarily from the manufacturing sector (i.e., Lean Thinking, (Teich & Faddoul, 2013) Six Sigma, (Pyzdek, 2003) had been executed within clinical settings, and it led to me to question the role that policy plays in 'change' or 'reform' of healthcare. The Clinical Service Re-design project was able to demonstrate improvements at a facility level in the area of Emergency Department performance according to the Key Performance Indicators, which included the eight hour rule, cessation of hospital diversion, and decreased ambulance ramping, and the reduction of the elective surgery waiting list (MacLellan et al., 2008; O'Connell et al., 2008). However, while the Clinical Service Reform Program (CSRP) achieved many of its ambitious targets, including decreasing elective surgery waiting lists (McGrath et al., 2008; O'Connell et al., 2008) and improved Emergency Department performance (MacLellan et al., 2008; O'Connell et al., 2008), broad system-wide failures continued and were highlighted in the Garling report in 2008 (Garling, 2008; Skinner, Braithwaite, Frankum, Kerridege, & Goulston, 2009). The CSRP failed to innovate, create clinical champions, or initiate a 'bottom up culture' of innovation (Masso et al., 2010). Essentially, it failed to deliver system-wide change.

The rationale for the research and its significance

Countless billions have been spent on the examination and reform of the health system in all major developed countries around the world (Alford, 1975). Schneider (2009) stated that President Barack Obama earmarked $634 billion dollars over a 10 year period to begin reforming healthcare; however, his own administration acknowledged that this "… *would not be enough to fully fund a comprehensive reform of the health care system and that administration officials would need to work with Congress to find even more money*". My study sought to understand why the health system is so resistant to change or 'reform'. I did this through examining the health system's inability to implement new models of care that would meet the needs of older people with chronic conditions through the lens of Robert R. Alford's 1975 *Health Care Politics: Ideological and Interest Group Barriers to Reform*. The focus of 'reform' in this thesis centres on the needs of older people with chronic conditions, with a specific focus on models of care in the state of NSW, the state with the largest population and the largest health system in Australia (NSW Department of Health, 2009). Alford summarised three major factions or interest groups that exist in health systems whose collective friction and tension stymies change.

The three structural interest groups Alford (1975) identified were 'Professional Monopolists', 'Corporate Rationalists', and 'Equal Health Advocates'. 'Professional Monopolists' are the doctors and specialists, the Medical Board, and associations such as the Australian Medical Association, that represent their interests. The 'Corporate Rationalists' are government and government-funded entities that seek to control the operation of healthcare, namely NSW Health and Area Health Services. 'Equal Health Advocates', as the name implies, are the consumers, who are by no means a homogenous group. At the time Alford published his work, the 'Professional Monopolists' were made up of physicians and their training schools, the 'Corporate Rationalists' were made up of all layers of government who "*… perform the core functions of organizing, financing, and distributing health care*" (Alford, 1975, p. 191). Finally, the 'Equal Health Advocates' were those *"… who seek free, accessible, high-quality health care which equalizes the treatment available to the well-to-do and to the poor*" (Alford, 1975, p. 191).

Alford asked why healthcare reforms did not ‘solve’ the ‘crisis’ that led to the inquiries he examined within the New York health system in the first place. He observed that each Inquiry generated hundreds of solutions in the form of recommendations, often ignoring the inquires of the past. His theory identified ‘dominant’, ‘challenging’, and ‘repressed’ interest groups; the ‘Professional Monopolists’ who held the ‘dominant’ structural interest, the ‘challenging’ interest provided by the ‘Corporate Rationalists’, and the ‘Equal Health Advocates’ as the ‘repressed’ interest group. Commenting on the power of organised medicine (the ‘Professional Monopolists’) he noted:

> *Dominant structural interests are those served by the structure of social, economic, and political institutions as they exist at any given time. Precisely because of this, the interests involved do not continuously have to organize and act to defend their interests; other institutions do that for them* (p. 14).

Alford asserted that dominant structural interests maintain their dominance because the system inherently supports their position through a variety of mechanisms such as regulation, funding rules, and policy. He suggested that ‘Professional Monopolists’ maintain their power within the health system because the system itself is designed to support their fiscal and positional status (Alford, 1975). Other institutions also advocated for their superior position, such as the various Professional Colleges and the Australian Medical Association (AMA).

In Alford’s analysis of the New York health system, he argued that in a pluralist system, combined with democratic principles where every interest group has a voice, effective health planning, let alone effective improvements or ‘reform’ in the health system, were stymied (1975, p. 175). He also argued that once doctors are accepted into their professional group, they guard their own and become a part of a protected class. The problem, as he saw it, resided in pluralism itself. He wrote:

> *The problem is to discover just how the pluralist system works, how it manages to throttle effective action and reduce coordination to manipulation in order to secure greater resources for existing component*

> *units (whether from local, state, or federal sources). This is politically analogous to the procedures adopted by members of an oligopolistic industry in which all members are protected, even the weaker ones, once they have become members of the club* (p. 175).

The utopian vision for health is that it is effective and efficient, of the highest quality, informed by the latest research, and that access to medical technology is easy and medications available and affordable. As a person ages and develops chronic conditions, health professionals are assumed to work in partnership to assist with the maintenance of health and well-being for the ageing population. The Australian community expects to be able to access Emergency Department treatment when they need it, and to not have to endure long waits either to be assessed, or if requiring hospitalisation, to be admitted to the appropriate ward in a timely fashion (Commonwealth of Australia, 2009). We also expect GPs and allied health professionals to assist us in maintaining good health either through preventative medicine or via effective management of chronic conditions. If hospitalisation is required, there is an expectation that the care will be 'handed back' to primary care providers such as GPs. All too often, these expectations of coordinated care fall short, while the rising costs of healthcare are of significant concern to governments where annual expenditure is increasing. In 2015-16, the Australian Institute of Health and Welfare (AIHW) estimated that 10.3 per cent of Gross Domestic Product was spent on healthcare, which was a rise of 3.6 per cent compared to 2014-2015 (Australian Institute of Health and Welfare, 2017). The AIHW reported that health expenditure in 2016-2017 grew by 1.2 per cent over the previous year, and that two-thirds of these funds came from government – government spending on healthcare currently represents 24.4 per cent of tax revenue (Australian Institute of Health and Welfare, 2019, p. iv). These figures demonstrate why governments are focused on curtailing the rising costs of health expenditure.

However, despite government commitment, health 'reform' fails, and appears to be unable, to change. For example, Menadue (2019) noted that the health system has been unchanged since the Hawke Government introduced Medicare in 1983, which was based on the Whitlam Government's 1975 Medibank scheme. This is despite the National Health and Hospital Reform Commission Report (Commonwealth of Australia, 2009) and countless state-wide inquiries, such as the Garling Inquiry (Garling, 2008) and targeted investments in health reform such as the Clinical Services Redesign Program (Ben-Tovim. et al., 2008; MacLellan et al., 2008; Masso et al., 2010; McGrath et al., 2008; O'Connell et al., 2008). Davies (2011) described health reform as being analogous to a cappuccino: "*… an approach to reform which focused on the milky froth of health sector institutions while leaving the underlying, thick, rich espresso of health care delivery largely untouched*". In discussing a systems approach to change in public hospitals, authors such as Braithwaite et al. (2017) have highlighted that hospitals are more like frogs than machines; that is, they are complex organisms with intrinsic characteristics including a natural inertia, a political culture, and embedded structures that are resistant to change. They are also subject to legislation and regulations outside the control of leaders within the hospital (Balding, 2015).

Observing the apparent failure of health reforms, I set out to learn from the experts, through a series of interviews, why they thought this was so. The respondents were defined as 'health leaders' and included senior Commonwealth, state, and Area Health Service executives, as well as CEOs from peak bodies. The respondents would be classified within Alford's typology as either 'Professional Monopolists' or 'Corporate Rationalists'. 'Equal Health Advocates' (consumers) were not included in this study. A small number of consultants who had been involved with the Clinical Service Redesign Program were also included. These 'health leaders' were charged with the implementation of policy and the need to influence policy in particular directions to meet the needs of the ageing population. The majority of respondents were employed in the government sector and this study does not address the private hospital sector.

The timing of the interviews conducted in this study was significant, as they occurred during the period when the final report of the Health and Hospitals Reform Commission (Commonwealth of Australia, 2009) had been released and reforms from the report were underway. This was highly topical and was reflected upon by many of the respondents when answering the interview questions.

My enquiry went further to determine how the new model of care came about; that is, what lead to its implementation? What were the conditions in which the new model of care was established? This data was then viewed using Alford’s theory of structural interest groups. First of all, was there evidence in the Australian health system of Alford’s structural interest groups, and did they operate in the way he described, given that the Australian system differs from the USA? If these structural interest groups did exist, did ‘temporary coalitions’ between groups lead to the implementation of a new model of care, were there other mechanisms in play, or was reform always blocked? Seeking answers to these questions may contribute to expanding the body of knowledge on how governments and clinicians can instigate change that improves patient care in large and complex health systems.

The structure of the Australian healthcare system and relevant terminology in 2009-2010 in New South Wales

To understand the health system at the time the interviews were conducted (2009-2010), I describe below the organisation of the public healthcare system in Australia, including New South Wales. Medicare is Australia’s publicly-funded healthcare insurance system. It was established in 1983 and covers primary, community, and acute or tertiary care, as well as access to pharmaceuticals. Primary care includes general practice, which is funded directly by the Federal Government, as well as a range of community-based services. Acute or hospital care, including emergency care, is funded by the six state and two territory governments with considerable, and variable, financial assistance from the Federal Government. Agreements between the states and territories and the Federal Government are brokered roughly every five years and variously referred to as Medicare Agreements, Australian Health Care Agreements, or National Health Care Agreements (Australian Government Department of Health, 2019).

Key Performance Indicators set by the Federal Government or the various state governments in relation to public hospitals in 2009 included ‘off stretcher times’, patients exiting the Emergency Department within 8 hours, and triage targets (NSW Health, 2011). Off-stretcher times, literally refers to the time taken once an ambulance arrives at an Emergency Department for a patient to be transferred from the stretcher to the hospital gurney. The ‘8 hour rule’ deemed that once a patient had been diagnosed as needing admission, they would be transferred to the ward within 8 hours (NSW Health, 2011). Triage targets refer to the Australasian Emergency Triage targets through which patients, on presentation to an Emergency Department, are classified according to their presenting condition/s. There are five categories with triage category one being the most acute with the patient having to be seen immediately with a performance threshold of 100 per cent. Patients presenting as triage category five must be seen within 120 minutes with a performance threshold of 70 per cent (Australasian College for Emergency Medicine, 2013). The flow of patients from the Emergency Department is dependent on the number of free beds at the beginning of any given period. Logically, if a hospital has 85 per cent of its beds occupied, there will be beds for the admitted patients to occupy from the Emergency Department; on the other hand, if a hospital has 100 per cent of its beds occupied, it is clear that there will be blockages in the Emergency Department. These were the system metrics for public hospitals in Australia during the period the research was conducted in 2009-2010.

Apart from the public healthcare system, Medicare, Australians can choose to purchase private health insurance and have hospital cover and/or ‘extras’ cover for non-medical treatment such as dental, allied health therapies, optometry, and audiology services. Patients electing to be treated in a private hospital must fund this themselves, either through their private medical insurance or out of pocket. Many GPs and medical specialists also require a ‘gap’ payment which the patient must pay. Ambulance costs vary across Australia with some services requiring patient payments (Willis, Keleher and Reynolds 2015). The section below outlines a range of primary and acute services highlighting the complexity of funding arrangements between the states and the Federal Government.

General Practice

GPs are responsible for primary healthcare in Australia. While funded by the Federal Government, the vast majority of GPs are self-employed. GPs work either in group practices of varying sizes or in isolation (Royal Australian College of General Practitioners, 2018). They generate revenue through the Medicare system, claiming eligible items which are available through the Medicare Benefits Schedule (MBS). They can elect to either accept the MBS fee as the total charge (referred to as ‘Bulk Billing’) or request a co-payment from their patients. General Practice is very much an individualised activity in Australia, and group General Practices differ greatly in their composition. For example, in 2009, 988 GPs from around Australia participated in the BEACH study (Britt et al., 2010) which found that 41 per cent of GPs worked in a practice with 5-9 other GPs, and this was the most common practice size. Another 79 per cent worked in practices with one or more practice nurses, 49 per cent had a pathology collection centre, 44 per cent had a psychologist, and 29 per cent had a physiotherapist located within 50 metres (Britt et al., 2010, p. xii). During this same period, Super Clinics were formed and, in particular in NSW, HealthOne clinics were established. These will be discussed in Chapter Six: Models of Care.

The introduction of Enhanced Primary Care later called the Chronic Disease Management Plan (CDMP)

In 2008, one-third of all General Practice consultations were attributable to the management of chronic conditions (Foster et al., 2008). To reflect this significant proportion of work dedicated to the management of chronic disease performed by GPs, Enhanced Primary Care (EPC – and then later in 2014, re-branded as the Chronic Disease Management Plan) item numbers were introduced into the MBS Schedule (Department of Human Services, 2014) by the government in 1999 (Foster et al., 2008). EPC planning items were originally envisaged as a means of encouraging improved coordinated multidisciplinary care for patients with chronic disease and complex needs by providing incentives for GPs to collaborate with other health professionals (Australian Government Department of Health, 2014). Patients with an EPC were able to access five Medicare claimable allied health treatments in 2009. Note that for the purposes of consistency, EPC is the terminology adopted throughout this thesis.

Community Health

Many state governments continue to support community health services. Community health in New South Wales is varied in its composition and location, and in the early years of the 21st century, was funded by the state government. Generally, community health staff consist of a range of nursing, allied health, and mental health professionals.

Of relevance to this study are those community health centres that run either cardiac or respiratory rehabilitation programs for chronic disease. In New South Wales, these programs were offered (at the time of writing) either through a community health service (for example, Moree Community Health Service) or via an outpatient department in a hospital (e.g., the Royal Prince Alfred Hospital Chronic Obstructive Pulmonary Disease (COPD) Rehabilitation Program).

Home and Community Care (HaCC)

Home and Community Care (HaCC) provides services for the elderly and people with a disability in their homes. Aged Care funding policy in Australia was led by the Commonwealth and state governments and administered through Commonwealth-funded community-based programs in 2009-2010 (for example, the Home and Community Care program was run by the state government and funded by the Commonwealth up until 2015). State initiatives to support older people (e.g., NSW Carer's Action Plan 2007-2012 (New South Wales Department of Health, 2007) were also funded and managed by the state. In 2009/2010, the Home and Community Care Program (HaCC) was administered by the Department of Disability, Ageing, and Home Care (DADHC) in New South Wales. The aim of the HaCC program was to support frail older people and people with disabilities and their carers to live independently (Black, Osborne, & Lindeman, 2004). Community-based supports were available to older people in the form of individual assistance for the Independent Activities of Daily Living (IADLs – e.g., shopping, transport, etc) or the Activities of Daily Living (ADLs – e.g., showering, dressing, grooming, etc). People with higher-level support needs were assessed via an Aged Care Assessment Team (ACAT) for various care 'packages'. These included a Community Aged Care Package (CACP) (O'Leary, 1999), an Extended Aged Care at Home (EACH) and Extended Aged Care at Home package with an additional supplement for Dementia (EACH-D) (Henderson & Caplan, 2008). Lower-level supports were available through the Community Home Support Program (CHSP) which generally involved one to two lower-level service types such as domestic assistance and gardening. A significant proportion of the CHSP, CACP, EACH, and EACH-D services were sub-contracted to non-government organisations. However, this led to a multitude of providers across the state of New South Wales which meant that discharge planners in the hospitals had to navigate multiple agencies in order to gain services to support an older person upon discharge.

Area Health Services

In 2009-2010, New South Wales was reorganised into eight Area Health Services, Greater Southern, Greater Western,; Hunter-New England, North Coast, Northern Sydney-Central Coast, South Eastern Sydney-Illawarra, Sydney South West, and Sydney West (NSW Department of Health, 2010). During the period of the interviews, each Area Health Service had an agreement with NSW Health whereby their key performance indicators and funding were set. In 2011, the governance arrangements covering New South Wales Health infrastructure were significantly altered. The Ministry of Health was established and core business defined in strategic terms. Area Health Services were transitioned to become 15 Local Health Districts (LHDs) and two speciality LHDs in the areas of Paediatric and Children's Health and Justice, Forensic, and Mental Health. NSW signed the National Health Reform Agreement on 21 April 2010, as did all other jurisdictions with the exception of Western Australia. This led to the establishment of 15 Local Health Networks, which were renamed Districts in May 2011 (Health, 2011). The rationale for the move to LHDs was stated in the New South Wales Health Annual Report 2010-2011 as:

> *In May 2011, legislation was passed to establish Local Health Districts and Boards in lieu of Local Health Networks and Governing Councils. The establishment of Boards and Districts reflects the New South Wales Governments' priorities of devolution and local decision-making, greater transparency and accountability, and strengthened clinician engagement* (Health, 2011, p. 2).

For the purposes of consistency, the term Area Health Service (AHS) is used throughout this thesis. The major difference between Area Health Services and Local Health Districts is that the latter were run by governing boards while the former were governed via the centralised bureaucracy within the New South Wales Department of Health.

The environment of health reform circa 2009 in New South Wales

One of the central arguments put forward by Alford (1975) is that governments instigate successive health policy reforms in an attempt to improve the system and to provide a better service. In this section, a range of state and Federal health reforms are briefly discussed to illustrate the reform climate. The first explores attempts by the NSW Government to move a hospital to an outer suburb, the second reports on the Garling Inquiry and three federally-based reforms. This is followed by an exploration of Federal inquires and attempts at health reform.

Closing and moving beds

The healthcare system in Australia is founded on the principles of ‘universal healthcare’ (Willis, Reynolds, & Keleher, 2016). Australians believe passionately that it is their inalienable right to access high quality healthcare that is largely publicly funded (Commonwealth of Australia, 2009). One profession claims dominance in both the structure and foundations of healthcare. Scientific evidence-based medicine, with the dominance of the medical model, is at the heart of our healthcare system (Benoit, Zadoroznyj, Hallgrimsdottir, Treloar, & Taylor, 2010; Grimmer et al., 2014; Harris et al., 2017; Kenny & Duckett, 2004). Structures that align to this hegemony, namely hospitals, are the grounds upon which community passion, political will, and health debates are focused. If a government wishes to close a hospital, a unit, or even a single bed, a media storm and community outcry often results. For example, in 1990, Lloyd, McCarthy, and Nolan (1990) described the closure of 678 public hospital beds in the Inner, Southern, and Northern Metropolitan Health Regions in New South Wales, and the transfer of these beds to the Western suburbs for reasons of equity. They noted that this movement of beds triggered a series of public protests, street marches, political debates, and conflict between the Health Department, the government (including the political opposition), and members of hospital boards, unions, and health professionals. These actors suggested that the media played to an emotive public in the redistribution of these beds – despite the public outcry, this redistribution went ahead, but what was important was that these beds were *transferred* to other parts of metropolitan NSW – the beds were moved not closed, but still, this caused significant public outcry and emotive media stories (Lloyd et al., 1990).

This emotive and political relationship between healthcare and the community is not unique to Australia. In the United Kingdom, research from the London School of Economics demonstrated how damaging hospital closures can be in politically sensitive areas. Researchers have shown that hospitals in marginal constituencies were much less likely to be closed down than those in safe parliamentary seats (Anushka & Denis, 2010). These researchers surmised that the reason for this was that people really care about hospitals and they want to know that they and their relatives will have the services they need when they need them. The research highlighted the case of Richard Taylor, a doctor who campaigned to keep Kidderminster Hospital open, which resulted in a Labour Minister losing his seat in 2001.

It is not only the threat of closing hospital beds that leads to public outcry, public concern is also raised when significant failures in hospitals lead to unnecessary patient deaths. Between 2005 and 2009, patients needlessly died or suffered unnecessarily at hospitals within the Mid Staffordshire Trust in the United Kingdom. The resultant public outrage lead the UK Government to instigate the Francis Inquiry (Francis, 2013), which resulted in a total of 290 recommendations. This situation is not unique to the United Kingdom, and at the time this research commenced in 2009, a similar Inquiry had been held in New South Wales lead by Peter Garling (Garling, 2008).

Public outcry leading to the The Garling Report

In New South Wales in 2008, the then Premier and former Health Minister, Morris Iemma, announed a Special Commission of Inquiry into the state’s health system (Garling, 2008). Public outcry at the time was high due to the Coroner’s findings regarding the death of Vanessa Anderson and a number of other high profile failures in the major hospitals. Vanessa was a 16 year-old from Hornsby who suffered a head injury from a golf ball and later died, not as the result of her injuries, but from an overdose of codeine and endone at the Royal North Shore Hospital. The Sydney Morning Herald quoted the Deputy State Coroner:

> *… time and again in medical cases such as this, the same issues had been identified: not enough doctors, not enough nurses, inexperienced*

> *staff, poor communications, poor record-keeping and poor management. … These are systemic problems that have existed for a number of years … There is little doubt that the NSW health system, while certainly staffed by dedicated professionals, is labouring under increased demand and expectations from the general public …* (Smith, Wallace, & Brown, 2008).

The Inquiry was lead by Peter Garling (a judge from the Supreme Court of New South Wales) and his resultant report, known as The Garling Report, was released in November 2008 with 139 recommendations (Garling, 2008). The recommendations were far reaching and included breaking down silos of practice, the promotion of team-based care, and defining tasks which could be performed by a suitably qualified health professional; for example, eliminating task barriers between Nurse Practitioners and doctors. He recommended system changes required to better meet the needs of patients, in particular, older people with chronic conditions:

> *The first step is to engage the dedication of clinicians in designing new models of care which are supported and actively championed by clinical leaders in the field, which are evidence-based best practice, and which can be monitored to track the degree of success. To achieve this, I have taken up the many existing networks of clinicians and recommended that they become part of a new, more comprehensive agency which will be tasked to coordinate and drive constant innovation across the whole system. I have suggested that it be called the Clinical Innovation and Enhancement Agency, and be responsible for continuing reform and improvement of clinical models of care and practices. The second step is to implement the changes required by the new models of care at the clinical unit level. This requires the active support of clinical leaders to be the champions of the changes* (Garling, 2008, p. 4).

Both the mid-Staffordshire and the New South Wales situations around the time the interviews were conducted brought to light critical quality issues and clinical leadership and governance arrangements. More recently, Leggat and Balding (2017) noted that 'quality' was viewed by hospital board members, managers, and staff to be an extra set of activities to be undertaken rather than a means to provide "*… sustained, safe, quality care"* (Leggat and Balding (2017, p. 179). They concluded that:

> *Despite enormous goodwill and positive intent, a lack of understanding of how to effect change in the complexity of hospitals has led the boards and senior managers in our sample to execute a technical, top-down approach based on compliance and reactive risk*.

Quality care is critical for all patients, but for older frail patients, the risk associated with sub-standard hospital care is greater, as I will later establish. Not only do older patients have a greater risk of iatrogenic events, they also occupy a greater proportion of hospital beds than any other age group. The ageing population's use of hospital beds was highlighted in Garling's report:

> *Demographic changes mean that Australia has an ageing population which will require proportionately more care as the age groups survive through their 70s and well into their 80s. In 2006-07, one-third of all public hospital patients were aged over 65 years, although that group made up only 13.5% of the state's population. By now, those aged over 65 years make up 45%, nearly one-half, of all public hospital patients* (Garling, 2008).

In response to the Garling Report (Garling, 2008), NSW Health released 'Caring Together – The Health Action Plan for NSW' (NSW Department of Health, 2009) in March 2009. The Action Plan responded to each of the 139 recommendations from the Garling Report and included three stages of implementation. Actions were focused on strategies to create better experiences for patients, improved safety and education, new ways of caring (models of care), and strengthening of local decision-making and methods to monitor progress. The action plan noted:

> *We need to be smarter in the way we manage demand, which will require workforce redesign and new models of care, particularly for the growing numbers of older patients with multiple chronic illnesses* (NSW Department of Health, 2009, p. 5).

A key observation offered by Alford (1975) in the 1970s in the United States is that crises in the healthcare system lead to a series of inquiries, investigations, and recommendations about how to improve the health system. This would appear to also be the case in Australia. It is this context, a health system continually ‘in crisis’ and under review, that is central to the arguments presented in this thesis. The significant costs associated with these inquiries and the lack of follow-up to determine the degree to which the recommendations are adopted are discussed throughout this thesis. Following Alford (1975), I argue that these inquires do not address the major structural interests and, as a consequence, do not achieve the desired outcomes. To illustrate this, the next section describes two further reform strategies introduced by the Federal Government during the period under discussion; the Australian Health Workforce Productivity Commission Report, and the Final Report of the Health and Hospital Reform Commission.

Australian Health Workforce Productivity Commission Report and Health Workforce Australia (HWA)

In 2005, the Productivity Commission released its report on the Australian Health Workforce and noted the need for new models of care to meet the health requirements of the ageing population. These models were not only needed to meet anticipated population demand but also because the health workforce itself was ageing. The Commission noted:

> *With developing technology, growing community expectations and population ageing, the demand for health services will increase while the labour market will tighten. New models of care will also be required* (Productivity Commission, 2005, p. XIV).

This report did not lead to any identifiable changes to the Australian health system with its findings echoed in the final report of the National Health and Hospitals Reform Commission (2009) four years later:

> *… significant increases in demand for, and expenditure on, health care due to many factors, including advances in medical technology, an ageing population, the increase in chronic disease, and the increase in consumer expectations* (p. 141).

In 2008, Health Workforce Australia (HWA) was established by the Council of Australian Governments (COAG). It commenced in January 2010 and ceased to exist on the 6 August 2014 with its functions being transferred to the Department of Health (Health Workforce Australia, 2014). It was established on a platform of coordination and reform in order to meet current and future healthcare workforce needs. Its mission was bold and was intended to cut across jurisdictional, sectorial, and professional boundaries (Health Workforce Australia, 2014). The Australian Health Practitioners Regulation Agency (AHPRA) was established in 2010 and operated under the Health Practitioner Regulation National Law which came into effect on 1 July 2010 (Australian Health Practitioner Regulation Agency, 2017). AHPRA supports 15 national boards which are responsbile for regulating the health professions in Australia.

‘A healthier future for all Australians – Final Report of the National Health and Hospital Reform Commission’ – Commonwealth led enquiry and reform in to the Health System 2008

In the lead-up to the national federal election in 2007, the public expressed concern over the on-going crisis within the healthcare system. This provided the incoming Prime Minister, Kevin Rudd, with a mandate to address these problems. He announced the National Health and Hospitals Reform Commission in February 2008 and made a commitment to address “… *the long term challenges in our system: duplication, overlap, cost shift, blame shift, ageing population, the explosion in chronic diseases, not to mention, long term workforce planning*” (Bennett, 2013, p. 251).

In 2009, the Commission released ‘A Healthier Future For All Australians – Final Report of the National Health and Hospitals Reform Commission’ (Commonwealth of Australia, 2009). The mandate of this report and its 100 recommendations was clearly articulated:

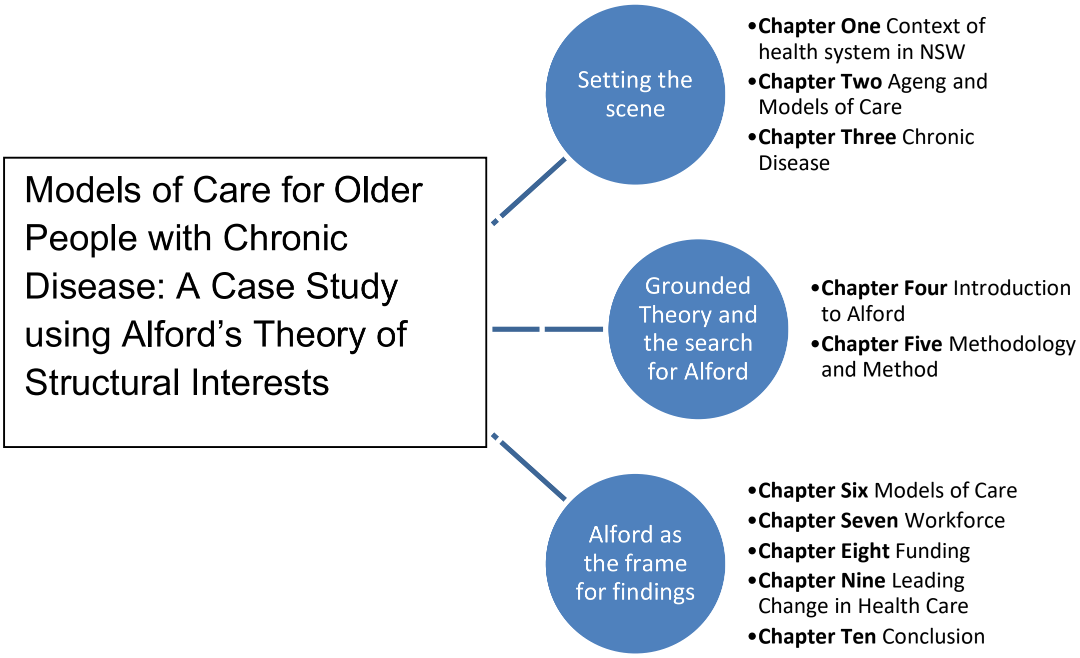
> *Tackle the major access and equity issues that affect people now; Redesign our health system to meet emerging challenges; and create an agile, responsive and self-improving health system for future generations* (Commonwealth of Australia, 2009, p. 2).

‘A National Health and Hospitals Network for Australia’s Future’ (Australian Government, 2010) mapped out structural reforms that established the financing and governance foundations of a National Health and Hospitals Network. As an integral part of this system-wide reform, the government specified that jurisdictions introduce Local Hospital Networks (which became Local Health Districts in NSW). It also led to the establishment of the Independent Hospital Pricing Authority (IHPA) which established a national efficient price for each hospital procedure (Independent Hospital Pricing Authority, 2019). The introduction of the IHPA led to even greater pressure on the NSW health system to ensure efficiencies in hospital processes and practices, and to eliminate the blockages in patient flow, such as ‘bed blocks’ in wards, given that the price per casemix was set federally and was calculated on time as well as acuity. ‘Bed block’ occurs when an older patient is stabilised but cannot be returned to their home without additional supports in place, or if they need to be transferred to another environment such as placement in a residential aged care facility (Travers et al., 2008). The label, ‘bed block’ is often seen as the major reason for ‘access block’ in public hospitals in Australia (Travers et al., 2008). I raise this contextual issue as it highlights the strong motivations in 2009/2010 to address the ‘ageing population’ and the impact they had on the hospital system. This issue, along with the federal and state inquiries underway (Garling, 2008; National Health and Hospitals Reform Commission, 2009) into the health system created an environment where there was huge pressure to change models of care to better address the needs of older people and, if possible, to keep them out of hospital. As I have also described, there was a dedicated three year program aimed at redesigning the health system, namely the Clinical Services Redesign program with a mandate to decrease the length of stay for older people in hospitals in New South Wales (Ben-Tovim. et al., 2008; MacLellan et al., 2008; Masso et al., 2010; McGrath et al., 2008; O'Connell et al., 2008; Phillips & Hughes, 2008; Smyth, 2009).

Organisation of the thesis

To provide the reader with an overall conceptual map of the organisation of this thesis the following diagram simplifies the construct:

Diagram One:



Traditionally, a literature review is conducted prior to the commencement of a research project; however, as I was committed to using grounded theory (Charmaz, 2006; Glaser, 1992; Glaser, 2007; Glaser & Strauss, 1967), in analysing the responses of the health leaders I interviewed, the literature review was undertaken iteratively. The relevant literature is presented throughout this thesis to provide context for the Australian healthcare system, models of care, and the ageing population with increasing rates of chronic disease (Chapters Two and Three). I also remind the reader that grounded theory methodology allows literature to be used from a broad time period as relevant to the themes that emerge from the data (Heath, 2006; Rolfe, 2006).

Chapter Four provides an introduction to Alford's theory of structural interests and of how other authors have used his theory to examine healthcare systems in the United Kingdom, South Korea, and Australia. Chapter Five outlines the methods and methodology used in the thesis as well as the rationale for the use of Alford. Glaser and Strauss (1967) developed Grounded Theory as a means of allowing researchers to use inductive methods to draw theory from data, rather than using the predominant paradigm of deductive research through hypothesis testing. I was guided by Charmaz (2006) and used in-vivo coding and memo writing, seeking to draw out themes from the codes. For reasons of practicality, Charmaz's method could not be strictly adhered to, as the 'health leaders' interviewed were restricted to one interview contact point. I therefore followed research that used a similar sample as my own, namely that of Baeza, Bailie, and Lewis (2009), and was guided by their methods of sampling and interviewing. I could not find traction in terms of an emergent substantive theory from the data produced from the interviews. This lead me to explore formal theories on health reform put forward by Pawson (Pawson, 2006, 2013; Pawson, Greenhalgh, Brennan, & Glidewell, 2014; Pawson & Tilley, 1997; Trisha Greenhalgh et al., 2009); Bacchi (Bacchi, 2009, 2012); Braithwaite (Braithwaite, 2006; Braithwaite et al., 2016; Braithwaite et al., 2017; Skinner et al., 2009) and Tuohy (Tuohy, 1999a, 1999b), before choosing Alford. All four are briefly summarized in chapter five and I appreciate this is unusual for a methodology and method chapter; however I felt it appropriate to guide the reader through the way my method evolved.

I ultimately chose Alford (1975) because his theory of structural interests had the greatest resonance with the research themes identified by respondents, and to remain true to the grounded theory method I chose the theory with the greatest alignment.

Findings and Discussion

The findings are presented over four chapters. The first chapter (Chapter Six) identifies the models of care that the respondents identified as being effective and which improved the care of older people with chronic conditions. The way in which they were established is described. The second findings chapter explores the issues surrounding the health workforce (Chapter Seven), and how legislation, regulation, training, job roles, scope of practice, and professional monopolies perpetuate the fundamental constructs of the health system and stymies change. In the third chapter, I focus on funding and how it both maintains the status quo and how it could play a role in driving improvements for older people with chronic conditions (Chapter Eight). Finally, Chapter Nine explores the leaders who have been able to achieve change within the health system and identifies which structural interest groups they belong to. It also explores the formation of 'temporary coalitions' of structural interest groups, as described by Alford, and how these coalitions are able to introduce change. Finally, Chapter Ten provides a summation of the key arguments presented in this thesis, outlines the limitations of the study, and provides a number of recommendations for future research.

Summary

This chapter has introduced my research questions and some of the key aspects of the design of the Australian health system during the study period. It also provides a brief overview of the environment of 'Inquiry' and stymied health reform that was evident at the time the study was conducted. The next chapter (Chapter Two) provides an overview of the ageing population, the rise of chronic conditions, and the various programs and policies that have been implemented to deal with these issues.

CHAPTER 2 AGEING AND MODELS OF CARE

Introduction

The inability of the health system to change or 'reform' was of significant concern in 2009. The design of the health system did not meet the needs of ageing people with increased rates of chronic disease (Caughey, Vitry, Gilbert, & Roughead, 2008). In order to contextualise my research questions, there are three topics that need introduction; the ageing of the population, models of care, and chronic disease. The purpose of this chapter is two-fold, the first being to provide context in relation to the ageing population, while the second is to provide an introduction to models of care. Chapter Three then provides a description of chronic disease in Australia. To recap, the research question for this thesis is '**Why is the health system so resistant to change or 'reform'?'** The research question was narrowed down to focus on older people with increased rates of chronic disease. The inability of the system to change was narrowed to focus on models of care. I examined why new models of care are difficult to implement, despite clear evidence that current models are ineffective. I assert that models of care are an expression of health policy.

The Ageing Population

The issue of population ageing has been the subject of Australian academic research since the early 1980s, including the work of Howe (1981) and later Kendig and McCallum (1990). Sax (1993) signalled that Australia was entering a phase of rapid ageing which would have significant impacts on health, housing, and welfare resources. Kendig, McDonald, and Piggott (2016) highlighted the broad range of issues that the ageing population has on public policy, society, economics, and in particular, the cost of healthcare. As highlighted by all these authors, the Australian population is ageing, meaning the median age of the overall population within Australia is increasing. Important to this research is that with advancing age also comes an upsurge in chronic diseases and morbidity (Australian Institute of Health and Welfare, 2019; Caughey et al., 2008) that have a significant impact on health, disability, and social service budgets.

It is anticipated that over coming decades, the increase in the ageing population will have implications for many Australia social services, as the number of people of working age who are able to contribute to the funding of government services through taxation reduces (working/non-working ratio), and the number of skilled workers diminishes (Australian Institute of Health and Welfare, 2018; Kendig et al., 2016).

Healthcare utilisation by older people

In the early part of this century, advances in medicine, public health interventions, and healthy living conditions, among other factors, meant that Australians were living longer. Approximately 2.9 million people, or 13.3 per cent of Australia's total population, were aged 65 years or older in 2009 (Australian Institute of Health and Welfare, 2010, p. 20), compared to 1971, when there were under 1.1 million people aged over 65 years or 8.3% per cent of the total population. When a comparison is made between these two years (1971 and 2009), the number of people aged over 85 years increased more than five-fold (Australian Institute of Health and Welfare, 2010, p. 20).

The Australian Institute of Health and Welfare reported that there were 7.4 million accident and emergency services (i.e. Emergency Department visits) in 2009, which had increased by 4 per cent each year since 2005-06 (Australian Institute of Health and Welfare, 2011). The report went on to state that there were 8.5 million separations for admitted patients which demonstrated an increase of 3.2 per cent on average for every year from 2005-2006 until 2009-2010 – this clearly demonstrated that hospital activity continued to increase every year, and it was assumed that this trend would continue unless models of patient care changed. Critically, admissions were identified as non-acute which raised the question as to why these admissions occurred. Notably, rates of rehabilitation and geriatric care also increased, reflecting acute hospital activity created by the ageing population in both the private and public sectors. As the AIHW noted:

> *… 4% of separations were for non-acute care. Between 2005-06 and 2009-10, rehabilitation care in private hospitals increased by 19% on average each year and **geriatric evaluation and management in public hospitals increased by 11% on average each year*** (Australian Institute of Health and Welfare, 2011).

In 1999-2000, there were 105 million GP services provided, with older people using 24 per cent of them while representing only 12 per cent of the total population, demonstrating that older people used GP services more frequently than younger people (Australian Institute of Health and Welfare, 2002, p. 68). As stated in the Australia's Health report by the Australian Institute of Health and Ageing, the ageing population places a greater demand on health services:

> *An ageing population, for example, is more than just a demographic trend. Simply because there are more older people, there can over time be more cases of ill health in the population, and more deaths … An increasingly older population also places extra demands on health services* (Australian Institute of Health and Welfare, 2010, p. 19).

This fact was further highlighted in NSW, where people aged over 65 years accounted for 14.4 per cent of the population, occupied 48 per cent of all acute inpatient bed days, and 36% of acute in-patient separations at a greater cost than average, and had longer average stays in hospital at 4.9 days compared to 2.7 days for people under 65 years (NSW Government, 2010, p. 4).

The baby boomers

In 2009, another significant group of Australians, known as the baby boomers (people born between 1946-1964), were about to reach retirement age (age 65 in 2011), and the anticipated demand of this population group will continue until 2030 (Australian Institute of Health and Welfare, 2002). Australia is not alone in the trend of an ageing population, as noted by Chiou and Chen in 2009:

> *The world is rapidly aging. The proportion of older persons (persons aged 60 years or over) is expected to double from 11% in 2007 to 22% in 2050* (Chiou & Chen, 2009, p. S3).

Discussing ageing in the European Union, Rechel et al. (2013) noted that:

> *The old-age dependency ratio (i.e. the ratio of people aged 65 years or older to people aged 15-64 years) is projected to increase from 25.4% to 53.5% between 2008 and 2060 – this means that the ratio effectively halves the numbers of people aged 15-64 years relative to over 65 years.*

> *[In addition] the proportion of very old people is projected to triple between 2008 and 2060* (p. 2).

The ageing population had a significant impact on acute care in New South Wales, as noted by Garling in the course of his Inquiry into the acute care system:

> *Demographic changes mean that Australia has an ageing population which will require proportionately more care as the age groups survive through their 70s and well into their 80s. In 2006-07, one-third of all public hospital patients were aged over 65 years, although that group made up only 13.5% of the state's population. By now, those aged over 65 years make up 45%, nearly one-half, of all public hospital patients* (Garling, 2008).

Ageing, frailty and disability

The physiological changes that come about through the ageing process have been highlighted by Cucinotta et al. (2004) who noted the complexity of the ageing system, its interplay with chronic illness, and the risk factors which can lead the progression from frail to disabled:

> *Physical frailty is a syndrome characterized by declines in multiple physiological domains including muscle mass and strength, flexibility, balance and neuromuscular coordination, and cardiovascular function (Binder et al., 2002). Chronic illnesses, poor nutrition, and physical inactivity contribute both to the development and to the progression from frailty to severe disability (Gray et al., 2002). This status greatly increases the risk of functional decline, institutionalization, morbidity, hospitalization, and mortalit*y (Hamerman, 1999, p. 107) cited in Cucinotta et al. (2004, p. 107).

In total, 65 per cent of women and 43.9 per cent of men aged over 85 years of age have profound or severe core activity limitations (Faulkner, 2007). As the proportion of the population over 85 years increases over the next three decades, so too will the rates of people living with disability (Australian Institute of Health and Welfare, 2002). Ageing, illness, and frailty can lead to older people requiring additional supports to remain in their own homes. In Australia, this occurs through informal networks (family, friends, neighbours) and formal networks (Commonwealth Home Support Program, Home Care Packages, self-funded in-home services). The AIHW (Australian Institute of Health and Welfare, 2004) found that in 1998, only 3 per cent of people who have restrictions on their activities of daily living through age-related frailty or disability relied solely on formal services, with the vast majority receiving assistance from both unpaid carers and through formal services (p. xii).

In New South Wales, Edelbrock et al. (2001) conducted the Sydney Older Person's study examining the use of social supports by people living in the community aged 75 years and older. Lower degrees of social support were associated with mortality, lower levels of wellbeing, and poor health (p. 173). They found that females received more instrumental support (Instrumental Activities of Daily Living such as shopping, and Activities of Daily Living such as showering, dressing, and grooming) from their social networks, reported greater numbers of people who provided emotional support, and attended more 'groups, clubs and organisations' (p. 174). Edelbrock et al. (2001) concluded that:

> *Lower levels of social support were associated with a range of sociodemographic variables including increased age, male gender, single marital status, and lower socioeconomic status* (p. 178).

In a further study, Edelbrock, Waite, Broe, Grayson, and Creasey (2003) studied 537 community dwelling people aged 75 years and over. This study examined people with the same disease or disability profile (as assessed by medical practitioners) and their patterns of service use and unpaid support. The results demonstrated that an unpaid network of support was provided for the instrumental activities of daily living (IADLs) and community services were not used, but medical services were used. The characteristics of older people who were frequent users of community services included being female, having a higher socioeconomic status, and living with fewer co-residents. Interestingly, males were found to spend more days in hospital. Edelbrock et al. (2003) concluded that:

> *… community IADL services and unpaid IADL network support work in a compensatory fashion. In contrast, higher users of medical services were greater users of unpaid network support* (p. 2).

Carers and the provision of home-based support are critical factors in assisting older people to remain in their own homes. The lack of carers and home-based supports can result in unplanned hospital admissions, and if chronic, lead to the need to enter supported care. When considering acute models of care, the ability for hospital discharge planners to co-ordinate services to put caring supports back in place for older people was a critical factor in effective discharge planning in 2009 (Bauer, Fitzgerald, Haesler, & Manfrin, 2009).

Discharge and readmission from hospital

At the time the data was collected for this study, timely discharge from hospital was a critical issue for older people with extended stays often due to an inability to return home without additional supports. Wilson, Eccleston, Marks, and Isouard (2003) found that many older people remained in hospital after the acute phase of their illness as they did not have the necessary home-based supports to allow them to return home safely. Discharge practices from the acute sector did not adequately support the older person to safely return home and their needs were not adequately catered for (Caplan, Brown, Croker, & Doolan, 1998; Cucinotta et al., 2004; Fitzgerald, Bauer, Koch, & King, 2011; Fjaertoft, Indredavik, & Lydersen, 2003; Richards et al., 1998; Wilson et al., 2003; Wong, Kong, & Wong, 2001). These included medical needs (including the effective management of multiple chronic conditions), home-based needs (if they needed assistance with their Activities of Daily Living once they returned home), and social needs (were they returning home alone, or were they the carer of an aged partner?).

In 2009-2010, the unplanned readmission rate in NSW public hospitals was 6.4 per cent, a figure that grew to 6.9 per cent in 2014-15 (Bolevich & Smith, 2015). The most common patient-related factors associated with unplanned readmissions were their age, and their poor general overall health and low socioeconomic status (Bolevich & Smith, 2015). In Chapter Six, which focuses on models of care, I describe a number of models that support discharge from acute care; for example, the Transitional Care Program which is specifically designed to support older people when discharged from hospital.

Caring and support post-hospitalisation

In the 2009-2010 period of this study, home-based support services were provided by the Home and Community Care (HaCC) program (a Commonwealth funded program) and included assistance with Activities of Daily Living (ADLs) such as personal care and domestic assistance, and Instrumental Activities of Daily Living (IADLs) such as shopping and transport to appointments (Black et al., 2004). Service workers and professionals such as personal care workers, nurses, and allied health professionals provided in-home care. The HaCC program also funded home modifications, assistive equipment and technology services.

The importance of home based supports was highlighted by Cucinotta et al. (2004) who studied the impact of additional home care attendants on older people who were discharged from hospital back in to their own homes. The control group received ‘normal care’ following discharge from hospital whilst the intervention group received 4-10 hours of additional home care by a trained lay-home care attendant. These researchers found, at the six month mark, lower mortality and readmission to hospital rates as well as lower rates of admission to institutions, (such as residential aged care), for the intervention group. In 2009, home care packages were allocated to providers by the Department of Ageing, Disability and Home Care (DADHC) in New South Wales who were responsible for the management of these Commonwealth funded packages through the Home and Community Care (HaCC) program. These packages were delivered by DADHC or a large number of not-for-profit providers. The packages were described in Chapter One.

Emergency Departments are not designed for the needs of older people

In 2008 Crilly, Chaboyer, Wallis, Thalib, and Green (2008) noted that older people were becoming an increasing proportion of those accessing Emergency Departments, and that those living in Residential Aged Care Facilities (RACF), were at greater risk of iatrogenic complications than other patient's accessing emergency services. These authors studied 6208 patients aged at or over 65 years who presented to one emergency department (ED) in Queensland from 1 July 2002 to 30 June 2003. Patients were identified who resided in Residential Aged Care facilities (RACF). One thousand and six patients were RACF residents and 5202 were not; RACF residents comprised a significantly higher proportion of admissions (76.6% versus 60.8%), ED re-presentation (66.0% versus 52.0%) and hospital readmission (36.5% versus 24.7%) (Crilly et al., 2008, p. 178). Patients from RACFs were more likely to have a longer stay in the ED, of six hours, versus five hours for older people who did not live in a RACF; they were also more likely to have a longer length of stay in hospital of five days versus three days. Given that many RACF residents are more likely to be frail, have functional impairments physically or cognitively, multi-comorbidities and/or challenging behaviours these results are not surprising. Importantly, in discussing these results, Crilly et al. (2008) concluded that patients from RACFs could potentially benefit from a '*targeted service delivery model*' (p.181). Patients from RACFs also featured as the only independent predictor of readmission which raised questions about the effectiveness of discharge practices, models of care and effective co-ordination between RACFs and hospitals.

Emergency Departments are designed for people who have experienced an episode of acute illness or trauma. The operational policies and infrastructure of emergency departments are not designed for the older patient who typically presents with a range of chronic conditions, one of more of which is in an acute phase. One example of the mismatch in operational policies is the use of the Australasian Triage Scales. In Australia, there has been ongoing debate about the adequacy of the Australasian Triage Scales to adequately represent the needs of the older patient presenting to an emergency department. Olofsson, Carlström, and Bäck-Pettersson (2012) state that chronically ill elderly patients are frequent users of emergency departments (EDs) and because of the characteristics of their presentation they are often assigned a low urgency triage category. Crilly et al. (2008) noted "*Previous models of ED care have been designed for the acutely ill and injured patient, not a medically complicated, slow moving, functionally impaired elderly patient*" (p. 182). These authors concluded that a new model of emergency department care was needed for older people, particularly the residents of RACFs, and proposed that the "*Hospital in the Nursing Home*" model of care should be considered in Australia. In Chapter Six, one of these models that emerged during the course of my study will be discussed.

Summary

In summary the population of Australia is ageing and with increased age comes an increased use of health resources. Models of care that were operational in 2009-2010 did not adequately meet the needs of older people as demonstrated by increased hospital bed days, longer lengths of stay and higher rates of re-admission. In the next section I ask what is policy and health policy in particular before moving to examine state and commonwealth policies that determine the services provided for older people with chronic conditions. This includes a discussion of advocacy groups and their influence in policy making. In the last section I define models of care.

What is policy and who makes it?

In the middle of the 20th century policy was defined by Harold Lasswell (1951) as '*the most important choices made either in organised or private life*' whilst Klein and Marmor (2006) stated that policy is '*what governments do and neglect to do*' (In Althaus, Bridgman, and Davis (2013) pp.5-6). Althaus et al. (2013) go on to define policy in terms of an *authoritative* choice made by a Government; as a *hypothesis* in terms of expressing a causal relationship and finally as an *objective of action* made by a government.

Using these various typologies, it can be argued that the models of care implemented in the public acute hospital in New South Wales at the time the research was conducted were an explicit expression by Government (NSW Health) to dictate the way care was delivered in a hospital setting. Models of care were the recipe book of how care was to be delivered and examples included GRACE (NSW Health, 2006); Community

Acute/Post Acute Care (NSW Department of Health, 2006) and Acute Care of the Elderly (ACE) (NSW Health, 2006).

Health Policies in Australia are made by the three tiers of Government (Federal, State and Local), and may be influenced by coalitions of structural interests such as political partnerships, industry (e.g. Australian Medical Association) and advocacy groups (formed by patients, consumers and carers). Senior Bureaucrats operating at the direction of their respective Minister, within the various Government Departments, along with established policies and programs such as the Medicare Benefits Schedule and the Pharmaceutical Benefits Scheme guide the operation of health care.

The first tier of Government includes Australian Government (or Commonwealth) Departments, for example, the Department of Health sets Medicare funding policy; the Pharmaceutical Benefits Schedule (PBS) is managed by the Department of Health and administered by the Department of Human Services. Policy directions also come from National Programs that are 'wired in to' State and Commonwealth co-operation via the Australian Health Ministers Advisory Council (AHMAC) (e.g. Australian Health Protection Committee (AHPC) and the Australian Population Health Development Principal Committee (APHDPC), two principal committees of AHMAC that operate through the Department of Health) (Department of Health, 2015).

The Australian Commonwealth Government is solely responsible for Aged Care funding and the associated policies that instruct the way the system operates. Two key pieces of legislation inform the provision of aged care services in Australia, namely the Aged Care Act 1997 and regulations (Commonwealth of Australia, 1997), and the Home and Community Care Act 1985 (Commonwealth of Australia, 1985). The Aged Care Act advocates a philosophy of 'ageing in place' essentially a desire to keep people in their own place of residence for as long as possible. The Home and Community Care Act guides the operation of Home and Community care services in NSW designed to provide in home care for community dwelling older people and people with a disability to allow them to remain healthy and independent for as long as possible by providing home based supports and services.

In both funding and policy direction for health services and ageing 2009/2010, the Commonwealth held the power over the states and territories. However, it was a complex landscape in terms of multiple policies instigated by both Commonwealth and state governments. In their audit of Australian chronic disease and end-of-life policies, Burgess, Braunack-Mayer, Crawford, and Beilby (2014) noted the myriad of policies at various levels of government and the sectors that guide the services:

> *In Australia, a complex web of policy, strategic plans, action plans, service delivery models and health reform processes guide the provision of chronic disease and palliative care services. These policies range across the health, aged care, community services and human services domains in federal, state/territories and local government jurisdictions* (p. 62).

State governments also prescribe policy in the areas of health, and in aged care and chronic disease management, given that they are responsible for managing and funding the public hospitals. For example, in 2009, states such as New South Wales were responsible for operating hospitals, and the policies that guided these operations were handled by NSW Health who devolved management to the Area Health Services via Area Health Service Agreements (NSW Department of Health, 2009).

Advocacy groups and their role in policy-making

National industry (e.g. Australian Medical Association) and consumer interest groups (Centre of the Ageing [COTA], Cancer Council, Alzheimer's Australia) also played an important role in setting policy and advocating for change. This is true both in Australia and in other countries as well. For example, Baggott (2011) studied the role of 'Health Consumers and Patients' Organisations' in health policy in the United Kingdom. She surveyed 312 of these organisations and found that while the majority still focused on health service provision, an increasing number were advocating for public health policy (i.e. prevention of ill health, health promotion, and early intervention). In Australia, there are powerful organisations such as the Cancer Council that not only run services and programs for cancer patients and their families, but also play a significant role in research and policy advocacy.

Government policies can also be met with resistance by powerful advocacy groups such as the Australian Medical Association or consumer groups. For example, in the 2014/15 budget, the Federal Coalition Government under Prime Minister Abbott, proposed a General Practice co-payment, as well as a proposed payment for 'GP-type visits' within Emergency Departments. Both proposals were later abandoned due to lobbying by the AMA and negative public opinion (Briton & Pha, 2014). This is one example where interest groups' successfully blocked government policy, and this is not a unique situation in the policy-making process, as noted by Bridgman and Davis (2003):

> *Government, after all, means constant trade and compromise. This is why the policy cycle includes 'consultation' to test opinion and win support — essential in the subjective world of policy-making …"* (p. 101).

Aged Care Policy in NSW circa 2009

NSW Health Policy

One of my main arguments, drawn from my own experience, but also from the interview data, is that in order to reduce the healthcare costs associated with the ageing population that result from inadequate models of care which see older people hospitalised and prematurely institutionalised, new models of care are needed. These new models of care must provide effective secondary prevention and effectively manage older person's comorbidities so that unnecessary acute exacerbation of chronic conditions do not occur. As I demonstrated in Chapter One, older people, once hospitalised have a longer length of stay, are at greater risk of iatrogenic events, and become deconditioned when confined to a hospital bed (NSW Government, 2010; NSW Health, 2006; Smyth, 2009). One preventable cause of admission to hospital is that of injuries relating to falls in older people. Milat et al. (2011) studied falls in community-dwelling older people in New South Wales in 2009 and found that 25.6 per cent of survey respondents reported having fallen in the last year. Furthermore, 66 per cent of older people who fell were injured, and 20 per cent required a hospital visit. One policy response to these and similar findings are falls reduction programs. For example, the Reduce Fall Injury Among Older People program (2003-2007) had reached the end of its life span by 2009, but Area Health Services continued implementing initiatives in relation to this policy and the NSW Health Department had started rolling out ‘Stepping On’, a falls prevention program (NSW Department of Health, 2009, p. 37). Examples of other key policies related to older people in NSW were the NSW Service Plan for Specialist Mental Health Services for Older People 2005-2015 as well as the Framework for Integrated Support and Management of Older People in the NSW healthcare system 2004-2006 (NSW Department of Health, 2004).

Commonwealth Policy

The Commonwealth Government also established aged care policy. For example, Commonwealth rules dictated the operation of the Aged Care Assessment Teams (ACAT) which was the mechanism by which older people were assessed and, if deemed appropriate, were able to access HaCC services (NSW Government, 2010). Access to programs such as HaCC are critical, as not only do they provide services to older people in their own homes, they also can assist with home modifications, which can include the installation of ramps, rails, and assistive equipment such as hoists to allow the older person to safely remain at home. This was especially important in 2009-2010 given the limited supply of residential aged care places in NSW.

The Commonwealth also set policy for the number of nursing home beds available per population. In 2005-2006, in one-third of the 71 aged care planning regions in Australia, there were on average less than three vacant residential aged care places for every 1,000 people aged over 70 years (Ergas, 2009, p. 31). This demonstrated a lack of supply of residential aged care places and led to ‘bed block’ in hospitals where older people had to remain until a residential place could be found (Travers et al., 2008), suggesting problems in the Commonwealth’s policy formulation process.

Ergas (2009) highlighted that in 2009, funding for residential aged care and community aged care packages in Australia cost 1.2 per cent of Gross National Income (GNI), and that by 2046-47, this percentage was predicted to more than double to 2.9 per cent of GNI (p. 39). The culmination of these factors created a strong economic imperative to keep Australians healthy, well, independent, and in their own home as they age. This is a significant challenge if chronic conditions are not prevented or well managed in older people.

In summary, the ageing population requires change to models of care in order to prevent acute exacerbation of chronic conditions that require expensive hospital treatment. Current models of care, such as Emergency Departments, are not designed for older people. The next section of this chapter takes a broad look at the concept of 'model of care' and how it has been explored in the literature.

Models of care

Models of care are descriptions of how care is provided in a health setting (Davidson, Halcomb, Hickman, Phillips, & Graham, 2006). A description of a model of care can take many forms from broad and generic (e.g. as described by Davidson and Elliot below) to specific and detailed (e.g. clinical pathways).

Pearson and Vaughan (in Davidson et al. (2006, p. 2), defined a model of care as "*a descriptive picture of practice which adequately represents the real thing*". Davidson and Elliott (2001) described a model of care as a "*conceptual tool*" that is "*a standard or example for imitation or comparison, combining concepts, belief and intent that are related in some way*" (in Davidson et al. (2006, p. 49).

Davidson and Elliott (2001) concluded that models of care should:

- *be evidence-based and/or grounded in theoretical propositions;*
- *be based upon assessment of patient and health provider needs;*
- *incorporate evaluation of health-related and intervention outcomes;*
- *be inclusive of consultation with key stakeholders;*
- *be considerate of the safety and wellbeing of nurses;*
- *involve a multidisciplinary approach where applicable;*
- *consider the optimal and equitable utilisation of healthcare resources;*
- *optimise equity of access for all members of society; and*
- *include interventions that are culturally sensitive and appropriate*
  (Davidson & Elliott, 2001, p. 123).

Fairbrother, Chiarella, and Braithwaite (2015) examined models of care from a nursing perspective and categorised four principal models of nursing care, namely primary nursing, individual patient allocation, team nursing, and functional nursing. The role and function of nurses are at the heart of many models of care. These models of care govern how the health professional practices in their interaction with the patient, not how the care is organised.

In the literature, a model of care is often discussed, but the term itself is not defined – leaving the reader to come to their own conclusions about the definition and the necessary elements of a model of care. In New South Wales, the Garling Report gave a working definition of model of care:

> *[A] Model of care is a description of how care is managed and organised … [it] provides the clinical and organisational framework for the service* (Garling, 2008, p. 10)

Garling went on to give emergency models of care as an example, which included Fast Track, which was a model of Emergency Department care based on the 'see and treat' model from the United Kingdom (Davies, 2007). He also noted that models of care can include clinical pathways or clinical protocols, and described methods of care at the patient level, and the clinical organisational framework at the unit level, hospital level, or even the state-wide level. Garling chose to adopt a broad based definition of models of care which is also reflected in the literature. As Balding argued, standardised models of care have the potential to provide 'high quality, consistent care' which should be available if a patient presents to Dubbo Base Hospital or to Royal Prince Alfred Hospital (Balding, 2015). Consistent statewide application of standardised models of care is one potential solution to the dilemma that Leggat and Balding (2019) identified in that "*Everyone has their own individual definition of safe, quality care',* which, in effect, represents policy governing care. As can be seen from the examples below, models may involve practice at the ward level for one professional group, through to how care is managed across a region or within a total health service.

The framework below is a method of grouping the different ways in which models of care have been described; these descriptions are an introduction for the discussion of models of care presented in Chapter Six.

- Hospital-wide models of care.
- Ward- or clinic-based models of care.
- Hospital to home models of care.
- Hospital cluster models of care.
- System-wide models of care.

Hospital-wide models of care

Hospital-wide models of care provide an overarching philosophy of how healthcare is delivered and how they are hospital-centric. Dunn, Shattuck, Baird, Mau, and Bakker (2011) described the development of a nursing model of care, known as the Lighthouse Model. This model of care described the role of a Registered Nurse in a 205 bed community hospital in the USA. In addition to professional elements of nursing, it included six beliefs, which were: coordination of care, advocacy, quality, respect, individualised care, and patient teaching (p. 8). Bakker and Mau (2012) went on to gain the patients' perspectives (or the consumer perspective) about what was included in the model of care. From the patients' perspective, they wanted to see:

> • *the concern for safety at a vulnerable time*
> • *the desire for the best outcome*
> • *the reduction of the patient's fear, anxiety, or stress during hospitalization*
> • *the patient's focus on healing and discharge*
> • *the patient's ability to have confidence in the nurses' competence*
> • *the patient's desire to have relational, individualized, respectful, and personal care* (Bakker & Mau, 2012, p. 10).

Bakker and Mau updated the Lighthouse Model to include patient safety, based on their analysis that this was the only feature of their model of care that they did not adequately articulate. In essence, this model of care prescribed clinical practice based on a health professional role, regardless of the patient’s disease type. It was applied to the whole of the hospital and could equally be viewed as a ‘professional role’ model of care. Conceptually, this model of care could be applicable to other professionals beyond nurses; however, in descriptions of models of care, they tend to be profession specific. For example, Carmichael et al. (2004) described a pharmacy system within a hospital as a model of care. Musanti, O'Keefe, and Silverstein (2012) described the functional units of registered nurse-nurse assistant partnerships supported by a patient care facilitator as a “Partners in Caring” model of care. These authors used knowledge transition methodology to inform implementation process and evaluation, to validate the model’s evidence base to ensure that outcomes would be achieved. Again, the partners in care could easily include professions beyond nursing.

Models of care can also be designed around specific patient disease types or across disciplines. For example, Dixon and Dixon (2006) described the PLISSIT model of care which was designed to assist patients who had a significant surgical intervention that resulted in sexual dysfunction. The model of care included 1. P—permission, 2. LI—limited information, 3. SS—specific suggestions, and 4. IT—intensive therapy. The first step, to gain the patient’s trust and permission to discuss sexual function, was critical. It then prescribed that the patient was assigned to team member/s with the necessary qualifications and experience to address the patient’s needs.

However, even when there is scope for a model of care to be system-wide, it is often only adopted in the true sense at the professional level, as is the case in the geropalliative model. Mahler (2010) described the implementation of a geropalliative model of care in a 721 bed healthcare facility in Boston, Massachusetts. The model of care was based on Watson’s Caring-Healing Theory, and highlighted the need for a sound evidence-base on which to construct a model of care. The implementation of this model of care was led by a Clinical Nurse Specialist and involved teaching basic palliative skills to all nursing staff, along with the implementation of assessment and care planning tools that included interdisciplinary collaboration. Again, Manning (2011) conducted a systematic review on heart failure hospital readmission to develop a usable framework for a bedside assessment tool. This allowed nurses in all wards to identify patients who were at risk of re-admission and to progress referral of high-risk patients to a Heart Failure Nurse, who used evidence-based guidelines to educate the patient on acute relapse prevention.

Ward- or clinic-based models of care

In clinic-based settings, there is also evidence of nursing-based models of care; for example, D'Amico and Nelson (2008) described a model of nursing care at a domestic violence shelter. In their model of care, they discussed the important processes that must be followed:

> *The essential steps of the process include developing a therapeutic nurse care manager-client relationship, identifying client-centered goals through the exchange of information, providing information and offering choices, identifying barriers to and motivation for change, collaborating with other professionals involved in the plan of care, implementing change, evaluating outcomes, and reconnecting with the client* (p. 30).

This is a model of care that was derived from a theoretical intervention for domestic violence, thus articulating the evidence-base.

Evidence for a model of care can also be derived from the consumer experience. Wielenga, Smit, and Unk (2006) evaluated how satisfied patients were with their Newborn Individualized Developmental Care and Assessment Program (NIDCAP®) model of care in a neonatal intensive care unit (NICU) at the Emma’s Children’s Hospital in Amsterdam. The NIDCAP is a developmental assessment which is repeated over the course of an infant’s stay in the NICU. The results of the assessment informed caregiving plans, along with information about the developmental stage of the infant and individual family needs. In using the observation tool, caregivers learned to evaluate infants’ reactions and modify the environment to meet their needs within the NICU.

Hospital to home models of care

Models of care can also be used to describe transition – from hospital to home. These models seek to prescribe how hospital staff transition patients back into the community, and vice versa. The idea is to facilitate a smooth transition for the patient from their in-patient journey back into the community, with the necessary supports and services they require to be safe within their own homes. The models of care are particularly relevant to older people as the safe transition from hospital to home is essential to prevent re-admission or further decline. These models also rely on adequate community-based services which may be outside the planning and funding brief of the hospital or health portfolio.

Models of care can also have a focus on patient outcomes. Nadash and Feldman (2003) described the clinical evidence that informed the need to establish a "restorative" model of home care. They found that 25 to 50 per cent of older people experienced functional decline during hospitalisation, while 66 per cent did not regain their function three months post-discharge. This led to the need to establish a model of care for patients at risk of functional decline after an illness or hospitalisation. The process to develop this model of care used clinical evidence from a multidisciplinary perspective, as well as incorporating knowledge from consumers and carers. The process included:

> *Develop[ment of] an operational definition of "maximizing functional independence" by:*
>
> 1. *Developing a tool to identify and track patients' functional assistance needs.*
> 2. *Identified structural, process, and attitudinal barriers to maximizing functional independence.*
> 3. *Identified strategies for overcoming barriers.*
> 4. *Tested these strategies, using small, local, short cycle changes in clinical practice, making adjustments by using the build-up of experience and data as the process unfolded* (p. 421).

From patient outcomes at one end, to acute interventions at the other, models of care have been applied to all aspects of a patient's journey, in particular, to ensure that a patient receives the right care at the first point of contact. For example, Sanders et al. (2012) developed a protocol for patients presenting to Monash Hospital Emergency Department that allowed them to triage patients who were having a Transient Ischemic Attack (TIA). They used a triage tool and ensured that such patients received rapid management in the Emergency Department that included a comprehensive assessment and clinical pathway. Upon discharge, patients were then referred to an out-patient program. Based on the triage tool, patients were assigned to appointments in the out-patient clinic based on their clinical risk. The author's model of care "pre-M3T" resulted in:

> *… most TIA patients were admitted to hospital. For the few patients discharged directly from ED, management and referral for neurologist follow-up were at the discretion of the emergency physician. Outpatient neurology referral from ED was not routine* (p. 2938).

By contrast, after the new model of care had been established, it defined a set of assessments which were mandatory, and a standardised clinical pathway designed to make the treatment of a patient who presented with TIA consistent. This model of care highlighted the various levels that models of care can operate at, either through philosophical statements about how patients should be treated, or through prescribed clinical pathways.

Hospital Cluster Models of care

Models of care can also be found operating across a group of hospitals. Krening, Rehling-Anthony, and Garko (2012) described a collaboration between Perinatal Clinical Nurse Specialists and Obstetric Nurse Educators in nine hospitals in the Colorado area who undertook a system-wide process-improvement project to increase safety for pregnant women receiving oxytocin. The nine hospitals were part of Centura Health, a non-profit, private healthcare provider. The model of care included the implementation of standardised processes and protocols based on best evidence, to reduce adverse events and improve outcomes for women receiving oxytocin. While this model of care was nurse-led, the resultant clinical pathways influenced the way the obstetricians practiced in terms of the administration of oxytocin.

Models of care operating across a cluster of hospitals can also direct the way hospital care is organised. Swick, Doulaveris, and Christensen (2012) described the introduction of a new model of care in a cluster of five hospitals in the USA, the Inova group. In their new model of care, they defined the responsibilities of the Registered Nurse (RN), which included making the RN the person responsible overall for the patient's care journey and accountable for ensuring this occurred, and for the implementation of a quality assurance system to monitor communication. A new handover model was established along with the introduction of multi-disciplinary bedside rounds. One of the major challenges was gaining the support of physicians. The authors described "*The diversity of physician practices at each hospital, legacy processes, and inconsistency in preferences created a work environment devoid of standardized work*" (p. 317). Inherent in this model of care was the assertion that standardised practice improved patient outcomes and decreased errors.

System-wide models of care

In developing a model of care for Emergency Departments (ED) in New South Wales, the driving forces were poor patient journeys, overcrowding, ambulance ramping, and 'bed block' (O'Connell et al., 2008). Traditional methods of addressing these issues were to inject more resources into the system (i.e. beds, staff). Davidson et al. (2006) stated that "*Existing models of care are often historically based and subsequently not responsive to the changing needs of contemporary health systems*" (p. 48). Therefore, it appears that adding more resources without changing the model of care will not solve the issues at hand.

In New South Wales, the Clinical Service Redesign Program (CSRP) methodology was used to map the patient journey. Disconnects in the flow of work were identified and new models of care emerged to address these disconnects. One of these models was the 'Fast Track' model of care (NSW Health, 2012), which was based on the 'See and Treat' model of care from the United Kingdom (Carson, Clay, & Stern, 2010). Critical to the success of this model of care was not only specification of infrastructure, dedicated staffing, and a multidisciplinary approach, but also the application of key performance indicators (KPIs). That is, if a patient did not enter and exit the ‘Fast Track’ area within four hours, the KPI was breached. Continual breaches of this KPI quickly indicated to management that the model was not working and that steps needed to be taken to address the issue.

The CSRP project methodology included not only consultation with key stakeholders, it also facilitated active participation in the redesign process, as well as the design, development, and implementation of the model of care. Patients’ and carers’ perspectives were also collected and shared to articulate the need for change, as often their stories were of poor experiences within the Emergency Department setting.

In response to poor patient retention, O'Connor, Osih, and Jaffer (2011) outlined a system-wide model of care for HIV positive patients in Johannesburg, South Africa who were receiving antiretroviral therapy (ART). In their model, patients who were stable on their ART for a period of at least six months, and who met five clinical criteria, were “down-referred” from a hospital-based outpatient clinic to Primary Health Care facilities. Introduction of this model of care improved retention of patients in the program.

The literature highlighted the different ways in which models of care are developed and the settings in which they are applied. Effective, evidence-based clinical practice, as well as improving patient outcomes, was the hallmark of the models. Davidson et al. (2006) noted that a model of care can be used to bridge the gap between the evidence base and current practice; thus, the introduction of a new model of care aligns current evidence with practice. In particular, the hospital-wide, cluster, and system-wide models of care exemplify the point that models of care are in fact an expression of policy, dictating or providing the ‘recipe book’ to the way in which care is delivered.

Summary

This chapter has presented the literature that relates to the central topics pertinent to this study, and included an overview of the ageing population and policy related to ageing in Australia. Significantly, older people can remain in their own homes, with a good quality of life if they have a combination of formal and informal supports and services. Importantly, their health needs must be met, and if they are hospitalised, they should then return home with additional supports as required. Australia’s population, like much of the developed world, continues to age and this raises questions about how ‘healthy years’ can be maintained and older people supported to ‘age in place’.

The second section of the chapter provided an overview of the literature and highlighted the various conceptualisations of ‘models of care’ and included discussion of the variations in the level of detail and scope of the various models described. Models of care were found within many contexts across the health system, from pharmacies, wards, and emergency departments, to hospitals, clusters of hospitals, out-patient clinics, community clinics, and home care. These models of care described how care is delivered within these settings. Standardised clinical pathways or protocols are a key feature of many of these models. The next chapter is dedicated to providing a comprehensive picture of chronic disease in Australia.

CHAPTER THREE CHRONIC DISEASE

Introduction

In this chapter, chronic disease is defined and its impact in terms of health costs is quantified in both the Australian and international contexts. The role of General Practitioners (GPs) in chronic disease management is discussed, as well as the core concepts in effective chronic disease management, namely chronic disease rehabilitation and self-management. Examples are provided of programs that were operational in New South Wales at the time the research was conducted, and are expanded upon in Chapter Six: Models of Care. The second part of the chapter focuses on chronic disease policies in Australia and New South Wales that were relevant to the time period of the study.

The research question for the thesis is: **Why is the health system so resistant to change or 'reform' as it is often described?** The research question was narrowed to focus on why change could not be achieved to improve care for older people with increasing rates of chronic disease. This chapter highlights the importance of addressing chronic disease in the community to prevent unnecessary, expensive, and risky hospitalisations for older people. Despite the recognised and projected impact of the increase in health costs for older people with chronic conditions, the inability of the system to change is also highlighted. This lack of change has resulted in the 'crisis' in Australia's health system, which has been well quantified. In addition, governments are concerned about the impact of chronic disease and ageing on Australia's health budget. Chronic conditions account for 70 per cent of total health expenditure and these costs are increasing (Feyer et al., 2014). The increasing rates of chronic disease are attributable to the ageing population, increased overall life expectancy, and lifestyle changes (i.e. an increase in sedentary behaviours). The challenge of chronic conditions and ageing are repeated in developed nations around the world (Carrier & Reschovsky, 2009; Corhay et al., 2012; Dahl, 2007; de Guzman et al., 2012; Dyer, Palmer, & Turnbull, 2006; Lynch, Estes, & Hernandez, 2005).

Chronic Disease

A chronic disease, otherwise known as a ‘chronic medical condition’, is defined by the Department of Human Services, for the purposes of the Medicare guidelines, as:

> *A chronic medical condition is one that has been (or is likely to be) present for six months or longer, for example, asthma, cancer, cardiovascular disease, diabetes, musculoskeletal conditions and stroke* (Department of Human Services, 2014).

The eight chronic diseases used for analysis by the Australian Institute of Health and Welfare are arthritis, asthma, back pain, cancer, cardiovascular disease, chronic obstructive pulmonary disease, diabetes, and mental health conditions (Australian Institute of Health and Welfare, 2019). The most recent statistics reveal that more than 11 million Australians, or just under 50 per cent of the population of 25 million, reported having at least one of the eight chronic conditions in 2014/2015, while 87 per cent of people over 65 years of age had at least one chronic condition (Australian Institute of Health and Welfare, 2019). One in three, or 39 per cent, of potentially preventable hospitalisations in 2013/2014 were due to these eight chronic conditions. One in three, or 30 per cent, of General Practice consultations are also for chronic conditions (Australian Institute of Health and Welfare, 2019). The prevalence of chronic conditions increases with age. Life expectancy at birth is currently 80.5 years for men and 84.6 years for females – over the past decade, life expectancy has increased by 1.5 years for males and 0.9 years for females (Australian Bureau of Statistics, 2018). Given this, if we use the example of a female with at least one chronic condition at the age of 65 years (but more likely, two or more conditions), on average, they will live with these disease/s for 19.6 years. The cost of medication, health treatments, aids, and the need to access both primary and acute healthcare services is significant. This highlights the need to ensure that health interventions both in the primary and the acute sector effectively treat the older person with at least one chronic disease and facilitate adequate capacity for self-care and self-management. To prevent the exacerbation of chronic conditions, new models of care are needed in the community that support older people to successfully manage their chronic conditions at home.

This issue is not new. In his discussion of the future direction of Medicare, Duckett (1995) described the need to enrol people with chronic conditions in evidence-based programs to manage their condition, involving coordinated care that would include doctors, nurses, and allied health professionals.

Chronic disease – a global issue

The challenge that chronic disease provides to health systems is common in the developed world. Alwan et al. (2010) highlighted the global impact of chronic conditions, noting that:

> *Globally, around 57 million people died in 2008, and 33 million (58%) of these deaths were due to chronic (non-communicable) diseases (mainly cardiovascular disease, diabetes, cancer, and chronic respiratory diseases)* (p. 1861).

In the United States, Medina, Haltiwanger, and Funk (2011) projected that by 2020, 157 million individuals will have chronic diseases. Chronic Obstructive Pulmonary Disease (COPD) incidence increases with age and the World Health Organization predicts that by 2020, it will be the third highest cause of mortality and the fifth highest cause of disability in the world (Corhay et al., 2012). This is echoed by Barlow, Wright, Sheasby, Turner, and Hainsworth (2002) who noted that the demographic profile is changing with longer life expectancy and increasing numbers of people living with chronic conditions. From a 2006 study of chronic disease in long-term care residents in Canada, Hirdes, Mitchell, Maxwell, and White (2011) found rates of dementia to range from 23 to 41 per cent, stroke from 12 to 31 per cent, heart failure from 9 to 21 per cent, diabetes from 20 to 30 per cent; emphysema or Chronic Obstructive Pulmonary Disease from 8.4 to 19.3 per cent, and less than 10 per cent of persons with schizophrenia or bipolar diagnosis (p. 377). Yohannes, Baldwin, and Connolly (2000) stated that in the United Kingdom, 80 per cent of all deaths due to Chronic Obstructive Pulmonary Disease occurred in people aged over 70 years, and the disease is ranked as the fourth leading cause of death in the United States. Chen (2003) stated that the number of older people aged over 65 years in Taiwan was increasing, and 76.06 per cent of these had at least one chronic disease.

Use of health resources and costs associated with chronic conditions

Current figures in Australia demonstrate that the leading causes of death are ischaemic heart disease, dementia, cerebrovascular disease, cancer of the trachea, bronchus, and lung, and chronic lower respiratory diseases – these five major causes of death account for more than one-third of all deaths (Australian Bureau of Statistics, 2019). Chronic disease requires ongoing management in both primary and acute care settings. Vetter Vetter (2005) noted the impact on hospital utilisation, with patients with chronic conditions being more likely to be admitted to hospital and to use greater numbers of inpatient bed days than those without chronic disease. However, it is not only General Practice and hospitals that are used frequently by patients with chronic disease, Gilbert et al. (2013) stated that most patients with chronic health problems in Australia see seven to eight health professionals and have approximately 80 health service appointments annually.

> *On average they will see the doctor every month and the pharmacist every eight days. The majority, 80% will also visit a specialist, usually five times per year. 80% will claim a pathology service, usually 11 claims per year, and 80% will claim a radiology service, usually 5 claims per year. Forty per cent are likely to be hospitalised within the year and the majority will also see allied health professionals* (Gilbert et al., 2013, p. 6).

These figures highlight the cost of chronic disease in terms of health service utilisation. To prevent unplanned acute exacerbation of chronic disease, effective primary care is essential; however, Chenoweth and Sheriff (2003) found that older people commonly contacted their GPs only when their illness was well established or became disruptive. If chronic diseases are to be proactively managed, support from health professionals is required before the condition becomes acute, and therefore, General Practice in Australia plays a critical role in the effective proactive management of chronic conditions. This is also true for Ambulatory Care Sensitive Conditions (ACSC), that is, hospital admissions that are potentially preventable if care had been provided in community based settings such as General Practice (Longman, Passey, Ewald, Rix, & Morgan, 2015).

Older people and their attitude towards chronic conditions

As noted earlier, people with chronic conditions are more likely to see their GP, have a team of health professionals working with them, and are more likely to require hospitalisation. Timely access to healthcare and information to manage chronic conditions, particularly recognising signs of exacerbation, are particularly important for older people; however, they are more likely to delay consulting a GP about their condition until it is well advanced. In a survey of 200 English speaking people aged over 65 years of age in urban and rural areas of New South Wales, Chenoweth and Sheriff (2003) asked these older people about health and well-being, health promoting behaviours, and perceptions about the role of their General Practitioner played in contributing to their health. These authors cited previous research that showed that older people considered themselves to be in good health if they:

> *... have close family and friendship networks, are able to live their lives in self-determined ways ... and they maintain reasonable functioning in daily aspects of living (p. 5). … The majority associated health with freedom from pain, illness, and stress, and also with optimum physical and mental well-being, getting adequate rest and sleep, and with maintaining their independence. Factors identified by half the sample included maintaining their spirituality, having financial independence, and keeping their weight down (p. 8).*

In total, 65 per cent of the respondents said they had no health or medical problems of concern. It was found that the:

> *... majority of respondents took it as a matter of course to place the responsibility for health monitoring with their doctors, and to take positive action to address health problems on the advice of their doctor. ... this highlights the power of social conditioning for these older persons in their belief that management of the health problems belongs in the realm of medicine (p. 9).*

This is an important point in the context of this research as it is a fundamental issue that needs to be addressed in care for older people with chronic disease. Effective chronic disease self-management requires the patient to be ‘activated’ (Lorig & Holman, 2003; McCorkle et al., 2011); that is to be interested in, informed about, and active in the management of their illness. Self-management requires an individual to become an active partner in the management of their disease, employing strategies on a day-to-day basis to appropriately medicate, triage crises, and take steps to prevent further complications (Barlow et al., 2002). The research by Chenoweth and Sheriff (2003) demonstrated that older people may not believe that chronic disease management is within their realm of control, as noted by Barlow et al. (2002):

> *The issue of those people who do not come forward to enrol [in self-management programs] warrants attention. Some of this group may not feel able to embrace the concept of self-management …* (p. 184).

Or in the case of older people, they may be in a fixed state where medicine has the responsibility for disease prevention and management, and is not within the realm of responsibility of, or possibility for, the individual. Lorig and Holman (2003) highlighted that this is a historical artifact; that is, one only sees a doctor if they are acutely unwell, and if they were acutely unwell, then a ‘fix’ could be provided by the doctor in the form of a procedure or a pill and the person would be cured. The paradigm has radically shifted today; the patient with a chronic condition cannot be cured, and the best that can be hoped for is maintenance of the condition so that it does not interfere with the patient's lifestyle, so they can continue to fully participate in society at the level they wish to. As Lorig and Holman noted:

> *For the first half of the 20th century, the primary reason for seeking healthcare was to treat acute illness. Thus, our healthcare system was formed to provide care for acute illness. In this system, the role of the healthcare provider was to diagnose and treat. In the second half of the 20th century, this picture changed. Chronic disease now prevails. When dealing with a long-term illness, the role of the healthcare provider becomes that of teacher and partner as well as professional supervisor. The patient must be able to report accurately the trends and tempo of the disease, make informed choices about treatment, and discuss these with the healthcare provider* (Lorig & Holman, 2003, pp. 2-3).

A fundamental change in the model of care in health is required to meet chronic disease management for older people. That is, care needs to move from the current episodic mode of health interventions in General Practice that are delivered in silos to long-term, team-based, holistic, and sustained partnerships with the patient to maintain optimum health and wellbeing. This argument is further examined in Chapter Seven (Funding).

Chronic Disease Self Management

In order to prevent acute exacerbations of chronic condition/s which lead to unplanned hospitalisation, Chronic Disease Self-Management is the 'gold standard' for effective management of conditions in order to maintain optimum health and well-being. In patients with chronic conditions, Lorig and Holman (2003) described self-management as having three tasks:

> *… medical management, role management and emotional management – and six self-management skills – problem-solving, decision-making, resource*

> *utilisation, the formation of a patient-provider partnership, action planning, and self-tailoring* (p. 1).

The term self-management implies that the *"… patient is an active participant in treatment"* (p. 1) and aims to keep *"… wellness in their foreground perspective*" (p. 1). In assessing an individual's capacity to engage in self-management, issues such as literacy must also be considered. For example, Rajda and George (2009) highlighted that older patients with poor literacy are at risk of exacerbation of their chronic disease as these skills are required to read prescription bottles, consent forms, and educational information.

Proactive healthcare teams

Primarily in Australia, patients manage their chronic disease with the support of their GP and this may include allied health professionals as required; particularly, if a patient makes use of the chronic disease management program provided through Medicare (Enhanced Primary Care packages). Many General Practices in Australia employ practice nurses who assist the GP in managing patients with chronic conditions. In the United States, Litaker et al. (2003) studied the impact of a similar program which included a nurse practitioner and a primary care physician compared to an 'existing model of care' (primary care physician alone) for patients with hypertension and diabetes mellitus. Over the course of the study, they found that while the team care approach was more expensive, patients in the team treatment group experienced significant improvements in glycosylated haemoglobin HbA(1c) and high-density lipoprotein cholesterol (HDL-c). Importantly, patient satisfaction with their care improved significantly for team-treated patients. In Australia, Foster and Mitchell (2015) found that patients were more likely to engage in a team care approach for their Chronic Disease management if there was a sense of 'personal obligation' and sufficient financial incentive. In Chapter Six, I describe the HealthOne Model of Care that was established in New South Wales during the study period that sought to engage more holistically with patients with chronic conditions who were at high risk of hospitalisation.

Another model frequently noted in Australia is the collaboration between GPs and specialists. For example, in the case of an older person with diabetes, the GP might work in collaboration with an endocrinologist. Russell et al. (2013) evaluated patient outcomes for an integrated primary/specialist care model for patients with complex type-2 diabetes compared with 'usual care' from an outpatient department within a tertiary hospital. The integrated primary/specialist model involved a GP with advanced skills in partnership with an endocrinologist. Effectiveness was measured by HbA(1c) concentrations at 12 months, serum lipids, and blood pressure. Overall, 42 per cent of patients receiving the new model of care achieved the HbA(1c) target of <53 mmol/mol (an increase from 21 per cent) and demonstrated significant improvements in blood pressure and cholesterol (LDL) readings. The authors concluded that this *"... community-based, integrated model of complex diabetes care, delivered by General Practitioners with advanced skills, produced clinical and process benefits compared with a tertiary diabetes outpatient clinic*" (p. 1112).

Effective chronic disease management by proactive supportive health teams

To maintain health and wellbeing, older people with chronic conditions benefit from self-management, and this needs to be encouraged by their GPs or their specialist. As McCorkle et al. (2011) noted, on the one hand, it is important for the patient to be 'activated' and engaged in self-management, and on the other, a supportive and proactive health team is needed. Patient involvement is particularly important, as noted by Litaker et al. (2003):

> *To succeed clinically (and economically), physicians must develop and implement chronic disease management strategies that incorporate effective patient education, promote adherence, and encourage self-management in a cost-efficient way* (p. 224).

It is also essential that in the medical management of chronic diseases that all the factors that contribute to the older person's quality of life are considered and holistic treatment plans adopted. For example, Hutchinson et al. (2015) explored the relationship between health-related quality of life (HRQoL) and comorbidities and acute healthcare utilisation in adults with chronic disease. The authors found that over a three year follow-up period, the first year comorbidities were a better predictor of hospital presentation, but over the three year period, HRQoL and comorbidities were a better indicator of acute care utilisation. The authors suggested that in the first year, bio-medical interventions should be the focus of management, and from then on, a more holistic approach should be taken to bolster HRQoL and enhance health independence. This finding is also critical given that Gilbert et al. (2013) reported that 19 per cent of older people with chronic conditions did not follow the medical advice given to them because *"... they did not agree with it (17 per cent); that it was too difficult to follow (11 per cent), or that it cost too much (11 per cent).*" Models of care that encourage self-management and respond to the unique needs of an older population are critical in the prevention of unnecessary hospitalisation due to exacerbation of chronic conditions; however, this is a challenge given that it has already been established that the majority of older people only access their GP when they are already quite unwell.

The design of primary care relies on the older person instigating a consultation with their GP. Then once assessed, the GP will conduct assessments to address the presenting issue. For an older person, there is often not a single condition, but multiple chronic conditions overlaid with complex physiological changes which occur as a result of the ageing process. For example, non-steroidal anti-inflammatories, which may be used to treat osteoarthritis, are contraindicated in people with heart failure. Similarly treatment for Chronic Airways Disease with corticosteroids can exacerbate heart failure (Gilbert et al., 2013, p. 37). For an older person, using heart failure as an example, *"... 24% will have chronic airways disease, 17% will have gout, 16% will have diabetes, 12% will have glaucoma and ... as many as 50% will have osteoarthritis"* (Gilbert et al., 2013, p. 37). Not only are there inherent treatment conflicts if Chronic Disease Clinical Guidelines are adhered to, the risk of polypharmacy also increases as does the patient not adequately understanding how to identify signs of a chronic condition entering the acute phase. As Gilbert and colleagues noted:

> *One quarter of Australians with chronic health conditions reported they did not receive clear instructions about symptoms to watch for and when to seek further care when discharged from hospital. Of more concern was that 15% did not know who to contact for questions about their condition or treatment after discharge* (Gilbert et al., 2013, p. 9).

Access to chronic disease rehabilitation programs

While many older people with chronic disease will at least have contact with their GP (and possibly a specialist) to manage their chronic disease/s, proportionally few have access to chronic disease rehabilitation programs. As the name implies, the aim of chronic disease rehabilitation programs is to improve the capacity of the individual to self-manage their chronic disease as well as to provide an opportunity to achieve functional improvement. Older people are also under-represented in the research regarding models of chronic disease rehabilitation, as noted by Austin, Williams, Ross, Moseley, and Hutchison (2005):

> *Elderly patients who are often under-represented in clinical trials, are perhaps most likely to benefit from such a multidisciplinary approach [cardiac rehabilitation] because of polypharmacy, co-morbidity, and poor health-related quality of life* (p. 411).

The under-representation of older people in chronic disease rehabilitation research is significant because if a model of care is to be effective for an older person, they have to be included in the development of the model.

The efficacy of chronic disease rehabilitation is well demonstrated; for example, Kara (2007) and McKee, Houston, and Barnes (2002) demonstrated the positive impact of rehabilitation for pulmonary and cardiac disease. Kara (2007) described the use of the Roper, Logan, and Tierney model of nursing care on outcomes for patients with chronic obstructive pulmonary disease. In their study, they recruited 60 subjects in Turkey who were assigned to treatment and control groups. In the treatment group, patients were treated with the Roper, Logan, and Tierney model of nursing care, which they described as "*Nursing care through assessment of the patient needs, … consisted of three components: (a) education, (b) exercise training, and (c) psychosocial components that include relaxation*" (p. 223). The study found that patient outcomes improved in the intervention group. Chronic disease rehabilitation not only has physiological benefits, but also psychological benefits, as noted by McKee et al. (2002) who studied the impact of rehabilitation programs on patients with COPD or cardiac disease. They found that patient's perceptions of positivity increased after rehabilitation noting the positive psychological and physical impacts of chronic disease rehabilitation.

Many authors have demonstrated that Chronic Disease Rehabilitation is effective in older people. For example, Austin et al. (2005) conducted a randomised controlled trial to determine if cardiac rehabilitation improved physical functioning and health related quality of life, and reduced re-admissions in older patients with heart failure. Patients who participated in cardiac rehabilitation programs had better outcomes on all three measures than 'usual care' (which consisted of follow-up with a cardiologist and specialist cardiac nurse). The benefits of chronic disease rehabilitation have also been demonstrated for older people; for example, Pulignano et al. (2010) explored which older patients (over 70 years) with heart failure, benefited the most from Disease Management Programs (DMP) in an outpatient clinic. These authors found that patients who were assessed to have mild to moderate frailty achieved significant improvements; and those with higher frailty scores also demonstrated improvements. In contrast, patients who were not frail did not demonstrate significant benefit. The study was able to demonstrate cost savings for moderately frail patients, but not for non-frail or severely frail patients; therefore, the DMPs were less costly and more effective than usual care in moderately frail patients. These authors concluded that a multi-dimensional assessment of frailty is a useful assessment to inform the selection of the most effective model of care.

Even the older of the old can benefit from chronic disease rehabilitation, as noted by Arena, Greenspan, Tevald, and Haas (2003) who studied the effectiveness of pulmonary rehabilitation with female patients of advanced age (>70 years) with mild to moderate chronic obstructive pulmonary disease (COPD). They found that aerobic exercise training was safe and effective for this group of patients and was important given the prevalence of COPD with advanced age, with a rising trend in females being diagnosed. Corhay et al. (2012) studied the impact of a six month intensive outpatient pulmonary rehabilitation on three age groups of people with COPD. Group A had an age range of <65 years; Group B 65-74 years, and Group C >75 years. They raised the assertion that some clinicians question the effectiveness or benefits of pulmonary rehabilitation in people aged over 75 years. However, this study found that pulmonary rehabilitation was efficient in all three age cohorts participating in the study with benefits found at 3 and 6 months and sustained at 12 months post-treatment. Pulmonary rehabilitation included education about self-management, the effective use of drug treatments, aerobic exercise and muscle strength training, inspiratory muscle training, nutritional advice, and psychosocial support.

Courtney et al. (2012) identified 128 patients aged over 65 years who were at risk of readmission to hospital. A total of 64 patients received an individually tailored exercise program, home visits, and regular telephone follow-ups for 24 weeks. Compared to the control group (64 patients), significant improvements were found in Instrumental Activities of Daily Living and the Walking Impairment Questionnaire, with the greatest improvements evident at 4 weeks following discharge. The authors noted the importance of physical activity in both primary and secondary prevention for older people with chronic disease, as well as the importance of returning older people to their levels of pre-morbid functioning through access to a rehabilitation program.

Chronic Disease Rehabilitation in New South Wales

As Australia's population ages and the number of people with chronic diseases increases, not only in number of individuals affected, but also in the number of years individuals are living with a chronic disease, care models that support effective chronic disease rehabilitation and management become increasingly important. It was a stated goal of NSW Health during 2009/2010 to increase the number of people using chronic disease rehabilitation programs in order to prevent avoidable hospitalisation.

Alternatives to hospitalisation were also explored, particularly in the context of end-of-life care, and the 2008/2009 NSW Health Annual Report highlighted work being undertaken by some Area Health Services in end-of-life decision-making through the use of advance care planning (NSW Department of Health, 2009, p. 285).

In 2008, NSW Health developed a business case to invest in the continuum of care for people with chronic disease, in particular, access to chronic disease rehabilitation and the promotion of self-management. The target groups were patients at risk of unplanned hospital stays or Emergency Department visits. Five high-risk chronic diseases were targeted as they caused the highest number of hospital admissions (NSW Agency for Clinical Innovation, 2013). The chronic diseases included diabetes, congestive heart failure, coronary artery disease, chronic obstructive pulmonary disease, and hypertension. Funding to Area Health Services commenced in 2009/2010 and the total investment was $200 million over a six year period (Feyer et al., 2014). An independent evaluation of the program was commissioned in early 2011 and released in May 2014. This report highlighted the importance of the program given the impact on in-patient bed days for this population (Feyer et al., 2014). The evaluation report noted:

> *With older people and those with chronic disease utilising a significant proportion of health services in NSW and accounting for almost half of total acute inpatient bed days, a new model of coordinated, joined-up, and shared care was mandated* (Feyer et al., 2014, p. xiv).

Advance Care Directives

Advance Care Directives have been actively promoted in Australia over the last two decades, with some states introducing legislation and policy to support their adoption. In a special feature in *The NSW Doctor* journal, it was noted that 85 per cent of Australians expect to have to care for the health needs of their ageing parents, yet 64 per cent of these respondents had not spoken to their parents about the medical treatment they would or would not want (The NSW Doctor, 2014). This highlighted the need for families to have such conversations early, and a part of continuing advocacy for people to consider Advance Care Directives or Enduring Power of Guardianship.

End-of-life care is a critical component of effective chronic disease management. Chung, Gordon, Yang, and Bell (2004) studied the impact of having a caregiver at the end of life. They compared the characteristics of dying among 1,112 older people who either had, or did not have, a primary caregiver. Those with a primary caregiver were more likely to have entered hospice care earlier, have hospice care, have a longer hospice stay, and to die at home. They were also less likely to die of chronic disease or preventable ambulatory care sensitive conditions. The inclusion of Advance Care Planning in Hospital in the Home models of care are discussed further in Chapter Six.

Chronic disease policy in Australia and New South Wales – circa 2010

Chronic disease in Australia is informed by national policy through the Australian Population Health Development Principal Committee, one of two key committees reporting to the Australian Health Ministers Advisory Council. The management of chronic disease is also informed by Medicare funding, particularly for General Practice, issued by the Australian Government, Department of Health. State policy is led by NSW Health, Area Health Services, and local hospital and community health policies.

National Policy

The National Public Health Partnership was replaced by the Australian Health Protection Committee and the Australian Population Health Development Principal Committee (APHDPC) in 2006. These were the two principal committees of the Australian Health Ministers Advisory Council (National Public Health Partnership, 2010). The Australian Population Health Development Principal Committee was made up of senior health bureaucrats from each jurisdiction. The Committee incorporated the previous National Health Priority Action Council, its expert advisory sub-committees, and the National Public Health Partnership, in particular, the Chronic Disease and Injury Prevention Working Group and the National Obesity Taskforce. In the period under discussion, the APHDPC’s stated purpose was to coordinate national efforts towards an integrated health development strategy that included primary and secondary prevention, primary care, chronic disease, and child health and wellbeing (National Public Health Partnership, 2010).

In 2002/2003, the Australian Health Ministers' Advisory Council approved the development of the National Chronic Disease Strategy – a policy designed to provide the strategic direction for the prevention of chronic disease and the care of people with chronic diseases. The policy was released in 2006. In addition to the strategy, five National Service Improvement Frameworks were developed in the areas of asthma, cancer, diabetes, heart, stroke and vascular disease, osteoarthritis, rheumatoid arthritis, and osteoporosis (National Health Priority Action Council, 2006).

The Medicare program designed to assist people with chronic disease was called the Enhanced Primary Care (EPC) Program and was first implemented in November 1999 (Gibson, Moorin, Preen, Emery, & D'Arcy J. Holman, 2012). Its aim was to reduce avoidable hospitalisations in people with chronic disease by enabling GPs to plan and coordinate healthcare for patients with chronic conditions. As stated by Gibson et al. (2012), the Medicare Benefits Schedule described the new item numbers:

> *These items comprised annual health assessments, multidisciplinary care plans, and case conferencing reimbursement (Department of Health and Aged Care, 2000-2005). The annual health assessments are limited to patients aged 75 years and over to assess whether preventive or educational services should be offered to the patient (Department of Health and Aged Care,* p. 2).

The EPC was renamed the Chronic Disease Management Program (CDMP) in 2005 (Department of Human Services, 2014). Once a patient had an EPC, they became eligible to access five Medicare claimable nursing or allied health services in a calendar year (Gibson et al., 2012). While the uptake of EPC's has been slow, they have demonstrated the increased activity of GPs in team care arrangements and in allied health referrals (Britt et al., 2010). Britt et al. (2010) analysed data from April 2000 to March 2005 as part of the BEACH program, a continuous national study about General Practice activity in Australia. During the period, the authors identified 1,071 EPC MBS items (0.3% of all activity over the study period). The BEACH data demonstrated that GPs engaged in EPC activity referred to other healthcare providers at four times the rate of average General Practice encounters. Referrals to allied health professionals were eight times higher than to the average General Practice – this activity demonstrates a willingness to move towards a more multidisciplinary approach to chronic disease management.

New South Wales Chronic Disease Policy

Key policy documents have informed chronic disease activity in NSW, including The NSW Chronic Care Program (2000), The NSW Chronic Disease Prevention Strategy (2003-2007), The Rehabilitation for Chronic Disease Guidelines (2006), The Chronic Care for Aboriginal People Program (2008), and the Integrated Primary and Community Health Policy (2007-2012). All of these policies were developed by NSW Health. General Practice plays a critical role in the management of chronic conditions. In 2009, NSW Health was in the early stages of the establishment of GP Super Clinics and HealthOne to further facilitate and support multidisciplinary team-based care – these models are expanded upon and discussed in Chapter Six.

Summary

In summary, chronic disease is increasing as the population ages. Not only has the prevalence of chronic disease increased, but also the number of years people live with these condition/s. While many older people have access to at least one type of chronic disease management through their GP or specialist, many do not have access to chronic disease rehabilitation. Even when older people do have access to chronic disease rehabilitation, it is vital that the adopted model of rehabilitation accounts for the unique needs of the older person in relation to their own healthcare; that is, is it something they believe they have control over and can influence, or is it primarily in the hands of their GP or specialist? This perspective is not only important to recognise in primary care, but also has equal applicability in the acute sector.

In order to prevent ‘expensive’ and ‘risky’ hospitalisation in older people with chronic conditions, effective community-based care is required. This is a combination of an ‘activated’ patient committed to self-management and a proactive and responsive healthcare team. An older person has a greater chance to successfully self-manage if they have access to chronic disease rehabilitation. Chronic disease rehabilitation has been proven to be effective for older people. Policy exists at both the Commonwealth and state levels that advocate for the effective management and treatment of chronic conditions, with NSW Health dedicating funding to improving access to chronic disease rehabilitation during the study period. The next chapter focuses on the theoretical framework I ultimately used to understand my interview themes, that of the work of Alford (1975) and his theory of structural interests in healthcare reform.

CHAPTER FOUR: ROBERT ALFORD, INTEREST GROUP THEORY, AND HEALTHCARE REFORM

Introduction

In 1972, political sociologist Robert R. Alford turned his attention to New York City's healthcare system (Alford, 1972). This chapter outlines his seminal work "Health Care Politics: Ideological and Interest Group Barriers to Reform", and provides examples of its continued relevance as well as a critique. Prior to writing his book in 1975, Alford wrote a paper in 1972 which argued that healthcare reform failed due to the methods used to drive change, namely market reform or bureaucratic reform. In an effective market-based approach to reform, the inefficient practices of the medical profession could be erased by the savvy consumer who purchases health like any other commodity. The logic of this position is that poor quality products fail to survive in the marketplace. In this market-based paradigm, the autonomy of doctors to operate as independent agents is paramount, as well as their ability to have control over their services, fees, and how they work with hospitals. Conversely, the Bureaucratic Reformers wish to bring the medical profession under their control in order to achieve co-ordination, eliminate fragmentation, and drive efficiency to maximise the utility of the health dollar. The consumers want efficient, affordable, and accessible healthcare. In his 1972 paper, Alford wrote, "*Although the paper generalizes from the scholarly literature as well as from documents and from interviews which took place in New York City, it should be regarded as a set of "outrageous hypotheses*" (Alford, 1972, p. 1). The central argument of his theory is that there are three structural interest groups that operate in the health system: the 'Professional Monopolists' (doctors); the 'Corporate Rationalists' (administrators), and the 'Equal Health Advocates' (consumers). Alford argued that the medical profession held the balance of power and stymied any reform that was not in their interests. He backed up his hypothesis drawing on a series of commissioned inquiries into the healthcare system within the state of New York conducted between 1950 and 1971, and demonstrated a lack of tangible health reform.

The final section of this chapter describes how I used structural interest theory to explain the failure of the various health reforms in the public healthcare system in NSW, as identified by the respondents. I use models of care, which are an expression of health policy, as the measure of successful health reform. I defined a model of care as demonstrating that health reform had been achieved when it was implemented on a state-wide basis.

Alford (1975) was a highly respected political sociologist, and an accomplished pianist and craftsman. His 1975 book won him the C. Wright Mills Award from the Society for the Study of Social Problems – his work was recognised as the best book published in the United States in 1975 that addressed social problems (The Graduate Centre, 2003). In order to understand Alford's analysis, I will briefly explain the design of the US health system in 1975.

The American Healthcare System, circa 1975

In order to explore Alford's argument, it is necessary to describe some of the key elements of the US healthcare system in the 1970s, and in the state of New York in particular, that he saw as pertinent. These elements were an over-reliance on in-hospital care, overcrowded emergency rooms, the difficulty of getting doctors to engage in community-based care, over-prescribing, and a system that was highly dependent on fee-for-service to the exclusion of the poor. As he noted, this was partly explained by the unique position of organised medicine following the reforms of the Flexner Report in 1910, and the Hall-Burton reforms of 1946-1971.

The health system in the United States was described by Alford (1975) as being in a constant state of crisis due to rising costs and poor health outcomes, with infant mortality higher and life expectancy lower than in other comparable countries. This state of crisis had been ongoing since the 1930s, and costs had risen exponentially and faster than the overall economy.

Funding for health interventions was provided through universal programs such as Medicare and Medicaid, or through health insurance. Medicaid is a government-funded health insurance scheme for the poor which, from 1965, was funded by the state and Federal Governments. Medicare is a universal government-funded program for people aged over 65 years, or for younger people with a disability. Private health insurance, which is paid for by employers or individuals, was provided through Health Maintenance Organizations (HMOs) which provided a variety of products that funded primary and acute care services. Inevitably, there were those who fell between the cracks of these funding programs and were not insured – a problem that is as real today in the United States as it was during the period of Alford's 1975 study (Davis, 2007).

A key observation Alford (1975) made of the New York health system was the dominance of 'in-hospital care' and the over-hospitalisation of patients, which then resulted in system blockages in emergency rooms. Quite simply, patients were occupying hospital beds who did not need to be there, and it was estimated that this applied to 20 per cent of all patients. He wrote:

> *The Homestead Plan was initiated, according to the commission in 1957, "after a series of studies … showed approximately* ***twenty percent*** *of the patients in municipal hospitals did not need hospital services* (Alford, 1975, p. 37).

Access to General Practice, ambulatory care clinics, and outpatient services was difficult due to a paucity of clinics and physicians willing to undertake this type of work. The physicians held a monopoly on how healthcare was delivered, and favoured work practices centralised in hospitals leaving uneven access to services and massive gaps in community-based healthcare. Various funding programs attempted to fill these gaps during the period of Alford's 1975 study; for example, Neighbourhood Family Care Centres and Community Mental Health Centres. Alford (1975) quoted from the 1966 Haldeman Report, which noted:

> *Present organizational patterns and methods of administering and distributing services are outmoded, result in inefficient use of the City's total health resources, and are not always responsive to the health needs of the population. For the most part, the pattern of health services is characterized by uncoordinated effort, imbalance in distribution or, in some instances, critical shortages, disparity of quality, inadequacies in financing, and a variety*

> *of administrative and legal barriers to the provision of coordinated and comprehensive health services* (Alford, 1975, p. 42).

In the Kennedy-Johnson years, Medicare and Medicaid were established along with the expansion of the private health insurance schemes (Roberts & Bogue, 1975). By the 1970s, there was growing concern about increased health costs as well as the effectiveness of medical care. In the examination of perceived ineffective healthcare, the concern regarding unnecessary interventions was noted by Roberts and Bogue (1975):

> *Evidence of the delivery of ineffective or unnecessary services has begun to accumulate. Such overutilization includes unnecessary surgery, over-hospitalization, and over-prescribed or misprescribed medication. Moreover, using a criterion of empirical efficacy as measured by changes in health status rather than the norm of prevailing medical practice might result in a higher percentage of services being categorized as unnecessary. Perhaps the most provocative finding is that such overuse often seems to result from oversupply (e.g., excessive surgery is associated with too many surgeons relative to population)* (p. 643).

Alford (1975) referred to municipal and voluntary hospitals throughout his description of the hospital system in the United States. Municipal hospitals were funded through federal payments for Medicare and Medicaid patients and operated by the states, while the voluntary hospitals were funded and controlled by the private health insurance industry (Jonas, 1971). While the funding and control mechanisms of the two systems were different, Jonas (1971) noted that the doctor and patient roles within them were the same:

> *The patterns of practice are generally established by physicians. In the United States, the patterns of practice in both the public and private sectors are largely defined by the fee-for-service private practice system which prevails in most parts of the country. The fee-for-service system defines not only how*

> *doctors and patients relate to each other but, to a great extent, the organization and functioning of the majority of hospitals as well* (p. 918).

Two major influences on the design and organisation of healthcare were the Flexner Report on medical education (to improve quality) and the Hall-Burton reforms 1946-1971 (to improve access) which increased the number of hospital beds made available over that period.

The current model of medical schools were established in America following the Flexner Report in 1910, which called for strict regulation of the schools by medical professionals themselves modelled on the Johns Hopkins program. The Flexner Report was instigated in response to concerns about the quality of medical care provided by doctors. At that time, the Johns Hopkins model was the only undergraduate program in the USA where the teaching program was linked to medical research (Roberts & Bogue, 1975). The recommendations of the Flexner Report were welcomed by the medical community who supported the closure of 'inadequate' facilities as the *"… oversupply of unqualified physicians was lowering the earnings and prestige of the profession …"* (p. 638). Roberts and Bogue also noted that during this same period, specialised medical boards were established and professional licensing procedures introduced. The ownership of the doctors over medical education, medical research, and how hospitals operated was firmly established during this period. The introduction of the Medical Board and professional licensing processes entrenched the power that doctors had to accept or reject applicants into the sub-specialties. The overarching paradigm at this time was that doctors were the only profession that could lead and manage the operation of hospitals (Roberts & Bogue, 1975). As Alford (1975) stated, the hospital was seen as the 'doctor's workshop' arranged through the power of doctors over education, research, and hospital activity.

In 1946, the Hill-Burton program saw the hospital system staffed by doctors who had been trained in medical schools funded by the Federal Government (Roberts & Bogue, 1975, p. 640). The Hill-Burton Act increased the number of hospitals in all states across the country, and also provided grants to build hospitals to provide care for the poor, as well as others in the population.

The Flexner Report and the Hill-Burton Act firmly established the structural power of doctors in the healthcare system. It gave them autonomy to practice as they saw fit with accountability only to those on their relevant Medical Board. The proliferation of hospitals and beds during the subsequent period saw a growth in healthcare expenditure that became a serious concern in the late 1960s leading to a period of ‘Inquiry’ and ‘reform’, as Alford (1975) described it.

Alford’s theory of structural interests

It is within this context in the early 1970s that Alford developed his ideas about the failure of successive attempts at healthcare reform over the previous 20 years. He identified three interest groups; the dominant, the repressed, and those who challenge structural interests. He named these, the ‘Professional Monopolists’, the ‘Corporate Rationalists’, and the ‘Equal Health Advocates’. All three groups attempt to use their influence to shape the healthcare system in particular ways, and to achieve improvements. However, agreeing on which improvements (changes) would benefit the system remains an area of contestation. Contention reigns, and while these three interest groups struggle between themselves, change is stymied (Alford, 1975).

In the rare event that agreement is reached, while funding is won and improvements are achieved, a dominant group or groups have aligned themselves with political interests – the changes are at best piecemeal, and ultimately lead to further fragmentation of a system where cohesion is the aspiration. Because these coalitions are temporary, ideologically discordant compromises are often made, which degrade the potential for real change.

The other key concepts in Alford’s theory were the positions that interest groups take. Alford (1975) argued that the ‘Professional Monopolists’ rarely have to take the stance of the ‘challenging’ interest, as their interests are inherently protected by the design of the health system and the power of the medical schools, professional associations, and medical licensing bodies. Bio-medicine was the dominant model of healthcare delivery in the 20th century, and it is upon this foundation that medical dominance reigns even in the 21st century. This has led 'Corporate Rationalists' and 'Equal Health Advocates' to vie for the position of 'challenging' interest groups – forming temporary coalitions when common ground can be found. Commenting on the dominance of organised medicine, Alford (1975) stated:

> *Dominant structural interests are those served by the structure of social, economic, and political institutions as they exist at any given time. Precisely because of this, the interests involved do not continuously have to organize and act to defend their interests; other institutions do that for them* (p. 14).

Hunter (2004) stated that Alford (1975) characterised two types of reformers as 'market reformers' and 'bureaucratic reformers'. The 'market reformers':

> *"... hold state involvement in health care and bureaucratic complexity responsible for the ills of the health care systems; and 'bureaucratic reformers', who claim that the defects are all the fault of those who subscribe to markets and competition ..."* (p. 51).

Regardless of the reformer type, the changes introduced tend to fail because they do not take into account the ways in which groups within the healthcare system use their dominance to either maintain the status quo, or achieve their desired changes.

'Professional Monopolists'

The dominant structural interest group are the 'Professional Monopolists'. These are the doctors – their medical schools, the specialty boards which govern them, and their associations (such as the American Medical Association). The medical profession within the USA has maintained a close hold on membership to its professional ranks through the American Medical Association and the elite Colleges for the Specialties and General Practice. The strong association between medical science and rigorous training programs also maintained their high esteem, and after the two World Wars (1914-18 and 1939-45), they were increasingly consulted by governments in relation to health issues. Recall the earlier description provided by Roberts and Bogue (1975) and how the Flexner Report shaped medical education in the United States in 1910; Flexner believed that if a nation developed and applied scientific knowledge, the quality and effectiveness of healthcare would increase. Research conducted by the universities would be linked to patient care, and this would be practiced in the hospitals that were linked to the medical schools. This would, in turn, be accompanied by a rise in specialised medical societies and licensing. The assumption during the early 1900s in the USA, as suggested by Roberts and Bogue (1975), was that patients could not make decisions about what kind of care they required, or who was appropriately qualified to provide it; therefore, this should have been left in the hands of qualified doctors. The role of monitoring and improving the quality of medical care, education, and research was given to the medical profession with the authority to do so being provided by the state. These authors noted that much of what is wrong with the healthcare system has its roots in this design – once a doctor obtains his/her license, there are almost no legal restrictions on what procedures they can undertake or introduce. There is also a complete lack of external controls that are observed in other industries, such as with the introduction of new drugs or the licensing of airline pilots (Roberts & Bogue, 1975, p. 639).

The ‘golden age’ of medical dominance in Australia has been described by Evan Willis as being the four decades from the 1930s to the 1970s (Willis, 2006). He argued that doctors dictated the autonomy of their work and the work that other healthcare professionals could undertake, and acted as ‘institutionalised experts’ in all matters relating to health in society, which he labeled as a form of ‘sovereignty’ (Willis, 2006, p. 422).

The dominance of the medical profession in Australia has also been recognised by Kenny and Duckett (2004):

> *The services of medicine have been indispensable to government and the community and, in return, medicine has achieved power, elitism, and financial gain. Traditionally, doctors have controlled and directed medical knowledge in an absolute manner and this has been the basis of increasing power and dominance* (p. 1059).

Edwards and Saltman (2017) examined the characteristics of public hospitals in the United States and the roadblocks to change – in their examination, they identified structural dysfunctions – the dysfunction that comes with professional health sector organisations and the dysfunctional dimensions that are added when an organisation is politically managed. These authors highlighted the dominance of the doctors and specialists and their power to resist change:

> *… the macro and micro political power of the medical profession to exert influence is considerable and well documented. Their trusted position in society, control over how resources are used, their monopoly of special knowledge and other sources of power, deference, and influence are very significant in both creating and slowing institutional as well as organizational change* (p. 5).

Authors such as Ross (1999) have observed that physicians are endorsed by their professional boards and are then expected to abide by their standards, among which patient care is assumed to be the most important goal. He stated, "*Physicians are certified by the profession and its specialty boards and are expected to adhere to professional standards. The professional is assumed to be dedicated to the patient's well-being*" (p. 602). However, as quoted by Alford (1975), the Rockefeller Committee Report (p. 38) stated that "*Most clinics serving poor people are structured for the convenience of the doctor, not the patient*" (p. 182). This flies in the face of a profession oriented towards patient wellbeing. Alford (1975) went on to quote the Rockefeller Committee Report (p. 17), "... *without quite saying so, attributed many of the defects of health care to the interests of the physicians, the "dominant profession*" (p. 181). Mirror images of these professional entities can be found in the United Kingdom and Australia. Jennings (1998) who studied the medical profession in South Australia from 1836-1975, observed that the profession rose from one of a diverse group of 'trades' to a professional and cohesive group held in high moral, social, and economic regard. He attributed the rise to the registration of medical practitioners through the statute at state level, effectively registering the profession and giving them self-regulation that allowed their professional dominance to flourish.

‘Corporate Rationalists’

The ‘Corporate Rationalists’ are the bureaucrats in the various layers of government departments that fund healthcare (in Australia, government funds 70 per cent of healthcare, (Duckett, Breadon, Weidmann, & Nicola, 2014) or in private health insurance companies. As a consequence, the ‘Corporate Rationalists’ are constantly looking for ways to increase effectiveness, efficiency, and outcomes to ensure the health dollar goes as far as possible. Governments often lead the charge in seeking to provide the greatest return on investment for the health dollar.

‘Equal Health Advocates’

Consumer or advocacy groups were termed by Alford (1975) as ‘Equal Health Advocates’ representing the ‘repressed interests’. These groups advocate for the best healthcare – effective, efficient, respectful, timely, and seamless for themselves and marginal groups.

Other researchers have applied Alford’s theory to the health systems in the United States, the United Kingdom, and Australia, and these studies have highlighted that consumer advocacy is more mobilised and powerful today than it was in 1975. The foundation for consumer health advocacy in the United States was set by President Kennedy in 1962 with the introduction of the Consumer Bill of Rights (Heath, 2018). This Bill provided for four basic rights: 1. The right to safety; 2. The right to information; 3. The right to choose; and 4. The right to be heard. In 1985, the Bill was expanded to include the right to access basic needs (including healthcare), consumer education, and the right to a healthy environment (living and working environments) (Heath, 2018).

In her memoir of consumer activism since the 1970s in Australia and, in particular Victoria, Epstein (2013) noted that the consumer movement began as a largely ‘kitchen table’ exercise. She observed that the 1970s were a vibrant time for activism with protests against the Vietnam War and Aboriginal Rights. Prime Minister, Gough Whitlam had succeeded in galvanising social justice into the Australian psyche, including the right to access universal healthcare and public education through the establishment of Medibank.

The United Kingdom has probably done more to enshrine the place of the consumer in their public health infrastructure with funding conditions stipulating the need for community representation on Boards of Primary Care Trusts and various commissioning bodies. However, the voice of these groups usually only influences real change when their opinion aligns with government (the Corporate Rationalists) (Harrison (1999).

Temporary coalitions formed by structural interest groups

Alford's theory places the medical profession in a position of monopoly and as structurally dominant in the inherent design of the health system. 'Corporate Rationalists' and 'Equal Health Advocates' are left to vie for territory to effectively challenge the dominance of the monopolists, but most often, they remain repressed. 'Corporate Rationalists' are usually synonymous with funding bodies and therefore have some ability to challenge medical dominance through funding policy; however, unless carefully managed, this can backfire when the medical establishment mobilises public sympathy. 'Equal Health Advocates' form temporary alliances with 'Corporate Rationalists' or 'Professional Monopolists' depending on the nature of the issue. Examples of how these alliances play out are provided in the next section of this chapter, which explores how other researchers have applied Alford's (1975) work. The table below provides examples of Structural Interest Group members in Alfordian New York and today in Australia. A summary of Alford's three structural interest groups is provided in Table 4.1 with the relevant organisations for both Australia and the USA.

Table 4.1: Alford's structural interest groups, Australia and USA

Structural Interest Groups	United States 1975	Australia 2009
'Professional Monopolists'	American Medical Association (founded in 1847). Medical Boards. Medical Schools. Professional Associations.	Australian Medical Association (founded in 1962) and the Royal Colleges. Medical Schools. Professional Associations.
'Corporate Rationalists'	Federal Government.	Federal Government

	Health Management Organisations.	through Medicare. State Government. Private Health Insurance Companies. Private Hospital Boards.
‘Equal Health Advocates’	Manhattanville Health Group (Alford, 1975, p. 151).	Consumer Health Forum of Australia.

Alford’s New York Health Care system circa 1970

The US Health System’s universal problems, including fragmentation and poor coordination, were studied by Alford (1975) using New York City as a case study to analyse in detail these problems and why continued claims of ‘crisis’ were met with a panacea in the form of a ‘Commission of Inquiry’. Writing in 1975, he noted:

> *I am concerned with how a complex system of organizations handles a problem – in this case, how the New York City health agencies handle the problem of utilizing federal and state funds to establish ambulatory care centres, and how “crises” are handled by mobilizing a commission of investigation*. (Alford, 1975, p. 19)

In order to support his argument, Alford (1975) examined seven reviews of the New York healthcare systems conducted between 1950-1971. He explored the problems examined by the reviews, analysed how they were constructed, and looked at the prescribed solutions. Alford (1975) identified that the reports failed to look back to what previous reviews had considered and analysed, which solutions had been recommended, and if these recommendations had been acted upon.

Commentating some 30 years later, Hunter (2004) observed that the health system studied by Alford (1975) was in ‘crisis’ due to rising demand and costs, and was inherently resistant to change and characterised by reform fatigue:

> *Alford’s analysis remains invaluable in helping to understand why reform fatigue has become a feature of health care systems and why many of the desired changes have either, at best, not realised their full potential or, at worst, simply failed. He describes the situation as one of ‘dynamics without*

> *change'. Regardless of the precise nature of the various reforms of health care systems that have been both proposed and implemented, they become absorbed into a system that is enormously resistant to change* (Hunter, 2004, p. 51).

The 'Commissions of Inquiry' (referred to as reviews) examined by Alford (1975) were:

1. The Kogel Report (1950): Needs of the Department of Hospitals.
2. The Heyman Commission (1960): Health Services in New York.
3. The Eurich Report (1960): New York City and its hospitals.
4. The Haldeman Report (1966): Medical Economics.
5. System Development Corporation (1966): System Analysis and Planning.
6. The Piel Commission (1967): Community Health Services for New York and Staff Studies.
7. The RAND Institute (1971): Mental Health Service Delivery.

At this point, it is deemed useful to briefly remind the reader of the situation in New South Wales in the first decade of the 21st century when there were also a similar series of 'inquiries' and investigations into the New South Wales and the Australian* health system. These were the:

1. Final report of the Special Commission of Inquiry into Campbelltown and Camden Hospitals (2004).
2. Joint Select Committee on the Royal North Shore Hospital. Report on Inquiry into the Royal North Shore Hospital (2007).
3. *A Healthier Future for All Australians – Final report of the National Health and Hospitals Reform Commission (Commonwealth of Australia, 2009).
4. Final report of the Special Commission of Inquiry Acute Care Services in NSW Public Hospitals (Garling, 2008).

As Alford (1975) recognised, *"The health system is enormously resistant to change"* (p. 6). He also recognised that *"The term 'health delivery system' ... may be more a part of the ideological repertoire of an interest group than a term used for analytic purposes"* (p. 10). It can be difficult to define where a 'healthcare system' begins and ends; however, Alford (1975) included the end users of the system (the community), as well as community health programs, hospitals, funders, policymakers, managers, health educators, and health professionals within this domain.

In his introduction, Alford (1975) stated:

> *The purpose of this detailed analysis is to evaluate the reports with respect to their consideration of the causes, characteristics, and consequences of, and their policy recommendations on, the "fragmentation" and lack of "coordination" of the New York City health system. Our hypothesis is that these commissions represent a temporary coalition of "corporate rationalisers" attempting to improve the level of planning, organizing, integration, and coordination of the health system without, however, really attacking the dominant interests which presently control the major resources of the health system: private physicians and voluntary hospitals* (p. 26).

What Alford (1975) highlighted was that the 'Corporate Rationalists' constantly sought to improve the efficiency and effectiveness of the health system without ever really tackling the dominant structural interests at play, namely that of the 'Professional Monopolists' who held power over how physicians were trained, licensed, and functioned within the hospital setting. Recall earlier, the historical foundations of this power, as noted by Roberts and Bogue (1975); the doctors were given autonomy and control over healthcare when hospitals, medical education, and research were linked as a result of the Flexner Report, after which hospitals proliferated in order to increase access through the Hill-Barton Act. It was only in the 1970s that the government (the 'Corporate Rationalists') moved to reign in growth as a result of increased costs. As highlighted previously by Jonas (1971), the primary function of doctor's work was dictated through a fee-for-service paradigm, with the doctors having autonomy over which treatments they wished to undertake and how much they charged for these treatments.

The Kogel Report (1950): The needs of the Department of Hospitals

The Kogel Report was chaired by Marcus D. Kogel who was the Commissioner of the Department of Hospitals and was auspiced by the Mayor to examine capital construction needs at a number of municipal hospitals. The final report was a brief 12 pages which commenced by identifying key population groups that would require ‘careful health planning’, including the elderly. It also recognised the critical issues of increasing medical specialisation, rising health insurance premiums, and the need for ambulatory and home-based care. The Kogel Report recommended that all hospitals be affiliated with a teaching institution, and this recommendation strongly influenced policy over the next decade, although it was not supported by evidence. The rationale for affiliation was that it would lead to stronger professional competence through teaching and research opportunities. There was no economic or health outcome-based evidence to support the view that hospitals with such affiliations did better than those without. Strong community advocacy was not apparent at the time this report was authored, it merely accepted the ‘two class system’, municipal hospitals for the medically indigent and the voluntary hospitals for private physicians and those who had insurance or could afford to pay. The major point Alford (1975) highlighted was at the time this report was prepared, there was little notion of community control or of the need to match local health needs with health services. Alford (1975) felt that the document took a rhetorical tone, from one government department to another. The report assumed that co-operation would occur between public and private enterprises without offering explicit methods as to how this might occur. In Alford’s (1975) view, the period from 1950 to the next report in 1960, marked the *“… decade of crisis in which a torrent of exposes, investigations, recommendations, and reorganizations flowed*” (Alford, 1975, pp. 34-35).

The Heyman Commission (1960): Health Services in New York

Ten years later, the problem the Heyman Commission focused on was chronic understaffing, with not only low staffing numbers but an inappropriate skills mix. The Heyman Commission was again auspiced by the Mayor of New York with the investment banker and founder of the Health Insurance Plan of Greater New York, David M. Heyman as Chairman, and 39 other members drawn from health-related private and public organisations in New York City. This report highlighted that hospitals were in the practice of not staffing to budgeted levels, and then using less qualified staff to fill some shifts; for example, the use of nursing assistants rather than Registered Nurses. Many allied health disciplines were also chronically understaffed.

The second major problem identified was the number of unnecessary hospital admissions. Various studies reported that between 15 and 20 per cent of patients did not need to be in a hospital bed, and therefore, a “Homestead Plan” was proposed. Essentially, this plan was to increase the number of community-based ambulatory care and home care services to support patients in the home so they could be discharged from the hospitals. Little attention was paid to how these major changes could be financed. For example, it was recommended that physicians be paid to provide outpatient services, but the source of these funds were not identified. Overall, the recommendations from this Commission were ‘bureaucratic’, “*that is, they were reorganizations, transfers of authority, or establishment of new mechanisms of regulation and control*” (p. 36). They were not applied to voluntary hospitals even though they had similar problems. Hospital or bed closures were not recommended in this report.

The Eurich Report (1960): New York City and its hospitals

Six months after the Heyman Commission came the Eurich Report. Over a quarter of the Heyman Commission members were involved in the Eurich Report; not surprisingly, the problems identified and the solutions proposed were similar. This later report focused on the fiscal strategy and the responsibilities the voluntary hospitals had to their patients. It was proposed that patients who could pay should do so, and various strategies to increase income from patients with private health insurance were proposed.

Under-staffing was a common concern raised by both the Heyman and the Eurich reports. The need for ambulatory and home-based care was also raised as well as a recommendation for affiliations between hospitals and universities with a proposal that those without affiliation would be closed. Underlying this proposal was the assumption that “... *affiliation ... of a municipal hospital with a medical school or voluntary hospital – would have major effects upon the quality and quantity of professional staff available at the municipal hospitals*” (p. 41). Similar to the Kogel Report, no evidence was supplied that supported why this proposition would fix the identified issues, or how this would improve physician quality and quantity. This affiliation is now commonly referred to as an Academic Health Care Centre.

There were also calls for bed types to be fixed within hospitals; for example, voluntary hospitals containing municipal beds. What this meant at the time was that municipal hospitals were funded to provide care for individuals through government funds (Medicare, Medicaid), while voluntary hospitals were funded through private health insurance (Health Maintenance Organisations) or through self-funding. Private hospitals (voluntary hospitals) were believed to be more efficient than the government-funded hospitals (municipal hospitals), without there being tangible evidence to support this view. The report recommended that private hospitals should include wings for patients receiving care through government funding. Significantly, the Eurich Report also recommended limits on the overall number of hospital beds.

With no evidence to support the assertion that voluntary hospitals were better managed, the report recommended that they be given greater control over the indigent patients and could rent and run wings in municipal hospitals. How this would improve the overall system was not stated. The issue of ambulatory care was neglected by this report as it was focused on the large hospitals.

The Haldeman Report (1966): Medical Economics

The Haldeman Report, a short report of only 28 pages, focused on inefficiency in the use of the health resources in New York, with a specific focus on administrative and bureaucratic processes. The authors were drawn from health insurers, public health organisations, hospitals, universities, medical schools, and planning councils. The existing organisational structures, administrative practices, and distribution of resources were seen as retrograde and the cause of system inefficiencies. The themes from the report could equally apply to Australia today, Alford (1975) noted:

> *A summary of issues identified in the report include incompetent health professionals, few or no facilities in some areas, nursing home and extended care facilities inadequate, 15-20 per cent of patients occupying hospital beds could be cared for in other [cheaper] ways, inadequate ambulatory care facilities, hospital emergency departments "being overwhelmed by constantly*

> *increasing numbers of patients", deficient home care, hospitals focused only on inpatient care, "no comprehensive patient-centred medical care services at the local community level", chronic under-funding, [and] inadequate care for the mentally ill* (Alford, 1975, p. 44).

The report asserted that if bureaucratic or organisational structures were reformed, the health system would improve, in the typical language of the 'Corporate Rationalists'. The report labeled the current system as "outmoded", "inefficient", "imbalanced", "uncoordinated", and "fragmented" – none of these terms were defined nor was empirical evidence provided to demonstrate the extent to which each attribute applied to the issues within the system or how they would fix these issues (Alford, 1975, pp. 42-43).

Alford (1972) quoted from the report which highlighted the lack of coordinated care, inequities in access and supply, and inefficient management:

> *Present organizational patterns and methods of administering and distributing services are outmoded, result in inefficient use of the City's total health resources, and are not always responsive to the health needs of the population. For the most part, the pattern of health services is characterized by uncoordinated effort; imbalance in distribution or, in some instances, critical shortages; disparity of quality; inadequacies in financing and a variety of administrative and legal barriers to the provision of coordinated and comprehensive health services* (Alford, 1975, p. 42).

Again, without evidence, the recommendations included a proposal that voluntary hospitals and their associated medical schools would take control of municipal hospitals. A major assumption made was that voluntary hospitals were a 'model for good care', that their control of municipal hospitals would, ipso facto, constitute a move towards a more coordinated system (Alford, 1975, p. 44). It was again assumed that municipal hospitals did not have the capacity to adopt a 'model for good care' nor did they have the ability to effectively manage voluntary hospitals. Voluntary hospitals were perceived to be more capable of efficient and effective management than the municipal hospitals, but no evidence was provided to substantiate these claims.

The litany of problems in the New York health system was described, but the causes of the problems were not explored. According to Alford (1975), this lack of analysis led the report to provide vacuous recommendations devoid of effective policy direction. It did however, again without any supporting evidence, state that the "*general hospital should be the core service providing institution* ..."; that is, the centre of health services, with all other services being either hospital-based or hospital-related (Alford, 1975, p. 45).

While this report was underway, a second report was not far behind. The System Development Corporation was a six-month study into the economics of healthcare within the system. The City Mayor was seeking solutions to health system failures. While this next report was released in 1966, it commenced in 1965 and was funded by the Health Research Council.

System Development Corporation (1966): System Analysis and Planning

The System Development Corporation was seen as an independent authority and there were hopes that it would present a systematic analysis and identify the root causes (and solutions) underlying the health system 'crisis'. It was chaired by Dr. Parks who was the chairman of the advisory committee to the Task Force on Medical Economics. Much of the report concerned itself with repeating the previously identified problems within the system and presenting a 'system planning' framework, including use of the concepts of outputs (episodes of care), inputs (patients), and processes (clinical treatments). The report then went on, in Alford's (1975) words, to describe the "*attributes of good medical care ... competence, comprehensiveness, continuity, patient/family centred care, early care, community orientated care*" (p. 48).

The report however failed to identify the link between these 'attributes of good medical care' and why they were deficient within the current system and what could be done to remedy the situation. Disappointingly, the 'solution' was a recommendation for a reorganisation at the highest bureaucratic level (the 'Corporate Rationalists') and the development of six implementation plans. These were:

> *Five Year Management Plan, Community Medical Service Centre Plan, Plan for Coordinated Hospital System, Chronic Care Plan, Unified Information System Plan, and Leadership Coordination Plan* (Alford, 1975, p. 49).

In Alford's (1975) view, the report was theoretical as no specific details of how to implement these plans were provided, nor were the resources needed to develop them identified. At best, the report provided a broad system analysis, but lacked an evidence base and displayed only tenuous links between the problems identified and the solutions provided. The timeframe stated for the development of these plans was five years, and the report also asserted that changes would need to be made to Medicare. The assumption was that Medicare legislation would automatically be changed to support the implementation of their various plans. This was not the case. The 'Corporate Rationalists' assumed that change would occur; they reasoned that if information was provided, individuals in the system would 'fall into line'.

Nine months after the completion of the report, Mayor Lindsay instigated another investigation, The Piel Commission (The Commission on the delivery of personal health services) led by Dr. Parks, who also was one of the authors of the System Analysis and Planning Report. Dr. Parks was the vice-president of Technomics Inc., which undertook a number of studies that made up the Piel Commission Report.

The Piel Commission (1967): Community Health Services for New York and Staff Studies

Alford (1975) was highly critical of this report and asserted that repetition replaced analysis. The report stated on the one hand that patients were receiving continuity in their care as they travelled from one facility to another, and yet there needed to be improvements in patient transport and information management. It also stated, "*Other than arrangements between emergency rooms to transfer patients, no evidence was observed of inter-municipal-hospital cooperation*" (p. 80).

Alford (1975) described this as an excellent example of the ideology of 'corporate rationalization' because it assumed that massive institutional changes would follow easily and readily once certain administrative innovations were established. Systems analysis, properly applied, should allow one to distinguish between those changes which have consequences for the system and those which are isolated and contained, as well as between those innovations which are so deeply embedded that they are enormously resistant to change and those which will serve the interests of powerful groups, and thus, will be relatively easy to install (p. 75).

Alford (1975) asserted that without defined criteria describing the systems analysis ...

> *... it seems plausible to infer that a so-called systems analysis is an instrument of certain interests which have no stake in a truly systematic and revealing analysis, but rather one in concealing and blurring the real relationships of power in the system* (p. 75).

This report went on to recommend two 'solutions' – to establish two new organisations – the Health Services Administration and the Health Services Corporation. It did not say how or why these two new entities would work to overcome system fragmentation (Alford, 1975, p. 88).

The report produced a set of guidelines to advise the system, which Alford (1975) summarised as being to:

(1) coordinate services;

(2) strengthen municipal-voluntary hospital partnerships;

(3) maintain existing operating budgets;

(4) reduce hospital beds;

(5) modernise budget and personnel policies;

(6) complete capital projects;

(7) avoid delays in construction;

(8) develop standards;

(9) support costs of reimbursement (pp. 561-63).

The recommendations (paraphrased and summarised) were to: (1) take steps to coordinate the system; (2) develop coordinated "medical service centers"; (3) limit specialised facilities and centralise other services; (4) close small hospitals; (5) design facilities for flexibility; (6) develop ambulatory care centres; and (7) create the capability in the Health Services Administration body for improving co-ordination (pp. 563-69) (Alford, 1975, p. 92).

The Piel Report ended with 14 policies for the Health Services Administration. Two were particularly interesting: Firstly, to "*Develop an 'optimum formula' for the development, change in, and application of, healthcare services at the regional level and within the communities of the city*" (cited in Alford (1975, p. 93), and secondly, that the Health Services Administration would ensure the effective use of health funds to achieve better health outcomes for the people of New York in comparison to other parts of the United States and the rest of the world.

> *The "operating policy" of Health Services Administration should be to "bring about realization of sufficiently improved health care delivery that New York City will not only achieve appropriate delivery for funds expended, but will achieve an outstanding rank in the nation and in the world for the delivery of health care …"* (Alford, 1975, p. 93).

Alford (1975) concluded that the report, which involved 300 interviews, 367 bibliographic items, and 4 appendices, was a *"… symbolic and meaningless response to the health "crisis*" (p. 93).

The RAND Institute (1971): Mental Health Service Delivery

The focus of the investigation by the RAND Institute was the evaluation of community mental health centres that were made possible through federal funding provided in 1963. This funding had three main aims; first, to increase both outpatient and inpatient services (the latter being more available than the former); second, to provide services to low-income patients; and finally, to coordinate service provision (within and between services).

The funding specifically required services to "*contain five components – inpatient, outpatient, partial hospital, emergency, and consultation and education services*" (Alford, 1975, pp. 94-95), and to ensure that all of these elements would be coordinated. However, these elements and their coordination for the benefit of the patient were not examined. As Alford (1975) noted:

> *"… nowhere are the problems of coordinating mental health services taken by themselves, and nowhere are the problems of coordinating mental health services with other health services mentioned, either as a theoretical or policy issue, or as questions requiring empirical data to answer"* (p. 96).

At the time the funding was released, it would have been seen as a progressive measure, "... *since it was not politically realistic to reform or reorganize the whole system*" (Alford, 1975, p. 99), and "... *this is a dilemma of piecemeal reform, if the coordination and integration of the entire health system is the goal*" (Alford, 1975, p. 100). However, Alford (1975) also noted that the report ignored the problems of coordinating mental health services within themselves (e.g., acute to community) or with other health services. The problems were not considered theoretically, from a policy perspective, or from a need to collect empirical data to find the root causes of the disconnects.

Common themes identified by Alford (1975)

Alford (1975) summarised his observations of these Commissions of Inquiry (1950-1971), noting that there was a striking lack of consideration given to previous reports to frame or inform the next Inquiry. Furthermore, the impact that previous reports had on the 'system' were not considered. Overall, there was a complete failure to systematically collect, analyse, and apply data that would inform the new Inquiry and allow assessment of the impact of the enactment of previous sets of recommendations. In his view, this was a significant waste of an opportunity, as Alford (1975) stated:

> *The reports are not part of an integrated, coordinated, and continuing program of research and evaluation. The result is a lack of a cumulative body of data which could be used for continuous monitoring of the outputs of the health system. Each new report must rely on the same sketchy body of data: income and age composition of areas of the city, hospital beds and occupancy rates, hospital costs per patient-day, funds spent by city, state, and federal agencies. None of these data, unfortunately, are aggregated or related to each other in ways which bear upon the crucial analytic or policy questions (p.100).*

The lack of objective data led these inquiries to recommend bureaucratic reshuffling or the introduction of new innovative programs or organisations that would ultimately further fragment and complicate the health system. Alford's (1975) assessment is summarised below under the following headings: lack of needs assessment and planning, and fragmentation.

Needs assessment and planning

Alford (1975) observed a complete lack of a systematic needs analysis in the New York health system. He noted that in the various reports, the autonomy afforded to the medical profession and the lack of correlation between the medical needs of the local population and availability of medical services. Many of the reports did not investigate local health needs, but rather focused on the 'problems' – over-hospitalisation, over-crowded Emergency Departments, and lack of skilled and qualified staff, pointing to deficits in needs assessment and planning and a failure to base findings on available evidence. Alford (1975) quoted Conant, *"… [who] defined … community health planning as the "effort to bring together and make rational use of private and public resources … in such a way as to meet all important health problems in the community*" (p. 173). In summary, Alford (1975) identified a systematic failure in needs assessment of the community's health requirements and, as a consequence, poor planning recommendations. Quoting a council representative, he wrote that *"... there ha[d] been no systematic assessment of relative need for services in neighborhoods throughout the city.*" This was a remarkable statement. Consider its implications: "*facilities are being* *developed on the basis of interest and initiative of institutions and local groups*" (Alford, 1975, p. 129).

In addition to a fundamental lack of needs assessment and planning, Alford (1975) observed that programs flourished as their funding window opened, and disappeared in a similar fashion when the funding ceased. For example, in 1967, funds were made available through Regional Medical Programs in local governments for ambulatory care facilities, which "… *undoubtedly provided a tremendous impetus to the development of plans for ambulatory care facilities in the city*" (Alford, 1975, p. 117). Another example was for methadone clinics and mental health programs in 1971. Alford (1975) wrote:

> *The history of the Neighborhood Family Care Centers illustrates the extreme dependence of local health programs upon the vicissitudes of federal legislation. The rise of a particular "hot" program such as the War on Poverty generates a flurry of activity – plans, proposals, meetings, new organizations – but this activity quickly dies down as another program appears which is advertised as solving the problems. However, the "crisis" continues, largely untouched, because no program which is politically feasible can also attack the causes of the problem and more than a few of the consequences* (p. 166).

The importance of the observation of short funding cycles is a theme that will emerge later in this thesis from the interview respondents with reference to the Australian system.

Another similarity to Australia were the short political cycles. This meant that needs assessment and systematic planning were also at the mercy of short political cycles. To illustrate this problem, Alford (1975), quoting Ida Hoos, reported that US$74 million was paid to consultants to design a bridge in New York City in 1969. It was then discovered that, since 1948, there had been 10 different studies undertaken in relation to this bridge and that the current Transportation Administrator was unaware of six of them and not one had been acted upon (p. 101). Again, this reinforced Alford's (1975) observation that none of the inquiries into the problems of the health system considered the reports that preceded it, nor the impact or effectiveness of the previous recommendations. As the bridge example illustrates, this was not necessarily unique to healthcare.

Fragmentation

The second major issue identified by Alford (1975) was fragmentation. Using the common language of these Commissions of Inquiry, he uncovered repeated phrases which were often poorly defined. For example, in The Haldeman Report, the term ‘fragmentation’ was repeatedly used but was not defined, nor were recommendations provided for system improvements to overcome this fragmentation. As Governor Rockefeller’s (1971) report had highlighted “... *medical care in the United States is more a collection of bits and pieces (with overlapping, duplication, great gaps, high costs, and wasted effort) than an integrated system in which needs and efforts are closely related*” (p. 181). Alford (1975) added:

> *These typical phrases – “outmoded,” “inefficient,” “imbalanced,” “uncoordinated,” “comprehensive” – which imply that the main barrier to the achievement of adequate health services is a failure of the organizational or bureaucratic structure, indicate the ideological viewpoint we have labelled “corporate rationalization”* (pp. 42-43).

The “*inadequacy of analysis and recommendations*” lead to recommendations for administrative reorganisations, “*whether to centralize or decentralize operations, will not solve all, or even any, of the multiplicity of problems consigned to their care”. Rather, the “innovations” introduced, far from integrating and coordinating the system, will further complicate and fragment it*” (Alford, 1975, pp. 100-101). Once again, this echoed the previous point Alford (1975) raised on the lack of systematic data collection to inform the inquiries that would have allowed them to quantify key system failures captured by these subjective terms. For example, if ‘inefficient’ had been quantified by the number of representations to an Emergency Department by the same patient in less than 48 hours, this would have provided objective data of an ‘inefficiency’ and a poor health outcome from the patient’s perspective.

The lack of systematic evidence given in the Commissions of Inquiry provided little fodder to address the problems in the healthcare system. Objective data may have enabled the inquiries to analyse the practices of the dominant structural interests that led to the subjective labels of 'fragmentation' and 'inefficiency'. Most studies reviewed by Alford (1975) had "… *not dealt systematically with the way in which dominant structural interests have created barriers to significant change in those institutions*" (p. 190).

Objective data could have assisted these inquiries to uncover the root causes of the system faults. The various inquires provided a series of system design changes and recommendations without considering 'who' would need to do 'what' differently, and 'how' they might react; namely, the doctors. There was a complete failure in these reports to identify the dominant structural interests that kept the health system operating in its current form. This is the core of Alford's (1975) theory; the dominant structural interest group stymies healthcare reform.

Section Two: Application of Alford's (1975) theory

Alford (1975) was writing in the second half of the 20th century and reporting on the healthcare system in the United States. This is a healthcare system very different from the Australian system at the time, or now in the 21st century. The question to explore is the relevance of his theory to the contemporary Australian context. This is undertaken with reference to the analysis of healthcare reform in Australian by Duckett (1984), North (1995), and Harrison (1991), the NHS in the UK by North and Peckham (2001), Ross (1999) on the USA situation, and Cho (2000) using a case study from South Korea.

Duckett's use of Alford's (1975) analysis

Australian health economist Stephen Duckett (1984) applied Alford's (1975) theory of structural interests to Australian health policy reforms over the period from the 1960s to 1984. He divided health policy in Australia into three distinct periods; 1965-1972, the 'Pre-labor years'; 1973-1975, 'the Labor Years'; and the following period to 1984 as the Fraser years. Duckett argued that the 'Corporate Rationalists' sought to control the 'Professional Monopolists' by manipulating Medicare (funding) policy in 1974, thus supporting Alford's (1975) theory of the conflict between the rationalists and the monopolists. The 'Professional Monopolists' rallied and sought to quash the moves of the 'Corporate Rationalists' to control their work and reduce their autonomy. The 'Equal Health Advocates' championed equitable access to healthcare, and such was the fervour of public commitment to universal healthcare, the Whitlam Government won power on this platform. It was a time when there was a coalition between the 'Corporate Rationalists' and the 'Equal Health Advocates', as the former wanted an efficient and effective healthcare system, while the latter wanted universal access.

Healthcare in the pre-Labor years (1965-1972) was shaped by the 'Earle Page' voluntary health insurance scheme which was established in 1953 by a Liberal Government. Gough Whitlam, who formed government in 1972, favoured a universal health insurance scheme which was very popular in the community and won the Labor Party significant support in the 1969 elections. The 'Professional Monopolists', represented by the Australian Medical Association, advocated and supported the voluntary health insurance system, and therefore, a user-pays approach. This model typified the 'Professional Monopolists' who desired complete professional autonomy, to act within the confines of their elite profession and to provide services as deemed necessary by them without challenges to their professional autonomy.

As noted earlier by Epstein (2013), the 1970s saw a rise in the egalitarian spirit of Australia where social justice issues were debated strongly and the early movement of health consumer coalitions were formed. Whitlam championed universal insurance and when he formed government in 1972, he established Medibank However, the establishment of Medibank did not mean that government was not concerned about the costs of healthcare. This concern about costs was reflected in the review into hospital activity commissioned by the government in 1974. In Duckett's (1984) view, this was the "... *high water mark of corporate rationalist influence within the health sector*" (p. 961) up until that time. The recommendations from the review were riddled with the language of 'Corporate Rationalists', including "... *an organised approach to the solution of health problems ... the formulation of policy and aims at a national level be improved by strengthening the machinery for policy making which jointly involves Federal and State* *authorities and professional organisations*" (p. 961). Other terms such as 'efficiency', 'co-ordination', 'policy-making machinery' and 'data' were used throughout. Duckett's observations were consistent with those expressed by Alford (1975), whereby government concern about increased health costs lead to an Inquiry, with a series of recommendations that sought to improve 'efficiency', 'efficacy', and ultimately, 'cost-effectiveness', followed by little action.

Medibank did not restructure, reform, or redesign the health system, but it applied a universal fee-for-service system designed to equitably and efficiently allocate funding. Medibank had three elements – medical insurance, hospital insurance, and hospital funding. The 'Corporate Rationalists' were satisfied with the inherent efficiencies Medibank provided, while the 'Equal Health Advocates' made a significant advance with 'free' or 'low cost' (85 per cent of the scheduled fee charged by the doctor or specialist with a gap no greater than $5.00) and 'accessible' health services for all. The 'Professional Monopolists' did not like the design of the hospital funding arrangements because they led to a rise in salaried medical officers rather than fee-for-service. There was a perception by the 'Professional Monopolists' that this arrangement of being salaried rather than being able to operate on a fee-for-service basis could potentially expand bureaucratic control. A single funder also meant that professional services could be scrutinised for activities such as over-servicing. The fact that Medibank was funded and run by government was an inherent threat to professional autonomy and monopoly. The Australian Medical Association led a generously funded attack which twice blocked Medibank legislation in the Senate, but ultimately, the bill was passed in 1974.

The principles of social justice informed campaigns by 'Equal Health Advocates' who typified Alford's (1975) criteria of the repressed interest group of consumers and the community. Although the 'Equal Health Advocates' were the repressed interest group, the Interim Committee for the National Hospitals and Health Services Commission enshrined community consultation into policy – paving the way for consumers and the community to have a voice. This policy, 'A Community Health Program for Australia', released in 1973, contained a requirement for consultation with the community in receipt of services by the program.

> *The objective of a national program should be to encourage the provision of high quality, readily accessible, reasonably comprehensive, coordinated and efficient and related welfare services at local, regional, state, and national levels. Such services should be developed* ***in consultation with** ... **the community to be served**. ... the provision of ... services with an **emphasis on prevention: ... continuity and co-ordination of service ... efficient management to support the professional teams** and to ensure courteous and prompt care for the public* (Duckett, 1984, p. 960) [emphasis added].

Not surprisingly, as a government policy, the program used the language of the ‘Corporate Rationalists’ by requiring efficiency, continuity, and co-ordination. The resultant Community Health Program had a significant impact in NSW, SA, and Victoria. The establishment of locally controlled health services, with salaried Medical Officers, was a fundamental challenge to ‘Professional Monopolists’ who valued professional control and autonomy.

Duckett (1984) asserted that Labor’s policy of creating infrastructure during this period was closely aligned with that of the ‘Corporate Rationalist’ doctrine with a stated commitment to ensure the fundamental right of every Australian to access the highest standard of healthcare. With ‘Corporate Rationalists’ and ‘Equal Health Advocates’ enjoying a relative heyday during the Labor years, this short but significant period in Australia’s history led to opponents being galvanized into action and in November 1975 the Fraser Liberal Government took office.

During the Fraser Liberal years from 1976 to 1983 (Duckett, 1984), the government immediately instigated the ‘Medibank Review Committee’ which signaled the beginning of five years of systematic ‘clawback’ of Medibank to its pre-1975 version. The focus of government was to save money on the basis that healthcare costs and the utilisation of health services were increasing. However, neither of these two statements were true; on the contrary, in the 1976-1977 budget, hospital expenditure was A$90M less than in the actual budget estimates (Duckett, 1984, p. 963).

By 1981, the ‘Professional Monopolists’ were satisfied as new measures were introduced to increase private practice fee-for-service activity. For example, no longer could patients receive ‘free’ hospital services, which were now subject to a strict means test. The aim of government was to increase those covered by private health insurance from 50 to 80 per cent (Duckett, 1984).

In summary, Duckett demonstrated vibrant activity from all three of Alford’s (1975) structural interest groups over a turbulent political cycle. He highlighted the importance of government health policy and the emergence of the ‘Equal Health Advocates’ during the Whitlam years. In spite of intense lobbying by the ‘Professional Monopolists’, Australia’s Medicare system remains a pillar of Australian health policy which successive governments have ‘reformed’, but ultimately, it remains as a system of universal health insurance. However, as I will later demonstrate, despite Medicare having been maintained, the Medicare item numbers, which can only be claimed by physicians, are fiercely protected by the ‘Professional Monopolists’.

North’s application of Alford’s theory in the United Kingdom

North’s paper (1995) described the application of Alford’s (1975) structural interests theory in the United Kingdom (UK). She stated that the ‘Corporate Rationalists’ in the UK resided within the Department of Health, regional and district health authorities, and provider trusts. As the UK has had a long-standing National Health Service (NHS), with healthcare being ‘free’ at the point of delivery, and therefore, historically there has been a slow mobilisation of ‘community’ advocacy groups. Since the 1970s, increased health consumer groups have emerged after the establishment of community health councils in 1974 (North, 1995). She argued that since the Community Care Act was established in 1990, the NHS aligned with the structural interests of the ‘Equal Health Advocates’ and the ‘Corporate Rationalists’, and strategies were put in place to create a “... *more efficient use of resources within the NHS* ...” (North, 1995, p. 120). The architects of this corporate rationalisation were the Conservative Thatcher and Major Governments. The way this system operated was that the NHS allocated funds to Regional Health Authorities, and GPs chose to continue to practice medicine on a ‘contracted’ basis and could compete to be fund holders for secondary care (some of which was in direct competition with acute care, such as family planning and minor surgery). If they were fund holders, they had to balance their medical ethics to deliver high quality primary and (potentially selected) secondary care, in which they may be the provider and the purchaser. Ultimately, the reforms meant that GPs who were providers (‘Professional Monopolists’) as well as fund holders (‘Corporate Rationalists’), had to manage this inherent conflict of interest. In Alford’s (1975) theory of structural interests, these two roles are inherently in conflict as ‘Professional Monopolists’ seek autonomy, fee-for-service, and want to practice medicine and set their own fee at a price they deem appropriate for the patient, with accountability to their own professional bodies. ‘Corporate Rationalists’ want to control expenditure, ensure efficient utilisation of health funds, and wish to hold ‘Professional Monopolists’ accountable in terms of the safety, quality, and effectiveness of their interventions.

Despite this inherent conflict, the NHS took this practice further by undertaking “total purchasing” pilots; for example *“... in Bromsgrove ... four practices were given a budget of £13.2M by North Worcestershire Health Authority to purchase all the health services for 40,000 residents*” (British Medical Journal, 1994 cited in North, 1995, p. 122). The ‘Corporate Rationalists’ forced the role of funder onto the ‘Professional Monopolists’:

> *... the steady incursion of the corporate rationalist on clinical autonomy ... surveillance of the effectiveness of hospital clinical practice by GPs, and more formally, by public health clinicians with the health commissions is gradually demystifying medicine and dissipating the power of key ‘Professional Monopolists’. ... It is not merely the process of clarifying what doctors do and exposing how well they do it which potentially weakens the profession. Schlesinger and Smithey (1994) observe that as providers in the US have become more commercially oriented, public belief in the service ethic has faded and with it, the public's faith in the professional-patient relationship. There are echoes of this in the concerns expressed in the UK about cream-skimming fund holders and in the high profile debates about the rationing of care for smokers or the elderly, none of which enhances the reputation of the medical profession* (North, 1995, p. 122).

The NHS encouraged community participation and motivated local authorities to seek out the views of the "local people" through consultation. The definition of who were the "local people" could be hard to establish – does "local people" include the professionals who served them or would their involvement represent the inherent conflict of interest discussed earlier? (that is the conflict of interest of the 'Professional Monopolists' as to what they believed was a priority vs. what individual community members would prioritise), and whose view should win, those of the experts or those of the lay community? North (1995) provided a relevant example:

> *A survey of Hackney GPs, consultants, public health doctors, local community groups, and a sample of the public revealed disagreement. In contrast to GPs, the public prioritised life-saving technologies over community services, while neither GPs nor the public gave high priority to family planning and health education which was, predictably, rated highly by public health doctors* (p. 123).

The 'community' in the UK were more likely to advocate for the prioritisation of 'acute' secondary and long-term care because they already had readily available access to primary care.

Harrison (1999) and modernisation of the NHS

Harrison (1999) observed that in 1997 in the UK, the term 'modernise' became the 'language of reform' and was directed at the medical profession. Harrison took the view that successful reform of the medical profession would see the reduction in the monopoly held by doctors. He cited the work of Colwill (1998) who postulated that when the NHS was conceptualised in the 1940s around a broader public health philosophy, it was rejected through an alliance of medical interests and civil servants, in Alford's (1975) theory, 'Professional Monopolists' and 'Corporate Rationalists', who formed a temporary alliance to influence the fundamental design of a government-run national health service. That is, 'Professional Monopolists' were awarded more autonomy, and therefore, held structural power in the original design of the NHS that later reforms, as will be discussed, have successively sought to reduce. ‘Professional Monopolists’ have had their power reduced by a coalition of the ‘Corporate Rationalists’ and the ‘Equal Health Advocates’, as I will now outline.

Clinical autonomy was firmly entrenched in the original design of the NHS. A 1944 White Paper from the Ministry of Health stated *“... whatever the organisation, the doctors taking part must remain free to direct their clinical knowledge and personal skill for the benefit of their patients in the way which they feel to be best*” (Harrison, 1999, p. 5). Harrison (1999) also noted the close relationship between the British Medical Association, the Royal Colleges, and the Department of Health which resulted in an approach to workforce planning that favoured the ‘Professional Monopolists’. Managers were seen to be the supporters of the doctors, and up until 1991, GPs could refer to a hospital anywhere in the UK and prescribe pharmaceuticals of any type, at any amount, for whatever period they deemed appropriate. There were no direct financial ramifications upon GPs for these decisions.

A summary of the evidence from 25 research studies conducted up to 1983 concluded that:

> *Managers neither were, nor were supposed to be, influential with respect to doctors. The quality of management (like the quality of the service itself) was judged by its inputs. Managers in general worked to solve problems and to maintain their organisations rather than to secure major change* (Harrison, 1988a, p. 51 cited in Harrison, 1999, p. 6).

Using Alford’s (1975) terminology, Harrison argued that managers were not a challenge to the ‘Professional Monopolists’ until the 1980s when the economic realities of growing healthcare expenditure lead to reform. As Harrison (1999) stated, the period of reforms in the 1980s were the first time the term ‘modernise’ had been used in relation to the health system, and these reforms signaled the rise to power of NHS managers. In 1984, general managers (later known as Chief Executives) were introduced into the National Health Service (NHS) as a result of the Griffiths Report. Harrison (1995) observed that the move to establish managers was shaped by the fact that in 1982, the government sought to have a review of NHS ‘manpower’; however, Roy Griffiths, Managing Director of Sainsbury supermarkets, was chosen to chair the review, but would only agree to chair if the scope of the review was focused on NHS management. The British Medical Association strongly opposed the introduction of these managers, seeing them as a threat to their professional judgement and clinical autonomy.

Prior to 1991, District Health Authorities were responsible for the allocation of healthcare resources and the provision of services in public hospitals, clinics, and domiciliary care. GPs were remunerated through contracts, fees, fees-for-service, and allowances – they were also free to refer to any hospital within the country without any financial ramifications. In 1990, the Prime Minister announced there would be a review of NHS funding. Purchaser/provider splits were the major outcome of the review with the introduction of District Health Authorities purchasing and GPs fund holding, with *“... both centred on the notion that the actual provision of services should be the function of NHS Trusts, independent of direct DHA control ...”* (Harrison, 1999, p. 10). By 1996, over 30 per cent of GPs had “volunteered” to be fund holders – the end result of the fund holding arrangements was that some secondary care services, previously held tightly in the domain of hospital activity, were successfully moved to primary care, such as elective surgery.

In 1999, Primary Care Groups were established and GP membership was compulsory. Clinical excellence was institutionalised through the establishment of the National Institute of Clinical Excellence (NICE). The hegemony of NICE was established through the bio-medical model and evidence-based medicine. Clinical guidelines for many common procedures were developed, and practices audited against them in the decades to come. Again, these clinical guidelines were opposed by the medical profession who claimed they encouraged “cookbook” medicine. However, the medical professions’ ability to block the implementation was severely hampered by community pressure at the time. The media and public response to a discovery that Bristol had low survival rates for certain paediatric cardiac procedures meant that community and government developed an appetite to more closely scrutinise and monitor the medical profession (Harrison, 1999).

At the beginning of Harrison's paper, he proposed that if reform had been successful there would have been a reduction in the dominant structural interest of the medical profession.

> *In this paper, 'successful reform of the medical profession' is taken to mean a significant reduction in what Alford (1975) has termed the 'professional monopoly' of the doctors* (Harrison, 1999, p. 2).

However, attempts to redress the imbalance of medical dominance are stymied when the professional bodies hold powerful positions within the government infrastructure.

> *The second institutional source of medical dominance is the corporatist inclusion of the 'peak associations' of medicine, particularly the BMA [British Medical Association] and the medical Royal Colleges, in government decision-making about health policy, along with a pervasive influence on local institutions* (Harrison, 1999, p. 15).

The authors summarised this point demonstrating the currency of Alford's (1975) theory of structural interests, with all three groups operating in a manner consistent with his theory; that is, the 'Professional Monopolists' fight to maintain their dominant position in the design and operation of healthcare. 'Corporate Rationalists' seek to improve efficiency and effectiveness and can form temporary coalitions with 'Equal Health Advocates', particularly when the quality of healthcare fails. 'Equal Health Advocates' are consistently the repressed structural interest group who seek high quality, safe, effective, and accessible healthcare.

Alford's (1975) theory applied to mental health in the United States

Ross (1999) applied Alford's (1975) framework to the mental health system and managed care within the United States and noted that *"... struggle amongst interest groups in a democracy is inevitable"* (p. 600). He used Alford's (1975) framework to examine and understand organisational dynamics in the system. 'Challenging' structural interests were identified as hospitals, public health agencies, and Managed Care Organisations (MCOs). He argued that MCOs were a new dominant interest group replacing the position once held by professional bodies. As in Alford's (1975) observation, repressed structural interests were the family, patient, and consumer groups that wished to promote the optimal provision of timely and high-quality care.

These three categories of structural interests support a different approach to accountability. Professionals rely on scientific evidence-based medicine to support their autonomy and clinical decision-making. MCOs are the purchasers of healthcare episodes and favour market-based approaches, securing the greatest return on investment available – in this case, it was the money that supplied the leverage. The repressed interest, the consumers or 'Equal Health Advocates', relied on the government to articulate and safeguard their interests.

The application of Alford's (1975) theory to pharmacy in South Korea

Cho (2000) used Alford's (1975) theory to explore a highly publicised case in South Korea where 'Oriental Medicine' (OM) challenged changes to the Pharmaceutical Act in February 1993. The changes were deemed necessary to clarify previous ambiguities in the Act regarding the prescription and dispensing of herbal medicines. It was unclear what the boundary was between herbal supplements and therapeutic herbal medicine. The National Health Insurance scheme only covered 56 types of herbal medicines which led to an escalating private market for these medicines. The 'Corporate Rationalists' sought to bring this situation under control by clarifying in the Pharmaceutical Act who could prescribe and supply herbal medicines.

The OM practitioners were disgruntled by the changes as they challenged their professional monopoly in the domain of prescribing and dispensing herbal medicines. Pharmacists were equally incensed as the changes introduced restrictions on what they could supply without a prescription from an OM practitioner. Both groups of 'Professional Monopolists' were challenged. The OM practitioners wanted to preserve their long-standing claim over herbal medicine. OM students refused to attend lectures in protest against the changes and OM practitioners closed their clinics. Suspicion emerged in June 1993 that pharmacists were behind the revision of the Act. Once the pharmacists heard about this allegation, which was by then under investigation by the

Public Prosecution Office, 19,000 pharmacists had handed in their licenses in protest and some went as far as commencing a hunger strike.

In December 1993, the new Pharmaceutical Act was established. It provided that:

> *... the new profession of 'OM pharmacy' would be established; the rights of the pharmacists who had already dispensed herbal medicine was guaranteed for two years; and after this grace period, pharmacists could only dispense herbal medicine under special arrangements* (Cho, 2000, p. 125).

In March 1995, the Ministry of Health and Welfare decreed that pharmacists could only dispense 100 types of herbal medicine (via a prescribed formula). This challenged the pharmacist's professional autonomy in dispensing herbal medicines and there were bitter protests. The pharmacists wanted 'OM pharmacy' under their jurisdiction, while the OM practitioners wanted to control it independently of the pharmacists. Once again, OM practitioners closed their clinics in protest.

The conflict re-emerged at the end of the two year grace period and once again the government tried to introduce a solution to appease both groups of 'Professional Monopolists'. The government introduced a one-off qualification process whereby pharmacists could become certified 'OM pharmacists'. Once again, bitter protests emerged over who would set and control the examination process that would qualify a pharmacist for OM certification. Ironically, 23,360 pharmacists passed the exam in June 1996 "... *making the number of herb-handling licentiates greater than the number of the country's retail pharmacists*" (Cho, 2000, p. 125). In July 1996, 'OM pharmacists' started dispensing herbal medicines and this led to protests in Seoul by OM practitioners, students, and academics.

During the years of conflict there were points where some analysts advocated that the changes to the Pharmaceutical Act were unconstitutional. The Korean Constitution protects freedom of business, so changes to the Act were potentially unconstitutional because they limited the ability of pharmacists to conduct their business freely. Both the pharmacists and the 'OM practitioners' were predominantly solo practitioners and were seen to be the most economically savvy players in the health system. What is fascinating about Cho's analysis is that throughout these bitter rivalries between the pharmacists and the OM practitioners, the government tried to find the 'middle ground', a way to appease both groups, which ultimately failed. During the process, a number of Ministers of Health were dismissed as protests escalated and the public became acutely aware of the battle.

The public were critical of both groups of 'Professional Monopolists' as they saw the dispute ultimately as a struggle over the 'rice bowl'. This was reinforced by the fact that the profit margin on herbal medicines was between 100 per cent and 500 per cent (Cho, 2000, p. 128). A number of opinion polls were taken during the period of the dispute. Overall, the public were critical of the government, supportive of the OM practitioners, and skeptical of the pharmacy profession. As per Alford's (1975) analysis, despite some community groups mobilising to attempt to resolve the conflict, they were ultimately ineffective against the 'Professional Monopolists' as they lacked a unified voice and political leadership.

North and Peckham find evidence for Alford's three structural interest groups in the United Kingdom

North and Peckham (2001) identified the key influencers in United Kingdom (UK) primary care organisations using Alford's (1975) categories of 'Professional Monopolists', 'Corporate Rationalists', and 'Equal Health Advocates', and examined the relationships between these three interest groups.

The formation of Primary Care Trusts and Primary Care Groups had led to pluralistic decision-making, through which these entities were required to gauge local community needs while being mindful of budgetary pressures, National Health Service (NHS) priorities, and national guidelines. The government allocated funding to the Primary Care Trusts and Primary Care Groups and had to manage the provision of services within the funding envelope – this created budgetary pressures as there was more demand for services than supply of funds. The composition of the Boards were of mixed representation including GPs, hospital bureaucrats and community representatives. North and Peckham (2001) asserted that despite the progressive reforms achieved during the 1980s and 1990s by ‘Corporate Rationalists’, GPs had proven to be “... *arguably the most intractable group of professional monopolizers in the NHS*” (North & Peckham, 2001, p. 428).

Incursions into the autonomous domain of the GP commenced in 1985 with the introduction of a limited prescribing list, with GPs contracting for these services in 1990 and Primary Care Groups in 1999. Primary Care Groups required all GPs to be a member. The service contracts that GPs had with local Primary Care Groups facilitated managerial accountability in both keeping their practice and prescribing costs within budgetary guidelines. GPs who were fund holders further exhibited behaviours associated with ‘Corporate Rationalists’, as they funded secondary care and, once again, could hold their hospital-based counterparts to account in order to achieve efficient services. GPs were motivated to adopt this behaviour as they had the ability to keep the monies not spent on population services, where they could achieve cost efficiencies in the hospital and community-based services they purchased. They became the ‘Corporate Rationalists’ from within. Further accountability was introduced with the National Institute for Clinical Excellence (NICE) in 1999 who produced clinical guidelines that introduced another mechanism of medical accountability. As noted by Harrison (1999), there was community and political will, the alignment of two structural interests, to promote this accountability due to a number of demonstrably poor clinical outcomes for patients. Harrison provided the example of how the Labour Government in the late 1990s exploited community concern about paediatric cardiac surgeons as the justification for the introduction of clinical governance within a specific hospital.

In Alford’s (1975) construct, the community comprised the poor and the medically indigent. The National Health Service (NHS) had advanced the voice of the consumer by requiring Primary Care Groups to have community representatives on their boards and to conduct community needs assessments (Mockford, Staniszewska, Griffiths, & Herron-Marx, 2011). While the practice may not have been perfect, in theory the practice of the NHS sought to institutionalise the role of the consumer to ensure their participation.

Critics of Alford’s (1975) theory of structural interests and the proposal of new structural interest groups

Critics of Alford’s (1975) theory of structural interests included Checkland, Harrison and Coleman (2009) who discussed the application of Alford’s (1975) theory of structural interests by various researchers and asserted that often a critique of Alford’s (1975) categories was overlooked. Using data from the United Kingdom, specifically ‘Practice Based Commissioning”, these authors “... *interrogate Alford’s work more critically*” (Checkland, Harrison, & Coleman, 2009, p. 607), arguing that the new structures established in the NHS from 2002 challenged the privilege of interest groups and formed a new category known as ‘Corporate Monopolisers’, which was subject to pressure from the ‘Professional Rationalisers’. ‘Corporate Monoplisers’ arose from the introduction of Practice Based Commissioning in England, which included ‘Payment by Results (PbR)’. This funding paradigm led to hospitals holding a corporate monopoly as they were able to define their workload and hold the local community as a captive market, because patients did not want to travel to receive healthcare. The doctors who challenged this paradigm were termed ‘Professional Rationalisers’ and were the GPs who challenged the corporate monopoly held by the hospitals and the specialists who worked within them. Checkland et al. (2009) argued that the GPs were acting in ways consistent with ‘Corporate Rationalists’ in that they were bureaucratic and used clinical guidelines and sought to govern how patients were managed by using patient pathways.

Alford’s (1975) structural interest group taxonomy points to the inherent design of a health service always favouring certain interest groups. When a system advantages one group of interests over another, the dominant interest group does not have to defend or advance their position because the inherent structure automatically does this for them. In any position of domination, the emergence of ‘challenging interests’ seeks to address the inherent bias. In Checkland’s example, the ‘Professional Monopolists’ were split; the specialists’ dominance was favoured by the Payment by Results (PbR) funding design, and so the GPs challenged this dominance using bureaucratic mechanisms. Again, in Alfordian terms, a dominant structural interest will always be challenged, and of course, the dominant interest will resist any changes that threatens their dominant position.

Checkland et al. (2009) examined the changes in the NHS once the Labour Government formed in 1997. This government ceased GP fund holding and replaced it with longer-term service agreements. Health Authorities became Primary Care Trusts and it was compulsory for all GPs to be members of these trusts. In 2002, ‘payment by results’ was introduced, which assigned each ‘episode of care’ to a casemix category known as a ‘HealthCare Resource Group’ (HRG). The concern with this type of funding arrangement was that it created an inherent incentive for hospitals to undertake more episodes of care which correlated with increased funding. However, the hospital needed to ensure that their internal systems of efficiency maximised the likelihood of the episode of care being at the agreed rate of reimbursement for the HRG. Unfortunately, when hospitals were funded via casemix methodology, perverse incentives emerged. Checkland et al. (2009) cited an example reported during their interviews from a Primary Care Trust (PCT) employee who recounted a move to address short hospital admissions for pregnant women. The analysis conducted by the PCT concluded that 80 per cent of these admissions were avoidable and a community midwife, who monitored women in their own homes, could have reduced many of these unnecessary admissions. It was proposed that £100,000 would be used to employ two community midwives. However, when the Finance Director of the hospital heard of this plan, it was stopped as each admission attracted a HRG payment which annually resulted in £500,000 in income to the PCT. The risk of iatrogenic complications by admitting pregnant women into hospital was outweighed by the perverse fiscal incentive generated by the HRG payment system.

The contracted HRG payment rules led to specific guidelines for clinical management being created, including in relation to the use of financial incentives. For example, if a patient was admitted for a fractured neck of femur, operating on this fracture within 24 hours reaped a higher HRG payment than if it occurred 48 hours after admission. This is an example of where the terms of the service agreement had a direct impact on how patients were clinically managed and how the hospital was performance managed.

Checkland et al. (2009) asserted that the introduction of ‘PbR’ inherently favoured the hospitals and provided them with a ‘corporate monopoly’.

> *Hospitals are monopolists under this structure because their ability to define their workload and income, combined with the reluctance of patients to travel and of commissioners to destabilise local services, gives them a local monopoly in a context where the market has come to be seen as the natural way to organise health services* (Checkland et al., 2009, p. 620).

Alford's (1975) description of hospital managers working across areas as 'Corporate Rationalisers' was not seen in this environment, as the PbR incentivised hospitals "... *to compete with and draw business from their local competitors*" (Checkland et al., 2009, p. 620). The 'Professional Rationalisers' were the GPs who challenged the hospitals on their activity, case coding, and clinical management of patients. GPs mobilised collectively through their subscription to Practice Based Commissioning and therefore they became a rationalising interest:

> *... in the sense that they are behaving in ways that are essentially formal and bureaucratic justifying their demands in terms of guidelines such as those produced by NICE ... and seeking to govern their relationship with hospitals through formal rules, such as 'patient pathways'* (Checkland et al., 2009, p. 621).

Summary

This chapter provides an overview of Alford's (1975) theory of structural interests. In the 1970s, Alford (1975) developed his theory to uncover the structural interests that stymied effective health improvements in spite of countless cycles of inquiries. His three structural interest groups take on unique roles in healthcare, each afforded their position by legislation, regulation, infrastructure, and history. The 'Professional Monopolists', made up of doctors and specialists, hold the dominant position – their role is to defend their territory and stave off any move that threatens their professional autonomy or funding. The 'Corporate Rationalists', largely made up of government and bureaucrats, are in the role of a 'challenging interest' as they strive for effectiveness and efficiency in healthcare. The 'repressed interest' is that of the 'Equal Health Advocates' – the consumers of healthcare. Temporary coalitions can form between two of the interest groups, and examples were provided from authors who have used Alford’s (1975) theory to analyse healthcare in Australia, the United Kingdom, the United States, and South Korea.

Duckett (1984) identified Alford’s (1975) three structural interest groups operating within the Australian health system in the period from the mid-1960s to 1984, behaving in ways consistent with Alford’s (1975) theory. In the United Kingdom, North (1995), Harrison (1999), and North and Peckham (2001) observed Alford’s (1975) structural interest groups and their associated behaviours within the National Health Service. Ross (1999) work reinforced the existence and hierarchy of the interest groups within the mental health system in the United States, while Cho (2000) looked at the professions of pharmacy and oriental medicine in South Korea. These authors all provided evidence of Alford’s (1975) structural interest groups in their respective health systems.

Checkland et al. (2009) expanded upon Alford (1975) work in examining the era of ‘Payment by Results’ in the United Kingdom, in which hospitals took on a monopolistic role requiring GPs to take up the role of the challenging structural interest group, the latter operating in a manner consistent with Alford’s ‘Corporate Rationalists’. The application of Alford’s (1975) theory to the themes that emerged from my interview data will be discussed in the discussion chapters six through nine; the next chapter will describe on the methodology and methods of the research.

CHAPTER FIVE METHODOLOGY AND METHOD

Introduction

The purpose of this chapter is to outline my position on the nature of knowledge, which forms the epistemological and ontological foundations for this research. I then use this foundation to validate the method employed to answer the research questions. The research method is based on Grounded Theory, as described by Charmaz (2006, p. 3); unfortunately an emergent theory did not present itself so I drew upon various theoretical frameworks which ultimately allowed me to make sense of the themes that emerged from my data. I read the work of many authors, with the major ones being briefly presented at the end of this chapter, before finally choosing Alford (1975) as his theory had the greatest resonance with my own findings and with that of those I interviewed.

The positivist tradition

Epistemology is the theory of knowledge – that is, how we 'know' anything – and each theoretical discipline has its own hierarchies of evidence, reliability, and validity. These hierarchies underpin the differentiation between conjecture, opinion, and 'fact'. Ontology is the study of the nature of 'being' and which things exist; how we understand ourselves to be, and then in turn, how we can know what things are. The foundation of the natural sciences has been that of 'empiricism' within a 'positivist' tradition (Lee, 1991). 'Positivism' asserts the scientific verification of 'facts' through the establishment of controlled experiments which can be replicated. It is based on the premise that 'reality' exists separate to that of the researcher. The researcher can therefore objectively observe 'reality' and manipulate variables to achieve different outcomes. Underpinning this ability to study and observe the world is the notion of 'realism' which asserts that there is an external reality which scientists can study and that this is separate from our descriptions of it (Bryman, 2016, p. 25). In the natural world, the controlled repeatable experiment is the foundation of scientific evidence and medicine (Goldenberg, 2006). Realism shares a number of concepts with that of 'positivism', with adherents believing that there is an external world which can be studied and understood, and that the social world should be studied using the same disciplines and principles that underpin the study of the natural world. As Charmaz stated:

> *Positivist theory aims for parsimony, generality, and universality, and simultaneously reduces empirical objects and events to that which can be subsumed by the concepts. Positivist theory seeks causes, favors deterministic explanations, and emphasizes generality and universality. In short, positivist theories consist of a set of inter-related propositions ...”* (Charmaz, 2006, p. 126).

In the social sciences, the question that is often posed is, should the social world be studied through the same paradigms as those used to study the natural world? (Bryman, 2016). An alternative is ‘interpretivism’ which posits that the social world – people, institutions, society – are fundamentally different constructs from those of the natural world, and therefore, require a different form of enquiry (Schwandt, 1994).

Understanding the social world

Qualitative research involves the notion that the researcher and the researched cannot be separated, and that it is the interplay between the researcher’s social construction of reality and reality as constructed by others that the researcher seeks to describe. The key construct is that of causality; in the positivist tradition, causality is an observable phenomenon, whereas in the social sciences, causality is a more complex construction that involves the interpretation of relationships through their context, the actors, and the outcomes. For example, Weber viewed sociology as a “*science which attempts the interpretive understanding of social action in order to arrive at a causal explanation of its cause and effects*” (Bryman, 2016, p. 27).

‘Interpretivism’, the epistemological camp in which my research resides, moves beyond naturalistic constructs of social science research (Schwandt, 1994). At its foundation, ‘interpretivist’ sociological methods include the researcher in the context of the research, and acknowledges his or her bias in the subsequent analysis of the findings. If the researcher is to be included in what is being researched, then we must seek to understand ourselves, including how others see us. Mead explored how our sense of self evolves and is influenced by how others view us. Herbert Blumer, a student of Mead, coined the term ‘symbolic interaction’, which places the researcher in dialogue between what he or she is researching and what is being researched. As Bryman noted:

> *Symbolic interactionists argue that interaction takes place in such a way that the individual is continually interpreting the symbolic meaning of his or her environment (which includes the actions of others), and acts on the basis of this imputed meaning* (Bryman, 2016, p. 27).

Bryman (2016) defined symbolic interactionism as “*A theoretical perspective in sociology and social psychology that views social interactions taking place in terms of the meanings actors attach to action and things*” (p. 697). Drawing on this, Charmaz (2006) noted that interpretive theory has the following aims, to:

- *Conceptualize the studied phenomenon to understand it in abstract terms*
- *Articulate theoretical claims pertaining to scope, depth, power, and relevance*
- *Acknowledge subjectivity in theorizing, and hence, the role of negotiation, dialogue, understanding*
- *Offer an imaginative interpretation* (p. 127)

From this, the view is that our knowledge of the world is constructed in our own minds and we, as researchers, are not separate from the topic under investigation.

Ontology

There are two main ontological viewpoints relevant to this study, ‘objectivism’ and ‘constructionism’. Objectivism positions social phenomena as external objects (Holden & Lynch, 2004); for example, a hospital is an organisation that has an inherent way of operating due to its internal staffing structure, policies, procedures, protocols, and funding contracts. Through an objectivist lens, it would be seen to operate independently from those who work within it. Alternatively, *constructivism* asserts that social phenomena, such as hospitals, are shaped by the actors who operate within them. Strauss, Schatzman, Ehrich, Bucher & Sebashin (1973), in their work on ‘The

Hospital and its Negotiated Order', found that the way a hospital was run was through a social order, and agreed modes of work which came about through the shared understandings of staff, rather than being imposed by the objective constructs of policy and procedure (Bryman, 2016, p. 30). Similarly, Braithwaite (2006) studied structural and cultural changes in hospitals by examining clinical directorates using a Giddens-Weick Paradigmatic Approach; he concluded that the clinical directorates were designed to "… *change behavior and practices, to improve care and focus attention on specific aspects of acute care delivery*" (p. 99). However, the observations of how these structures influenced the practices of clinical professionals were extremely doubtful, as exemplified in the following quote: "*The organizational chart says one thing, but the behaviors and practices manifest differently*" (Braithwaite, 2006, p. 99).

In the research tradition of grounded theory, there are two streams that follow these ontological positions, one from an 'objectivist' perspective, the second from a 'constructivist' position. The 'objectivist' position places the researcher in a position of neutrality, while the 'constructivist' position draws upon the concept of 'symbolic interactionism', whereby the interaction between what is researched and the researcher builds the concepts that are drawn from the data. Writing on this, Charmaz noted that:

> *Constructivist grounded theory views knowledge as located in time, space, and situation, and takes into account the researcher's construction of emergent concepts. ... Objectivist grounded theory shares an emphasis on constructing emergent concepts, but emphasizes positivist empiricism with researcher neutrality while aiming for abstract generalizations independent of time, place, and specific people* (Charmaz, 2011, p. 365).

Charmaz (2006) stated that Glaser's theory contained a strong positivist slant. Strauss and Corbin (1998) (cited in (Charmaz, 2006) had some positivist leanings, but stressed the relationships between the content and concepts in the data to form theory, in their view, *"... theory means 'a set of well-developed concepts related through statements of relationship, which together constitute an integrated framework that can be used to* *explain or predict phenomena*'" (p. 127). Charmaz (2006) version of grounded theory resides within the ontological position of *constructivism*.

Ontology of the Constructivist Approach

The *constructivist* ontology positions reality as a concept that we construct in our own minds and which is created by us (Ghezeljeh & Emami, 2009). Denzin and Lincoln (2011) reminded us that the constructivist revision of Glaser and Strauss's original theory had a different ontological view than their original theory. The post-positivist, social constructionist view was that reality is created in our own minds. Glaser and Strauss (1967) saw the researcher as being objectively separate from what was being investigated, while the constructivist revision recognised the interplay between the researcher and the research, through which meaning is constructed. As Denzin and Lincoln reported:

> *The constructivist revision of Glaser and Strauss's (1967) classic statement of grounded theory assumes that people construct both the studied phenomenon and the research process through their actions. This approach recognizes the constraints that historical, social, and situation conditions exert on these actions, and acknowledges the researcher's active role in shaping the data and analysis* (Denzin and Lincoln (2011, p. 360).

'Constructivism' rejects the notion of objective reality. Reality is therefore subjective and dependent upon the social construction created by the individual (Ghezeljeh & Emami, 2009).

Grounded Theory

In 1967, Anselm Strauss and Barney Glaser developed Grounded Theory (Glaser & Strauss, 1967) which evolved into separate theories in a methodological debate that ultimately led to Glaser writing his own book on the basics of Grounded Theory which differed from that of Strauss (Glaser, 1992). Strauss was a student of George Mead and was therefore strongly influenced by 'symbolic interactionism', whereas Glaser held an objectivist position (Birks, Hoare, & Mills, 2019). The application and evolution of the method has been developed by other authors such as Charmaz (Charmaz, 2006) through which this research has been guided. Charmaz was a student of Barney Glaser at the University of California, San Francisco, while Anselm Strauss was the chair of her dissertation committee.

Grounded Theory is presented from its two origins, one with a positivist leaning (Glaser & Strauss, 1967), while the second emerged from the 'interpretivists', which takes as a given that knowledge is a *social construction* (Charmaz, 2006). That is, the researcher constructs knowledge through the interaction between the researcher and the researched.

The recognition of the researcher in the research process is contrary to the traditional view of scientific enquiry where the researcher is a separate, neutral, and impartial observer of 'reality'. Early qualitative research was conducted using the constructs of positivism which attempted to establish the researcher as being independent of the variables under investigation. Objective data was collected using methods that were able to be replicated with the implication that if the study were to be repeated by another researcher, the same findings could be expected. Empirical research is grounded in the positivist tradition; that is, the world can be understood and predicted if objective 'facts' are observed and recorded by the researcher and analysed through quantitative methods (Lee, 1991). To allow the scientist to observe the world, the notion of 'reality' is inherent; that is, the world is observable and exists separate to the scientist. Alternatively, an interpretive posture is available, that 'reality' is *constructed* by the researcher through the process of interaction with the external world (Charmaz, 2006). The researcher is entwined in the construction of knowledge. Charmaz's important contribution to Grounded Theory was to provide clear guidance for the new researcher, as I was, guided by her 2006 work Constructing Grounded Theory: A Practical Guide through Qualitative Analysis, as well as providing a 'constructivist' revision of Grounded Theory. My epistemological position is that we construct knowledge through our interaction with others in the world, and therefore, it was a natural progression for this position to lead to Charmaz's version of Grounded Theory. The element of Grounded Theory that appealed to me the most was the coding methods that allowed the data to speak, rather than forcing preconceived codes onto the data. For example, in-vivo coding means that one uses the exact words from the respondent to create codes and looks for other examples of the same theme in the data.

The qualitative research tradition emphasises the use of a broad range of strategies that allow the researcher to gain an increasingly deeper understanding of the research materials. Denzin and Lincoln (2011) noted that:

> *… qualitative researchers deploy a wide-range of interconnected interpretive practices, hoping always to get a better understanding of the subject matter at hand. It is understood, however, that each practice makes the world visible in a different way. Hence, there is frequently a commitment to using more than one interpretive practice in any study* (p. 4).

Glaser (1992) stated that grounded theory is an inductive method. Qualitative research can be conducted using deductive or inductive methods. In a deductive design, the theory is the foundation of the research paradigm. Alternatively, an inductive design seeks to generate theory (Bryman, 2016). In this study, the word paradigm, as defined by Guba (1990, cited in Denzin and Lincoln (2011) is employed whereby it defined my epistemological, ontological, and methodological assumptions. The paradigm directed my method as it reflected what I believed to be the nature of the world and of reality, and therefore, how it should be studied. Grounded Theory aims to generate theory from the respondents' answers and to look for common themes by recording them as memos. From this, the researcher can then generate theoretical models to test with subsequent participants. Riessman (2009) noted that:

> *Grounded theory is a category-centered approach to social research. The goal is to inductively generate theoretical generalizations about human processes that hold across individual participants* (p. 391).

I was drawn to Grounded Theory as I wanted a way to ensure that the data had an opportunity to speak for itself without the constraint of a pre-conceived formal theory that might inhibit the emergence of themes coming directly from the respondents. This is in line with the tenets of Grounded Theory, as noted by Charmaz:

> *Glaser and Strauss's book, The Discovery of Grounded Theory (1967) ... advocated developing theories from research grounded in data, rather than deducing testable hypotheses from existing theories* (Charmaz, 2006, p. 4).

Glaser is noted to be truer to the original method he developed with Strauss in 1967 (Markey, Tilki, & Taylor, 2014), while Charmaz (2006) asserted that her version responded to the inherent limitations and vagaries of the original approach. Grounded Theory, as informed by Charmaz (2006), is based on the perspective that we construct reality through the interpretation of our data: *"We* construct *our grounded theories through our past and present involvement and interactions with people, perspectives, and research practices"* (p. 10). Charmaz went on to say that any theory that is generated is a construction or portrayal of 'reality' rather than being an exact copy of it. She further noted that "*Qualitative research has long attracted researchers who hope that their studies will matter in the public arena as well as in their disciplines*" (p. 359), and this was indeed the motivation behind my research design.

While I coded the emerging data according to the Grounded Theory method of Charmaz (2006), the reality was that while I could identify emergent themes, I could not identify any patterns upon which to form an emergent theory. I performed line-by-line coding, and generated in-vivo codes. I endeavored to not overlay preconceived ideas onto the data; I focused on listening to, and reflecting on, what the respondents had told me.

After coding and sorting the data into themes, four major themes emerged from the data, Models of Care, Funding, Workforce, and Leaders. What was also evident in the respondents' answers was that three groups of 'actors' were constantly referenced, namely doctors, bureaucrats, and patients. The latter group had often received poor treatment. However, I could not find a pattern or 'emergent theory' arising from the data. Therefore, I searched for a theoretical construct upon which to compare my findings and turned to Alford's theory (1975) of structural interests. My data became a case study that supported Alford's theory, but as will become evident, with considerable variation according to the passage of time and the associated changes in healthcare systems. This is not unusual in the qualitative research process, as noted by Denzin and Lincoln

(2011), as a wide range of strategies are used by qualitative researchers to better understand the world in different ways.

> *… qualitative researchers deploy a wide-range of interconnected interpretive practices, hoping always to get a better understanding of the subject matter at hand. It is understood, however, that each practice makes the world visible in a different way. Hence, there is frequently a commitment to using more than one interpretive practice in any study* (p. 4).

METHOD

Introduction

In order to answer my research questions, I sought out health leaders from New South Wales and the commissioners from the National Health and Hospital Reform Committee. My rationale was to understand the insights these leaders had in attempting to improve or reform the health system for older people with chronic conditions. I wanted to know what these leaders thought led to the implementation of new models of care that were best suited to meeting the needs of older people with chronic conditions. I also sought to understand the transformations in the health system that had occurred to meet the needs of older Australians with chronic conditions. Extensive data were gathered from these key informants and then analysed. The respondents were drawn from different areas of the system, from the primary care, acute, and tertiary sectors, and hence, provided a variety of perspectives. My enquiry went further to determine if there was a government policy connected to the new model of care and/or how the programs came about – and what lead to their implementation? Why did this happen? How was change achieved? After the data were analysed using an inductive method informed by Charmaz (2006) approach, they were compared to Alford's formal theory of structural interest groups.

Recruitment

A non-randomised, snowball, purposive sampling strategy was employed to recruit participants for the study. The key criteria for inclusion in the study were individuals who were in health leadership positions in Australia. I invited the most senior leaders I could from the New South Wales health system as well as the National Hospital and Health Reform Commissioners. From August 2009 until June 2010, the potential participants were invited to participate in the study, and once consent was obtained, the interviews were conducted. To commence the data collection process, interviews were conducted with New South Wales (NSW) Health leaders as well as leaders from within the NSW Area Health Services. At the completion of the interview, the participants were asked who else could be approached to participate in the study. Using this method, a total of 30 interviews were conducted.

Potential interviewees were sent a letter of invitation which included a brief description of the study (Appendix One) and a Participant Information Sheet (Appendix Two). Once they had agreed to participate, the interviewees signed a consent form (Appendix Three), and I followed the interview schedule as shown in Appendix Four. A total of 35 people were invited to participate over a 12 month period, with 30 agreeing to participate. All interview participants were given the option of a face-to-face or a phone interview. In total, 18 interviews were conducted face-to-face while 12 were conducted by telephone.

Table 5.1 Respondents and their primary affiliation:

Hospital and Health Reform Commissioners (4) Australian Government Executives (2) State Health Department Executive (1)	NSW Health Senior Bureaucrats (5) NSW Area Health Service Executives (4) NSW Area Health Services Senior Managers (6)	Private Sector Senior Consultants (1) Senior Academics (3) Executive Not-for-profits (4)

A total of 15 respondents came from ‘inside’ the New South Wales health system who were senior bureaucrats in the NSW Department of Health, or executives or senior managers in Area Health Services. Meanwhile, 7 respondents were drawn from outside the NSW Health system, but with strong leadership roles in relation to health, notably the four who were, at the time of the interviews, involved with the Health and Hospital Reform Commission instigated by the Rudd Government (Commonwealth of Australia, 2009). A total of 8 respondents were senior academics in healthcare, consultants, or executives in not-for-profit health-related organisations. The majority of the respondents had a health background in either medicine, nursing, or allied health.

Grounded theory and method: Interviewing

Ghezeljeh and Emami (2009) and Denzin and Lincoln (2011) noted that grounded theory studies frequently include interviews. Interview questions can be formed through broad and loosely guided exploration of key topics through to semi-structured questions (Charmaz, 2006, p. 26). I favoured the latter. Charmaz also noted that when the respondents answer the questions, the *"... result is a construction – or reconstruction – of a reality*" (p. 27) rather than a positivist 'fact'.

My approach drew on the work of Baeza et al. (2009) who used the policy component of the World Health Organization's Innovative Care for Chronic Conditions to examine key informants' perspectives on chronic disease prevention and management in rural and remote communities in Australia. Their method involved interviewing a purposive sample of 21 interviewees by telephone using a semi-structured interview. The sample included senior state and Commonwealth public servants, state/territory public servants, Aboriginal Community Controlled Health Organisations, and a health consultant. The methodology used in this study is consistent with the data collection method used by these authors. In the Baeza et al. (2009) study, the aim was to interview those who were responsible for policy development and implementation. The interviews were then content analysed to identify the inherent themes. The interviews covered the following aspects:

- The information base for chronic conditions.
- Current health policy for chronic conditions.
- Inter- and intra-agency partnerships, relationships, and collaborations.
- Legislative/governance frameworks for chronic conditions.

- The prioritisation of chronic conditions in plans.
- Financial arrangements.
- Workforce development (Baeza et al., 2009, p. 213).

These authors identified major themes that emerged from the responses from the key informants. In a similar fashion, my research identified four major themes in relation to innovative models of care for older people with chronic disease, *models of care, workforce, funding, and leading change in healthcare.*

My original research question was '**Why is the health system so resistant to change or 'reform', as it is often described**'? The research question was narrowed to the highly topical issue of older people with increasing rates of chronic disease. The projected impact of the increase in health needs of this population and the increased costs associated with these needs were highly topical in 2009. The inability of the system to change was narrowed to focus on models of care. As previously mentioned, I argue that models of care are an expression of health policy.

Conducting the interviews

As noted, 18 interviews were conducted face-to-face, while 12 were conducted by phone. The interviews were audio-recorded while I took notes throughout each interview. I was careful to ensure that rapport and eye-contact was maintained as much as possible, so that the note-taking process would not distract from the content during the face-to-face interviews. Each audio-recording was transcribed and then reviewed in detail to ensure accuracy. I transcribed 7 interviews, while the remaining 23 were transcribed by a confidential transcription service. I checked each transcription for accuracy by reading it while listening to the audio-recording, and any errors were corrected. These were few, and were mostly related to health acronyms and medical terminology, or to terms used within NSW Health.

The transcriptions were then imported into NVivo 10 which was used as the vehicle for coding and analysis. It is vital to stress that the use of NVivo was a **vehicle** to facilitate coding and analysis not as a substitute for genuine immersion in the data and careful consideration of coding and the identification of themes. The transcriptions were invaluable as they allowed me to go back and re-read the respondents' answers to ensure I had been true to their intended meaning. Charmaz (2006) noted that "*Transcribed, tape-recorded interviews make it easy to see when your questions don't work or force the data*" (p. 32).

The respondents were not given the opportunity to review their transcriptions, as this was not part of the study design, as I felt it would be a barrier to participation in attracting busy, high-level health leaders to the study. I acknowledge this imposed a limitation in terms of verifiable accuracy. The transcriptions were then imported into NVivo 10, which was used as an aid for coding and analysis. My coding was not checked by an external person; and whilst this could be perceived as a limitation it was also strength in consistency of data coding. I was strict with my coding discipline and interpretation, and this was facilitated by the use of NVivo10. I undertook further study in the use of NVivo10 and engaged a highly skilled and recognised trainer to ensure my use of the program was leveraged to full advantage for my analysis.

Interview question design

The interview schedule was constructed with a series of open-ended questions using a semi-structured approach. This deviated from the traditional view of Glaser and Strauss (Glaser & Strauss, 1967) who advocated letting the conversation emerge naturally. This semi-structured method was applied for a number of reasons. The subjects participating in this study were all senior health professionals working in significant positions within the NSW and/or Australian health system. Their time was limited and they were in high demand, and from a pragmatic perspective, the researcher's task was to gain answers to key concepts critical to the subjects under investigation. The questions arose out of my main research question, as follows: why is the health system so resistant to change?, what changes in the system are required to meet the needs of the ageing population with increasing rates of chronic diseases?, what models of care meet the needs of older people with chronic diseases?, and how did these models of care come about? My interview protocol was reviewed by my thesis supervisor at the time and approved through the ethics review process.

Analysis

The framework for the analysis was informed by grounded theory (Charmaz (2006) where the researcher sought to identify themes (via coding) that emerged from the interviews, rather than to impose pre-formulated codes upon the data. “A code in qualitative enquiry is most often a word or short phrase that symbolically assigns a summative, salient, essence-capturing, and/or evocative attribute for a portion of language-based or visual data” (Saldana, 2011). In order to achieve this, the analysis was conducted in three phases.

In phase one, the data was sorted into responses by question. All text for the question posed was included, until the next question was asked by the interviewer. This included, in some instances, dialogue between the interviewer and the interviewee. In practical terms, this meant scrolling down to the end of the response before the next question was asked, and highlighting all the text that appeared between when the first question was asked and the next question. This selection was then highlighted as Question One and so forth.

Four questions linked back to previous questions that had been asked (questions 6, 7, 8, and 10), so if for example, an interviewee did not answer question 5, I skipped questions 6 and 7 which related directly to the content of question 5. In the process of coding, discipline was necessary as in this phase, at times, supplementary questions were asked to clarify points in response to the respondent’s answer. This content was coded to the original question asked.

Once the data was separated by question, I then commenced the initial coding. I was careful to read and consider the full meaning of each response, as noted by Saldana (2011):

> *Note that when we reflect on a passage of data to decipher its core meaning, we are decoding; when we determine its appropriate code and label it, we are encoding. … simply understand that coding is the transitional process between data collection and more extensive data analysis* (p. 4).

Furthermore, in relation to novice researchers, Saldana (2011) stated that "*Researchers new to coding qualitative data often find in-vivo coding a safe and secure method with which to begin*" (p. 77). I found this to be accurate, as I would use the key word or phrase directly from the passage rather than create my own label. An initial coding set was used to organise each of the responses with the focus on simply identifying the key themes in the data. I also used 'in-vivo' coding as often as possible to stay true to the principles of grounded theory. 'In-vivo' coding is described by Strauss (1987) as *"the terms used by [participants] themselves"* (cited in (Saldana, 2011, p. 74). "*To codify is to arrange things in a systematic order, to make something part of a system or classification, to categorize*" (Saldana, 2011, p. 8). An in-vivo code is one in which the code is derived directly from what the interview respondent has said. Codes can summarise or condense the data – the aim is not to reduce it in conveying it's meaning, but to summarise it (Saldana, 2011, p. 3).

I found that initially, in-vivo coding was ideal, but as the analysis evolved, it was necessary to expand the codes as there were sub-concepts that related to the codes. For example, the in-vivo code 'Self-Management' was identified in its initial context as the need for more self-management programs for people with chronic conditions. It was then cited in the context of staff training in how to work with patients using a self-management framework. Other themes included the need for more funding for self-management programs, the need for a shift in community attitudes towards self-management treatments. So what I thought was initially the same theme, that is self-management, actually became two; one which focused on increased demand for self-management programs in the community, while the second was about the need to increase the health literacy of the population in relation to chronic disease management. Sipe and Ghiso (2004) stated that *"All coding is a judgement call"* since we bring *"our subjectivities, our personalities, our predispositions, [and] our quirks"* to the process (pp. 482-3) (cited in Saldana (2011, p. 7). Saldana went on to say that following the first round coding, the researcher should step back and go through the data again, and not be afraid to re-code, re-define, and then re-categorise the data. This can happen a third, fourth, or fifth time until the researcher feels they have adequately coded, defined, and categorised the data.

It was evident that during the first cycle of coding that there needed to be a broad brush applied to the emergent codes, so that sub-codes could be identified in the second cycle of coding. This experience reflected Saldana's observation that coding is a cyclical act. I coded on one occasion, and then went through to further refine and define the codes. Coding is an exploratory problem-solving technique without a specific formula to follow (Saldana, 2011, p. 8). True to the lack of any formula to apply, I was reassured by Saldana's assertion that "*You won't get it right the first time. Qualitative enquiry demands meticulous attention to language and deep reflection on the emergent patterns and meanings of human experience*" (Saldana, 2011, p. 10).

Saldana commented that sometimes data is coded for patterns. In this research project, I had a large data set and found the need to use the same codes repeatedly. Saldana stated that this is to be expected because there are patterns of actions and consistencies in human affairs, and one of the coder's primary goals is to find repeated patterns (Saldana, 2011, p. 5). Sometimes the researcher may code based on a commonality rather than the consistency of the content; for example, expressing a view on the Prime Minister – the content of the view may be vastly different; however, the commonality is that the data is demonstrating a theme about commenting on a Prime Minister (Saldana, 2011, p. 6).

Hatch (2002) observed that patterns are not simply stable regularities, but have varying forms. A pattern can be characterised by:

- Similarity (things happen in the same way)
- Difference (they happen in predictably different ways)
- Frequency (they happen in a certain order)
- Correspondence (they happen in relation to other activities or events)
- Causation (one appears to cause another) (Saldana, 2011, p. 5).

These relationships and patterns emerged throughout the second cycle of coding; for example, particularly in items related to views on the role of leaders and leadership. To illustrate this point, the interviewees commented on the importance of having leaders engaged when new models of care are introduced, as well as the importance of having the Chief Executive of an Area Health Service involved in the project. These comments also spoke to the importance of leadership from a variety of individuals within the health service, those in leadership positions such as the Chief Executive, and people in clinical leadership, such as the senior doctors.

Qualitative codes capture the essence of a piece of data. When clustered together according to similarity and regularity, a pattern emerges and this facilitates the development of categories, and thus, the analysis of connections.

Third and fourth cycle coding allowed for further refinement of the codes and their meanings. From these codes and categories, the themes emerged. Codes can be clustered to become categories, but within the categories, sub-categories may also emerge. Collectively, themes and concepts can emerge from the data which may lead to theory (Saldana, 2011, p. 12).

Four major themes were identified, *Models of Care, Workforce, Funding, and Leaders*. I also noted the major actors within each transcription, the doctors, the bureaucrats, and the patients who had often received poor care. These themes were then contrasted with Alford (1975) theory of structural interests. Constructed grounded theory allows the researcher to capture the experiences of interviewees and, during the writing process, to contrast or link their work to other theorists (Ghezeljeh & Emami, 2009). Charmaz (2011) described the research process as follows:

> *First, we compare data with data as we develop codes; next, we compare data with codes; after that, we compare codes and raise significant codes to tentative categories; then, we treat our major category(ies) as a concept(s), and last we compare concept with concept, which may include comparing our concept with disciplinary concepts. The analytic comparisons we make during our current phase of enquiry shape what we will in the next phase and cannot*

> *be ascertained beforehand. The method prompts us to interact with our participants, data codes, and tentative categories. Through these interactions, our nascent analyses emerge and take form* (p. 361).

I acknowledge that the analysis of the work of other authors and theorists does not traditionally reside within a methodology and method chapter; however I felt it assisted the flow of my argument to briefly clarify the considerations to other theoretical frameworks that could have led to the formation of my emergent theory and indicate why they were not used in this study.

Analysis of the emergent themes and the journey to Alford (1975)

Once I had coded the data and conducted the thematic analysis, it was clear that an emergent theory was not evident. The data was coded in 2013, and as outlined in the Introduction, I then presented and wrote about the major themes that emerged. I spent much of 2015 reading the work of Pawson and attempting to fit my analysis into the framework of realist evaluation (Pawson, 2003; Pawson, 2006; Pawson, 2006, 2013, 2015; Pawson et al., 2014; Pawson & Manzano-Santaella, 2012; Pawson & Tilley, 1997). Ultimately, this failed and I left the University of Sydney at the end of 2016.

When I recommenced work at Flinders University, I read the works of Bacchi (Bacchi, 2009, 2012); Tuohy (Tuohy, 1999a, 1999b); Braithwaite (Braithwaite, 2006; Braithwaite et al., 2016; Braithwaite et al., 2017; Skinner et al., 2009) before choosing Alford. I also immersed myself in my data, re-reading each transcription and reading the content of the major nodes I had identified in my qualitative analysis. In addition to Tuohy, Bacchi, and Braithwaite, my respondents all grappled with the issue of why healthcare systems are so resistant to change. Tuohy's book and article on Accidental Logics: The Dynamics of Change in the Health Care Arena in the United States, Britain and Canada (Tuohy, 1999a, 1999b), explored the transformation of healthcare in the United States, Britain, and Canada during the 1990s. As a political scientist, she examined the interplay of power within democracies, and the social and political processes that underpin healthcare in terms of a function of government or a market-based system. She examined from a historical perspective, the different experiences of the three countries by exploring the decision-making systems in the production and consumption of healthcare to determine why they each had experienced different results in their efforts to transform the health system. She examined the 'logic' of the design of the health system – *"… a logic generated by the balance of influence in each system across state actors, private financial interests, and healthcare providers, and by the mix of hierarchical, market-orientated, and collegial instruments of social control"* (Tuohy, 1999b, p. 115).

In Britain, the government sought to introduce more elements of a market-based system to drive efficiencies through commissioning and payment by results; however, in Tuohy's account, the introduction of these systems lead to substantial change in decision-making systems largely through bargaining between purchasers and providers – but this, in her view, was a far cry from the desired competitive market. Unlike the state-financed system, this contrasted with the mixed-market system in the USA, where there is a combination of private health funding and government-funded health services. The rising cost-consciousness lead to an increase in for-profit, investor-lead and owned health entities. The Canadian system which affords their medical profession a high degree of autonomy, with the government holding broad budgetary control, saw little change apart from the tightening of fiscal resources. One of the elements of her analysis contrasted the relationship between the state and the medical profession; in the 1960s, the Canadian and US health systems were virtually identical, a situation which changed as Canada introduced universal healthcare while the USA only adopted coverage for the poor and the aged. In Canada, there is greater evidence of collaboration between the professions and the state, whereas in the USA, the relationship is by explicit contracting, which is increasing, particularly by Health Management Organisations.

The comparison between Britain and Canada, both with universal healthcare, but different system design:

> *… were characterized by an "implicit bargain," a "second-level agency relationship" between the state and the medical profession with broadly similar terms: The state established broad budgetary parameters, and*

> *physicians were free to exercise clinical judgment in the allocation of resources within those parameters* (Tuohy, 1999b, p. 130).

Tuohy asserted that the ‘state’ and the ‘market’ represent two different types of decision-making systems. She argued that the ‘state’ is made up of a set of actors whereas the ‘market’ has a set of instruments. The introduction of contracting, a ‘market’ tool in Britain, did not fundamentally change the relationship between the state and the medical profession. The government still had to balance the political sensitivities of the communities within which they were elected and, at the same time, preserve support from the medical community. Tuohy argued that in state-financed health systems such as Canada and Britain, the relationship with the medical profession is one of bargaining which always aims at the establishment of a coalition of support.

The pace of innovation observed by private sector financed healthcare in the USA was viewed by Tuohy as unparalleled in any publicly-funded system, as investors can easily move their money to other more profitable organisations, and therefore, each healthcare organisation will attempt to retain their competitive edge. These innovations were not evident in the largely publicly-funded systems of Britain and Canada as the state had to continually maintain ‘coalitions of political support’ which moderated the pace of change that could be achieved. This is indeed reminiscent of Alford’s argument about ‘coalitions’ of structural interest groups aligning to achieve change. In Tuohy’s analysis she viewed them as ‘accidental logics’ or windows of opportunity when health policy could be progressed, such as, the introduction of the National Health Service in the United Kingdom. She argued that these opportunities are relatively rare as health policy is largely determined by the internal logic of each individual’s country inherent design or ‘logic’. In Alford’s taxonomy these moments of ‘accidental logic’ would be viewed as ‘temporary coalitions of structural interest groups’.

‘What’s the problem represented to be?’ is another approach to policy analysis put forward by Bacchi (2009). Bacchi sought to shift the focus from ‘problem’ solving to ‘problem’ questioning; that is, to interrogate the methods in which arguments for change represent how the ‘problems’ are constructed in the first place. By reading Bacchi, I became curious as to how I had constructed my research ‘problem’ i.e., the ageing population with increasing rates of chronic conditions. In fact, many of the respondents had talked explicitly about the problem with older people and people with chronic disease, the problems they faced in hospital, getting out of hospital, and their experiences in Emergency Departments. There was no doubt in my mind that the core of the problem was how care was organised in these settings, and why in the face of all these ‘problems’ of poor patient care, nothing had been done about it. Why was health so riddled with inertia? Or was the real problem one of why the older patient’s health had deteriorated to the point that acute care was required? Bacchi highlighted that the way in which we present a problem indicates our bias, as well as our perceptions about the potential solution.

The reconstruction of my research questions through Bacchi’s approach lead me to think about the inherent design of health, its history, and the key players involved. In the respondents’ views, these were the government, the medical profession, and the patients. As examination of this complex inter-relationship led me to the structural interests inherent within health systems, Alford (1975) theory was a natural and logical progression.

In Australia, Jeffrey Braithwaite and colleagues at the Australian Institute of Health Innovation explored the power, culture, and structural influences in healthcare innovation. Braithwaite et al. (2017) took a systems science perspective on how to affect change in public hospitals. These authors noted the unique role that clinicians, particularly doctors, can play in stopping change, especially if the changes are being introduced through a top-down approach. In Alford’s taxonomy, this would be the ‘Corporate Rationalists’ seeking to instigate change and the ‘Professional Monopolists’ pushing back on that change. Braithwaite et al., also highlighted the importance of workplace culture in influencing the behaviour of doctors, nurses, and allied health professionals (Braithwaite et al., 2016), as well as the importance of understanding that changes to the organisational chart does not lead to change in the behaviour of medical professionals (Braithwaite, 2006).

Ultimately, I chose Alford's theory (1975) of structural interests as it had the greatest resonance with the themes identified by the respondents that emerged from the data. There was so much synergy between his descriptions of healthcare cycles of Inquiry in New York City and my respondents' descriptions of what was occurring in New South Wales and Australia during the study period. In addition, his structural interest groups were also strongly represented in the themes that emerged from the respondents in my study, that Alford's theory was a logical choice. This choice also reflected a commitment to grounded theory in which I did not want to force the data into a theoretical paradigm that was inconsistent with the data. However, as will become clear, I uncovered modifications to Alford's position that were the result of the passage of time, shifts in power between the state and the medical profession, and a growing consciousness among some members of the medical profession of the need to champion reform.

Use of Alford's Theory

Originally, I set out to code my data using Grounded Theory and I believed that a theory would emerge. However, this was not the case – once I had considered other theorists, I found Alford's (1975) themes and his three structural interest groups reflected throughout the respondents' transcriptions which became dominant themes in the data. My research questions included:

1. ***Does Alford's theory explain why reform within the Australian healthcare system is difficult to achieve?***
2. ***Was there evidence of Alford's three structural interest groups in the themes that emerged from respondents?***
3. ***Did these interest groups behave in a manner consistent with what Alford described?***

The theory by Alford (1975) allowed me to contrast my major themes with his theory of structural interest groups and how they block or facilitate change in a health system. The four major themes that emerged from respondents are represented in the four discussion chapters, namely Models of Care; Workforce; Funding, and Leaders. Ultimately, this inductive, and then deductive, process lead to the formation of a new emergent category of a fourth structural interest group which built on Alford's original theory. Within the four discussion chapters is evidence that supports Alford's theory of structural interests. I also postulated the emergence of a fourth structural interest group, the 'Professional Advocates' as a new contribution to Alford's original theory. Alford's three structural interest groups are 'Professional Monopolists' (doctors), 'Corporate Rationalists' (bureaucrats), and 'Equal Health Advocates' (patients). A detailed introduction to Alford was provided in Chapter Four.

Method for Literature Review

Glaser and Strauss (1967) advocated that a literature review should not be conducted until after the data has been collected. This is to reduce the likelihood of the researcher adopting a bias from the literature and forcing the emergent data into existing constructs. However, as noted by Charmaz (2006) and Lempert (2007 in Denzin and Lincoln (2011, p. 366), few doctoral students and professional researchers can achieve this, as they are unlikely to come into their field of research without some knowledge of their topic. However, to attempt to be true to the intent of grounded theory, the literature review occurred after the data collection. El Hussein, Kennedy, and Oliver (2017) stated:

> *The issue of the literature review remains a conundrum and a controversy within the discourse on grounded theory methodology. Grounded theory researchers are expected to minimize preconceptions to ensure the concept of interest is grounded in data, yet at the same time, are required to evaluate existing literature to support institutional ethics and scientific review of the research proposal. In addressing this dilemma, we espouse that literature review in grounded theory should comprise a multi-stage non-linear approach to the literature and introduce a framework for novice grounded theory researchers. This framework offers a reflexive, dynamic, and integrative process for conducting a literature review that allows researchers to minimize preconceptions while maintaining the original intent of grounded theory methodology* (p. 1199).

However, as noted by (Charmaz, 2006), no researcher comes into their field without pre-existing knowledge of that field. I was highly informed about health system design having worked in it for several decades, along with first-hand experience of a large statewide program to improve the health system for older people with chronic conditions. Therefore, I cannot claim to lack preconceived notions of the challenges in improving the health system, but what I attempted to do was to open myself up to hear what the interviewees were saying, and using their words to generate themes rather than imposing a pre-conceived coding framework upon their thoughts. Heath (2006) stated that the literature review is delayed until the theory begins to emerge and the literature is then used as data – and this is exactly how I approached the literature. For example, when the respondents had identified models of care that better met the needs of older people with chronic conditions, I was able to examine the impact of each model of care because of the time lag between the data collection and the write-up of this thesis.

To begin with, I searched the literature and used the following method. The ageing population, chronic disease, policy, and innovation were the central themes of my research, and therefore, the core concepts of the literature reviewed. Each term was searched, and then combinations of the search terms were combined to refine the selected literature. Terms were combined using the terms ‘AND’ and ’OR’. I used the Medline, Informit, and CINAHL databases to search using the defined criteria. The Medline search yielded 91 references. In a subsequent review of these references, 21 were pertinent to the current study. Using the full search criteria, the Informit database yielded 0 results. In response, the criteria were systematically reduced (and therefore broadened) until 118 references were found using the phrase “ageing or older people or elderly”. A number of these articles were found to be duplicates, thus reducing the number to 76. A further manual review of these references by reading the abstracts reduced the number to 29 relevant papers.

The search of the CINAHL database, using the full criteria, yielded 0 results. The criteria were then systematically reduced until 254 references were found using the phrase “ageing or older people or elderly AND chronic disease or chronic conditions or chronic disease management”. These 254 articles were manually searched and 49 relevant articles retained. Manual searching and references obtained from citations within journal articles were also considered for the literature review.

The literature review was conducted according to the recommendations of El Hussein et al. (2017); that is, after the interview data had been collected. The literature is presented throughout this thesis, particularly in Chapters One (Introduction); Two (Ageing and Models of Care); Three (Chronic Disease); and then throughout the four discussion chapters. A further literature review was conducted using the search term ‘Alford’ to identify other authors who had used his work using the Medline and Psychlit databases – the results of this search are included in Chapter Four.

To examine the impact of the models of care that the respondents identified as better meeting the needs of older people with chronic conditions, the relevant literature was examined and will be presented in Chapter Six, Models of Care. To examine other issues that the respondents identified, namely issues related to the health workforce and funding paradigms, the related literature was also examined and will be presented in Chapters Seven and Eight. To examine the role of leaders in Chapter Nine – the literature used to provide an objective view to substantiate the subjective view provided by the respondents was also utilised. This again highlights the fact that in grounded theory, the literature can be drawn from across a broad time period to elucidate themes emerging from the data. In some instances, this literature draws on research undertaken after 2009-2010 that supports the models of care being implemented at this time, or confirms the observations of the participants (Heath, 2006; Rolfe, 2006).

Ethics Approval

Ethics approval was gained for the study from the Human Research Ethics Committee of the University of Sydney, project number 03-2009/11455.

Summary

This chapter has provided an overview of the epistemological and ontological paradigms relevant to the research. It has introduced ‘positivism’, ‘interpretivism’ and ‘symbolic interactionism’ as research concepts that inform this study. The constructs of ‘objectivism’ and ‘constructivism’ are discussed in the context of grounded theory. The ‘inductive’ and ‘deductive’ research traditions are described before moving onto a detailed account of the data collection process, method, and analysis. In-vivo coding has been described and used in this study. An account of how I arrived at Alford’s (1975) structural interest theory has been provided, along with the exploration I made of other theorists. A summary of the method for the literature review is provided along with the ethics approval obtained from the University of Sydney. The next chapter, Chapter Six, describes the models of care that were identified by the respondents using the methods described. This chapter is the first of the four discussion chapters.

CHAPTER SIX MODELS OF CARE

Introduction

This chapter outlines the models of care that emerged from the respondents’ answers to questions relating to innovative approaches that better meet the needs of older people with chronic conditions. The first section describes each model of care. The second section then examines these models using Alford’s framework of ‘Professional Monopolists’, ‘Corporate Rationalists’, and ‘Equal Health Advocates’. This examination demonstrates that all the identified models of care only came into being through new dedicated funding, with the exception of ComPacks and Community Acute Post Acute Care (CAPAC). The dedicated funding was derived from the ‘Corporate Rationalists’ seeking to reduce the most costly elements of healthcare, namely hospital admissions and subsequent in-patient bed days. All of these models, apart from CAPAC, in no way threatened or reduced the role, number, or autonomy of the ‘Professional Monopolists’. In translating Alford’s framework to healthcare in NSW, it is worth noting that doctors, specialists, and GPs make up the ‘Professional Monopolists’, while the ‘Corporate Rationalists’ are from either NSW Health, the Department of Health, or from within the corporate structures of each Area Health Service. Where funding was derived from the Commonwealth Government, this is indicated, and these groups are also designated as ‘Corporate Rationalists’.

The final section of the chapter highlights the model of care known as CAPAC, which was later rebranded as Hospital in the Home (HITH). This was the only model of care that threatened the role of the 'Professional Monopolists', and it took over 20 years for it to be adopted across the state of New South Wales and, in the end, required the intervention of the 'Corporate Rationalists' to install the model across the state. This example of the HITH is one in which a Professional Monopolist saw a different way of working, researched the model, and established it where they could, and then it required the intervention of the Corporate Rationalists to install the model across the state.

Identifying the Models of Care in the interviews

In the interviews, a model of care was identified when a respondent named it as such and provided a specific description about how it worked and where the funding came from. A model of care was described by Davidson et al. (2006) as "*an overarching design for the provision of a particular type of health care service that is shaped by a theoretical basis, evidence-based practice and defined standards*" (p. 47), and this definition has been used by other authors including Schultz et al. (2019), when developing a new model of care delivery. All the models described in this chapter aimed to integrate care through connecting services and ensuring continuity of care when patients were transferred from the acute sector back into the community. They also provided alternative models of care to a hospital in-patient stay that is an alternative to hospitalisation such as was the case with HITH. Recall in Chapter Three, I grouped the models of care on the basis of their primary setting – this is reflective of the models of care identified by respondents which are individually described in this chapter.I In summary they were:

Table 6.1: Models of Care and setting

Setting	Model of Care
Emergency Department	**1.** Care Navigation **2.** Acute to Aged Related Care Services (AARCS) **3.** Aged Services Emergency Teams (ASET) **4.** Geriatric Rapid Assessment and Care

	for the Elderly (GRACE)
Alternative to Emergency Department (ward-based Model of Care)	**5.** Medical Assessment Units
Community as an alternative to hospitalisation	**6.** Community Acute Post Acute Care (CAPACs or HITH)
Community to support successful discharge from hospital	**7.** ComPacks **8.** Transitional Care Program
Multiple	**9.** Advance Care Planning
Community General Practice	**10.** HealthOne

The first group of models were introduced into Emergency Departments, and include Care Navigation, Acute Aged Related Care Services (AARCS), Aged Services Emergency Teams (ASET), and Geriatric Rapid Assessment and Care for the Elderly (GRACE). The establishment of Medical Assessment Units is also described in this chapter as these were an alternative to the Emergency Department environment where older and more complex patients had a dedicated multi-disciplinary team that could comprehensively assess their needs for up to 48 hours. Models designed to substitute hospitalisation or reduce the length of stay in a hospital included Community Acute Post Acute Care (CAPACs or HITH), ComPacks, and the Transitional Care Program. Two other models also discussed which were highly topical in NSW during the period of the data collection, were the Medical Assessment Units (MAUs) and a grouping of models in relation to Advance Care Planning. HealthOne was an initiative of NSW Health designed to combine General Practice and Community Health services.

All of these care models were introduced by either the Federal or state governments and sit firmly in the domain of the ‘Corporate Rationalists’ introducing new funding for the initiatives. They were introduced with discreet government funding and did not seek to challenge any defined role or functions of health professionals; rather, they ‘played at the edges’ by establishing new roles to fit into the existing system (Alford 1975). The only challenge to the ‘Professional Monopolists’ was the CAPAC, which replaced hospital in-patient care with home-based hospital care.

An important reminder from Chapter One is from NSW Health's 2009-2010 Annual Report in which there is a new distinction made in the hospital activity tables. For the first time, the annual report separated out bed occupancy of adults from older people (NSW Department of Health (2010, p. 61). This distinction highlighted the focus of the NSW Health Department on the utilisation of acute hospital beds by older people at the time the interviews were conducted, and represented the work of the 'Corporate Rationalists'. NSW Health also highlighted the establishment of 28 Medical Assessment Units across the state as well as $11.9M funding for additional Hospital in the Home (HITH) places, along with the chronic disease management initiative summarised below. These programs demonstrate the push by the 'Corporate Rationalists' to prevent and avoid hospitalisation for older people with chronic conditions. The NSW Health Department's 2009/2010 Annual Report highlighted an emphasis on reducing preventable hospitalisations in older people with chronic diseases. As noted:

> *NSW Health is implementing the Severe Chronic Disease Management Program to deliver more effective care and support to older people over 65 years and Aboriginal people over 45 years who are at high risk of being admitted to hospital because of their chronic diseases. This innovative new program is the first of its kind in NSW* (NSW Department of Health, 2010, p. 61).

A description of the 10 models of care that were discussed most frequently by the respondents will now be provided.

Care Navigation

Care Navigation was a concept that evolved out of Western Sydney's Blacktown Hospital. Initially, care navigators worked in the Emergency Department and were responsible for "in bound" care navigation for people with chronic or complex health needs that used the hospital frequently. Later, "out bound" care navigators were estabished to connect these patients with community and healthcare supports to prevent acute exacerbation. Care Navigation was funded by the State Government via NSW Health and the 'navigators' were typically specially trained nurses. They were responsible for co-ordinating the treating team to expediate the passage of the patient through the hospital system. The care navigators would ‘find’ patients in the Emergency Department, source their notes, advocate for specialists to review their care needs and, whenever possible, organise for them to safely return home with home-based supports and/or outpatient appointments to address the unmet needs that were the cause of their acute presentation. The rationale was to fast-track the work-up of these complex patients and provide them with the necessary supports to allow them to return home, or if they needed to be admitted, to get their care plan commenced as early as possible. The driver for this model of care was the 8 hour rule, whereby patients had to be discharged or admitted within 8 hours from the time they were first seen in the Emergency Department (O’Connell et al., 2008).

Professional monopolies were not challenged, with the doctor’s role remaining intact; the care navigators, who were nurses, were additional to the existing staffing model in the Emergency Department. As described by the respondent below, the doctors did not have to change their practice, and in fact, did not see the need to be part of this ‘system’:

> *Care navigation started at Blacktown and went to Auburn, Westmead, and Nepean. … You know, it wasn’t a smooth run, you know, getting these things up … But that system of identifying people as they come through the ED, having a process of risk assessment, having a referral onto the inpatient component, getting that inpatient component all together, that was probably our biggest challenge actually* ***because the specialists didn’t see the need to be part of this type of system.*** *... But I think we’ve slowly been chipping away at that and having the evaluation project here at Nepean will help settle some of those fears or – not necessarily fears, blatant dismissal* [emphasis added] (Executive Sydney West Area Health Service, 2010).

This respondent also described how the medical specialists work in the hospital setting; they assess a patient, order tests, prescribe medication, write up the results and move on, not staying to oversee the coordination of the patient’s ongoing care. Note the respondent said, “… *this type of system*”, which means a model of care that connects all the assessments and combines them into a comprehensive picture of an older person’s conditions, and then systematically addresses these elements by employing all facets of available health and community care resources. The “*type of system*” the older person needs for comprehensive assessment and management is later described in the Medical Assessment Unit Model of Care.

Despite the lack of interest by medical specialists, the care navigators were able to assist patients to move at a faster pace through the Emergency Department. As one Executive noted:

> *… care navigation basically is a system that supports the identification of chronic and complex people when they hit ED, and then tracks them through the hospital, and then provides links to those [support services] in the community. There’s positions that get redefined to help support that journey and – called inbound and outbound care navigators, and the outbound care navigators have tended to have a community focus in the past which has helped with those links. The inbound care navigators have tended to be what we call patient flow, or discharge planning, you know, type of people – type of roles, to support people coming in, and identification of systems and flows from the ED to the hospital wards and back out to the community again* (Executive Sydney West Area Health Service, 2010).

Plant et al. (2015) explored the outcomes of the Care Navigation model in Western Sydney to see if it reduced the use of hospital treatment and had a positive impact on the quality of life of patients with chronic disease. The selected patients were aged over 70, with an unplanned hospital admission in the previous 12 months, as well as those aged between 16-69 years with at least one chronic condition (cardiac or respiratory). In total, 500 patients were randomised between May 2010 and February 2011, and those who accessed Care Navigation had a higher referral rate to community health services;

however, they did not show any statistical differences in re-presentation, re-admission, or quality of life. The authors concluded that "*Care Navigation (CN) did not improve quality of life or reduce unplanned hospital presentations or admissions, despite community health services almost doubling*" (Plant et al., 2015, p. 33). The role of nurses as care navigators has been recognised as an important and evolving model of care by McMurray and Cooper (2017), who stressed the importance of this role in both acute and primary care settings for patients with chronic and complex conditions.

In a similar way, Acute to Age Related Care Services (AARCS) and Aged Services Emergency Teams (ASET) Teams were also identified as having similar functions, that is hospital-based care coordination.

Acute to Age Related Care Services (AARCS) and Aged Services Emergency Teams (ASET)

The second model of care implemented across many NSW public hospitals was the Acute to Age Related Care Services (AARCS) and Aged Services Emergency Teams (ASET). These teams worked to identify and screen people to determine if they needed the support of aged related services, and if they did, to fast-track the patient into the services they required. Comments from three 'Corporate Rationalists' below identified issues with length of stay, the risk of adverse events, and the problem of funding for this cohort of patients, illustrating that the model provided additional support to older people in Emergency Departments. I also want to highlight that these models came about because of new funding, thus adding additional resources into the Emergency Department, but leaving all other functions the same.

> *AARCS is Acute to Age Related Care Services, ... for in-patients ... it's early identification of people who may or may not need referral to aged related services, not necessarily residential care, but ... identifying ... older people at risk of either ... increased length of stay, adverse outcomes and adverse discharge planning outcomes in hospital* (Operational Senior Manager NSW HNE Area Health Service, 2010).

> *The AARCS is a model that we implemented using the COAG* [Council of Australian Governments] *long stay older people funding and … so it's a liaison position …* (Senior Bureacrat NSW Health, 2009).

> *The AARCS system is as a liaison to co-ordinate the care needs of those people* [older people] *to try and facilitate a more timely and effective discharge* (Senior Bureacrat NSW Health, 2009).

In 2014, NSW Health published guidelines regarding these services and described the model:

> *The Acute to Age-Related Care Services (AARCS) … targets early and appropriate identification of the discharge support needs of older people admitted to hospital. AARCS workers are aged health specialist staff who provide support to older people in hospital, and facilitate their access to community and residential aged care by improving coordination between the hospital and those services* (Ministry of Health, 2014, p. 1).

The practice guidelines described the history of the model:

> *In 2006, the Council of Australian Governments (COAG) announced a four year budget measure, COAG Health Services – improving care for older patients in public hospitals. … In NSW, this funding was used to introduce AARCS in public hospitals across the state. Further Commonwealth funding became available under the 2011-14 National Partnership Agreement on Financial Assistance for Long Stay Older Patients to maintain and enhance the AARCS which have become key specialist aged health services the NSW Health system since 2006* (Ministry of Health, 2014, pp. 1-2).

As I have highlighted previously, the issue for hospitalised older people is that they have a longer length of stay, double that of their younger counterparts (Smyth, 2009). If hospitalisation can be avoided, this would be a positive outcome. As outlined in the earlier chapters, there was a strong push by the ‘Corporate Rationalists’ at the time the interviews were conducted to halt the actual and projected increase in bed days required by the aged population with increased rates of chronic disease. Coupled with this projection, there was a long-standing view that some older people who presented to the hospitals could be appropriately treated in other settings. Alford identified that 20 per cent of patients who were in hospital beds did not need to be there (Alford, 1975, p. 37). The reasons why patients unnecessarily remain in hospital are, typically their medical condition has stabilised and they are no longer acute; however, they do require additional supports to return home including transport, assistance with activities of daily living, home modifications, monitoring, assistance with medication, daily wound care etc. Given these issues, timely access to community-based services becomes critical.

ASET are models of care found in Emergency Departments with the same goal as the AARCS programs. Respondent’s described the model and identified its strengths:

> *ASETs are the Aged Care Services in the Emergency Department … the model basically has a multi-disciplinary team … that has clinical expertise in the Emergency Department, to work with the ED team, start the care plan to make sure that those particular risks from older people, the falls, continence, dehydration … delirium … and mobility are all addressed as far as possible in that environment, … the care plan gets started and gets transferred with the person into a ward, or again, if we can get them sent home with other services, but access to services is invariably part of the problem* (Senior Bureacrat NSW Health, 2009).
>
> *The advantage is that if they’re functioning properly, you’ve got someone that will identify if there’s additional issues other than …* [the patient’s] *presenting problem that may … need a follow-up or referral that haven’t already been dealt with. So they should be … looking at 90% of your problem … what are the other issues? … are there issues of cognition, safe use of medicine, social networking … mobility, are there issues that*

> *are existing that haven't been addressed …?* (Operational Senior Manager NSW HNE Area Health Service, 2010).
>
> *… if you want an example of a good change in policy, a good change brought about by policy ASETs are a really good example of that because ... it's sort of a bit of guerrilla warfare. The ASET nurses in EDs ... actually have affected change in the EDs … anyone that's likely to be in the ED for a while is a high risk of pressure ulcers ... gets put on an active mattress … they* [older people] *actually have their risks identified ... there's not just one clinician doing that, that one clinician* [the ASET nurse] *has actually effected practice across the whole ED* (Operational Senior Manager NSW HNE Area Health Service, 2010).
>
> *ASET team in Emergency Departments are good and they do help turn around people and organise people home where that's possible, and they troubleshoot, problem-find, refer early, get systems in place so that no one's lying on a trolley in an ED and getting a pressure sore while they're waiting for a bed. In-patient settings, we do need to move to more sort of enabling type of care. You know … that immobility is deadly and you know we don't have enough people on the wards to just walk people who are able to walk … and those sort of enabling care* (Geriatrician and Hospital Executive, 2010).

Shanley et al. (2009) wrote about the history of the ASET model of care in New South Wales. They reported that:

> *The Aged Care Services Emergency Team (ASET) program was introduced by the New South Wales State Government, Australia, in 2002 in response to the increasing numbers of older persons presenting to the Emergency Department with acute exacerbation of chronic and complex diseases. Initial funding was provided to set up the program in 34 metropolitan and rural hospitals. The overall aim of the ASET program is*

> *to improve the care and management of older persons who present to the Emergency Department* (p. 130).

The COAG Long Stay Older Patients (LSOP) program commenced in 2007-08 through a partnership with the Australian Government Department of Health and Ageing – this funding continued until 2011-12 and led to the implementation of 46 Aged Care Services in Emergency Team (ASET) services and 38 Acute to Aged-Related Care Services. A survey conducted "… *in 2009, indicated satisfaction with improved discharge planning, comprehensive patient assessment and follow-up, communication, and patient advocacy*" (NSW Department of Health, 2010, p. 82) as a direct result of the ASET model of care. Commenting on the ASET program, Shanley et al. (2009) highlighted the rationale behind the model of care in caring for older people in the Emergency Department:

> *Older patients presenting to the Emergency Department have special issues and needs different from younger patients. These include the impact of normal aging on their condition, the atypical symptoms with which older persons may present, comorbidities, and the multifaceted and complex nature of many problems with which this group presents. The traditional ED environment—with an emphasis on acute conditions with clear etiology, as well as rapid assessment and treatment—is not ideally suited to the needs of frail older patients presenting with acute-on-chronic conditions* (p. 132).

These authors went on to note that the success of the model at the four hospitals in the Sydney West Area Health Service resulted in NSW Health funding the program to be expanded across the state.

GRACE

GRACE stands for Geriatric Rapid Assessment and Care for the Elderly. It is a model of care in which Nurse Practitioners (NPs) working in the Emergency Department (ED) at

Hornsby Hospital were able to triage and assess older people who needed emergency treatment who resided in a Residential Aged Care Facility (RACF). The model included the development of tools for RACF care teams to trouble-shoot and resolve common medical issues on-site, or if needed, with assistance from the NP. The NP was also able to take supplies from the ED out to a RACF. One example of this was a gastro outbreak at a facility where eight residents were placed on IV fluids in the RACF. Their progress and treatment was supervised by the NP and delivered by Registered Nurses within the facility (NSW Health, 2006).

GRACE was established by Associate Professor Sue Kurrle in 2005 and aimed to:

- *support GPs and aged care facilities with enhanced hospital resources to provide care "at home" and reduce unnecessary hospital admissions.*
- *reduce the average length of stay of aged care facility residents in the Emergency Department and in hospital.*
- *collaborate with the GPs and aged care facilities to develop a Model of Care that:*
    - *provides a decision support system*
    - *provides hospital resources to assist with assessment and care provision*
    - *provides coordinated management plans*
    - *increases the profile and uptake of Advance Care Directives in aged care facilities* (NSW Government Agency for Clinical Innovation, 2013).

The respondents' spoke highly of this model of care:

> *The GRACE project … it was about enabling people in residential aged care facilities to actually die in place. And so it was working with them and making sure that their wishes were known, that advance care directives were established if possible, and that there were nurses that they knew and trusted who would come and provide palliative care for them. … that programme was run through Northern Sydney and out of Hornsby … they seemed to have enormous success in actually reducing the number of*

> *elderly they had coming into ED … supported and therefore could manage to keep those people dying in place* (Academic and NSW Health Consultant, 2010).
>
> *The GRACE model at Hornsby, ours is called 'ACT,' Aged Care Triage, works well* (Geriatrician and Hospital Executive, 2010).

Travers et al. (2008) explored the issue of 'bed block' in acute hospitals in Australia. They asserted that the hospital forms a safe holding place while the older person awaits a high-care Residential Aged Care (RAC) placement. These patients presented at the hospital from low-care RAC places or from the community. They found that "*The acute hospital sector often becomes a safety net to accommodate people with high-care needs who cannot be admitted into RAC in a timely manner*" (Travers et al., 2008, p. 120). This is an important consideration to understand at the time the interviews were conducted. Residential Aged Care places were of two types, high-care and low-care. This situation has changed since 2009/2010, with the abolition of high- and low-care places and increased home care packages; however, these changes have not completely solved the issue of patients who require additional home supports or residential placement blocking beds.

The GRACE model also offered a method of delivering care to residents of Aged Care facilities who required a higher level of input than a visiting GP and the nursing staff at the RACF could provide. NSW Health promoted GRACE as a model of care with the following efficacy statement:

> *Since August 2005, the number of GRACE patients who have avoided presentation has risen from two patients per month to ten patients per month in January 2006. Before GRACE was implemented, aged care facility residents had an average length of stay of six days. GRACE has helped to reduce length of stay, freeing up bed days* (NSW Health, 2006).

At the time of the interviews, the GRACE model and similar models such as 'Aged Care Triage' were established in a small number of the major hospitals. However, over the last 10 years, this model of care has been expanded across the state with proven reductions in hospital admissions for patients from RACFs. The NSW Ministry of Health renamed GRACE to GREAT, and in 2018, stated that GREAT had:

> *Achieved a 26.3 per cent decrease in hospital admissions and a 30 per cent reduction in in-hospital deaths by aged care facilities residents through the Geriatric Rapid Evaluation and Treatment (GREAT) service. GREAT is a nursing-based outreach program provided to local aged care facilities … This service also resulted in a significant cost saving, estimated at $7.7 million per year* (NSW Ministry of Health, 2018, p. 227).

Medical Assessment Units

As Shanley et al. (2009) noted, older people who present to Emergency Departments may require a longer period to establish their diagnosis due to the presentation of an acute issue overlaid with chronic conditons and their ageing body. Medical Assessment Units were designed to provide a more appropriate model of care for these older patients.

> *Medical Assessment Units (MAUs) have been established to deliver faster, safer, better care for the elderly and those with chronic conditions and as an alternative to treatment in the Emergency Department (ED). MAUs are designed to conduct rapid multidisciplinary assessment and provide earlier initiation of treatment. They are staffed by experienced doctors, nurses, and allied health staff who are specialists in caring for older people and/or people of all ages with chronic conditions. Once the MAU staff assess and diagnose the patient's condition, as well as provide appropriate treatment, they will arrange for the patient to either safely return home or transfer to a specialty ward within 48 hours* (NSW Department of Health, 2010, p. 38).

The length of stay in an MAU is no greater than 48 hours (the patient must then be discharged or admitted to a ward) and they were established in 2008 in the 21 major and busiest hospitals in NSW (NSW Department of Health, 2009). Of note, the 'inbound care navigators' within the Emergency Departments could triage and refer patients to the MAU and, at the time of inception, the Director of Geriatric Medicine was responsible for the MAU. The NSW Health Annual Report stated that in 2009-2010, there were 28 MAUs operational across the state equating to 340 beds which had assisted 70,000 patients (NSW Department of Health, 2010, p. 38).

Medical Assessment Units (MAUs) were often co-located with Emergency Departments (EDs). In NSW, metrics were critical as NSW Health had key performance indicators for off-stretcher times (time taken to transfer a patient from an ambulance gurney to a hospital gurney), and a mandatory eight hour threshold for the maximum time a patient could spend in the ED (NSW Health, 2011). The respondents felt very positive about the Medical Assessment Units and believed they played an important role in both comprehensively assessing an older person as well as ensuring that if they could return home, they did with the appropriate supports in place. MAUs were identified as a positive innovation as they provided an appropriate model of care for older people, and the staff had the skills to facilitate a supported discharge if the patient was to return home (e.g. home nursing) or timely admission to a ward if a hospital stay was warranted. Respondents appreciated that MAUs provided a better environment for an older person than an ED and facilitated assessment in a timely manner – MAUs also provided a method to explore alternatives to an admission into hospital using models of care such as the Hospital in the Home program (HITH earlier know as CAPAC) or supports provided through programs such as ComPacks.

> *So good medical assessment units, … have rapid assessment, senior decision-making very early … and then assertive treatment … So, it's good access to diagnostics, someone who actually makes a call … and then good access to support services like CAPACs, ComPacS, you know home nursing, … and some priority access for it. Or you just go into the hospital stream because you're acutely ill and that's where you need to be, no matter what we do at this part, you're still going to be in hospital for another 10 or 15 or 20 days or potentially going to be dead .... But instead of languishing and making that decision on day 6, we're saying that it*

> *should be made within 48 hours and if you start here, you pull back those bed days, so that builds part of them. So, the argument is the MAU actually delivers you an increased capacity over and above what it's, you've actually paid for. So, it's a bit more expensive to run, but if it works, it should shorten your total length of stay …* (Academic and CEO peak body, 2010).

The point raised by this respondent is a critical one. Once an older person is admitted into a hospital bed, their length of stay is longer than average and the risk of adverse events increases. This is supported by DeCoster, Peterson, Carriere, and Kasian (1999) who conducted a retrospective study of 26 hospitals in Manitoba and concluded that:

> *A high percentage of admissions and days of care were inappropriate. Overall, 49.5% of medical patients were acute at the time of admission, 1.6% required no health care services, and 48.9% could have received care through alternate methods or facilities. Only 33.4% of the subsequent days of stay were appropriate. For patients assessed as acute at the time of admission, by the 8th day of stay, only 47% were still acute and by day 30, only 27% were acute. Patients aged 75 years or older were just as likely to be acute at the time of admission as were younger patients; however, they accounted for 54% of the days in the study, and fewer than 30% of these days were acute* (p. 151).

This research is consistent with Alford's observation that a proportion of people, 20 percent (Alford, 1975, p. 37) who are in a hospital bed do not need to be there; that is, if a person is not acutely unwell, they could be discharged to lower levels of care in their own home with supports from services such as community nursing. This is not only an issue of the cost of the hospital bed, it is about the risk to the older person, as they are at greater risk of adverse events than younger patients (Sari, Cracknell, & Sheldon, 2008).

In 2009, it was reported by NSW Health that the average length of stay in hospital was four days, but for people aged over 75 years, it increased to nine days (Smyth, 2009, p. 6). This increase in length of stay for older people is echoed in the most recent report on the utilisation of the hospital system in Australia, which included both public and private hospitals, stating that:

> *Between 2011–12 and 2015–16:*
>
> - *hospitalisations for people aged 65 to 74 increased by an average of 5.9% each year, faster than the population growth for this age group (4.3% each year over the same period)*
> - *hospitalisations for people aged 85 and over increased by an average of 5.1% each year, faster than the population growth for this age group (3.9% each year)*
>
> *People aged 65 and over, who make up 15% of Australia's population, accounted for 41% of hospitalisations … and 48% of patient days* (Australian Institute of Health and Welfare, 2017, p. 23).

As one respondent noted, all the 'growth' in hospital beds in the 2008/2009 financial year went to Medical Assessment Units.

> *We funded all of our growth money this year when we took CAPAC services, not, other than a MAU bed, there was not any patient bed growth in the system, as a ministerial commitment, MAU got 60 of those, the other equivalent went into, and they ended up being about a hundred … all the rest went into CAPACs … as well … ComPacks* (Senior Manager NSW Health A, 2009).
>
> *… you're much better off frontend loading all their treatment and their evaluation and shortening the length of time they're in* [hospital] … (Senior Manager NSW Health A, 2009).

Sydney West Area Health Service (2008) described their Medical Assessment Unit (MAU) as an alternative to, rather than as a replacement for, Emergency Department Services.

> *MAU is an alternative pathway for adult non-critical medical patients; in many cases, these will be older patients with complex medical conditions with multiple co-morbidities. These patients may be transferred to the MAU from: - A triage point, from within Blacktown ED, or - From an external source, instead of going into the ED. These patients typically require extensive medical and multi-disciplinary assessment, which may take many hours* (Sydney West Area Health Service, 2008, p. 3).

In 2013, the NSW Ministry of Health funded an evaluation of MAUs and, noted that:

> *Since the introduction of the Medical Assessment Units in NSW in 2008, the number of patients assessed, diagnosed, and treated in a MAU has increased by 72%, and now has an annual investment of over $100 million. For MAUs to be successful, provide quality outcomes, and produce sustainable change for patients, they cannot function in isolation to the hospital as a whole … The benefit of MAUs has been quantified in terms of potential bed day savings and also conversion of bed day savings into a dollar amount … The NSW MAUs have produced system-wide change on implementation of 17,429 bed days or $13,124,338. This was demonstrated through the efficiency benefit produced by comparing ALOS for patients with a medical DRG prior to the MAUs being implemented to ALOS for patients with a medical DRG and had a proportion of their treatment in a MAU after MAU implementation. This change has been sustained as demonstrated with the efficiency benefit of 6,111 bed days or $5,225,076 in 2011/12. This benefit was produced by the reduction in ALOS of MAU patients that were transferred to a ward and the increasing quantity of services provided by MAUs. … The NSW MAU Model of Care has been successful in generating approximately 23,540 bed days for the*

> *increasing number of patients arriving to our system, while providing a valued Model of Care for our patients, as demonstrated through the exceptional patient experience rating of 88%* (NSW Ministry of Health, 2013, p. 90).

NSW Health (2012) reported under a section entitled Emergency Department Models of Care, the benefits of the MAUs:

> ■ *Reduction in undifferentiated, complex, chronic, non-critical, medical patients presenting to the ED by providing direct referral to the MAU*
>
> ■ *Reduced length of stay in the ED for undifferentiated, complex, chronic, non-critical, medical patients*
>
> ■ *Decreased in-hospital Length of Stay (LOS) by providing rapid assessment, faster diagnosis, and earlier treatment at the point of entry into a hospital*
>
> ■ *Reduced level of intensive investigations prior to decision-making*
>
> ■ *Reduced number of patient outliers on inpatient wards*
>
> ■ *Reduction in readmissions due to improved coordination and early activation for community care for those patients discharged home* (p. 46).

Community Acute Post Acute Care (CAPAC) or Hospital in the Home (HITH)

Community Acute Post Acute Care (CAPAC) provided Hospital in the Home services for a range of ambulatory care conditions to consenting patients. The Emergency Department or a dedicated physician had clinical oversight of the program with nursing and allied health staff deployed into the patient’s home to treat their condition rather than coming into the hospital. Common conditions treated by the CAPAC model are community-acquired pneumonia, cellulitis, and thrombolisis.

The first CAPAC model was estalished at the Prince of Wales Hospital by Professor Gideon Caplan, a senior consultant. In the funding year 2009/2010, NSW Health put into the Area Health Service Agreements the need to establish a CAPAC program in each area. The program was not without criticism – facilities such as the Royal Prince Alfred could demonstrate that it was inefficient to run a CAPAC program as the travel time in their catchment meant that treating teams spent more time in their cars driving than actually treating patients. CAPAC was eligible for Federal casemix funding, with the DRG (Diagnostic Related Group) attracting the same remuneration as the equivalent in-hospital treatment. To allow the CAPAC model of care to work effectively in Residential Aged Care Facilities, NSW Health worked with the pharmaceutical branch to change policy, so that injectable antibiotics and a small number of drugs could be kept within the Residential Aged Care Facility. As one physician noted:

> *But I see that there are people that drift into acute care who are at the end stage of their chronic disease and they're having to go to hospital to an Emergency Department because the GP really isn't geared to deal with that. Now this is where the CAPAC … have picked this up, and they're actually delivering acute responsive care to this group of patients* (Rehabilitation Physician and Hospital Executive, 2009).
>
> *CAPACs has been around – well, Hospital in the Home has been around for 15 years. I think some of the types of patients that are now going into the Hospital in the Home that weren't five years ago is probably innovative. … because of technology and drug advancements, there's going to be a whole group of new patients going home in that direction all the time. Once the community moves in that direction to say well, I can get my treatment at home, they're going to be starting to say they want it at home. And asking the health service to provide it at home. … it's about the early*

> *identification of patients that are going to tip over and require acute care. It still mightn't mean they require acute hospital care. … I've got a lot of people that think acute care, hospital. Rather than acute care, community acute care first* (Senior Manager NSW Health B, 2009).

The NSW Ministry of Health (2012) published a paper on the Hospital in the Home program, stating:

> *In NSW, there are 44 services that report 'Out of Hospital Acute Care' as a monthly service measure. Since 2007/8, the number of admitted and non-admitted services reported by Hospital in the Home services increased from 33,902 to 45,587. This represents an acute substitution rate of 1.6% of overnight separations in public hospitals. By increasing admissions to Hospital in the Home to the Victorian rate of 5.4%, NSW could release a potential annual efficiency of $33.7M* (p. 2).

The language used by the 'Corporate Rationalists' in the quotation above demonstrates the agenda of economic efficiencies that they were driving – this was to get the NSW Hospital in the Home rates to the Victorian benchmark of 5.4 per cent (at the time, it was 1.6 per cent) (NSW Ministry of Health, 2012, p. 2). The paper went on to highlight the economic benefits of the HITH program, including the 2011 Deloitte Access Economics 'Economic analysis of Hospital in the Home (HITH)' which concluded the potential savings of $109M across six DRGs. The paper is a 'call to action' to Area Health Services to increase CAPAC utilisation to the Victorian benchmark, and the NSW Health Ministry took an active lead in achieving this outcome. This is a prime example of 'Corporate Rationalists' seeking to instill a model of care from an economic standpoint – however, equally valid are the considerations that HITH is actually qualitatively better for some patient types. Given there are long-standing proven economic and patient outcome benefits for CAPAC/HITH, it is not clear why it is still an underutilised model across Australia.

The economic benefits of HITH have been well established previously. Coast, Richards, Peters, Gunnell, and et al. (1998) studied the Hospital at Home program in the National Health Service in England. They concluded that "*The mean cost for Hospital at Home patients over the 3 months was £2,516, whereas that for hospital patients was £3,292 … The Hospital at Home scheme is less costly than care in the acute hospital*" (p. 1802). Professor Gideon Caplan, one of the pioneers of Hospital in the Home (HITH) services in New South Wales, and a prolific researcher in the area, noted the lack of functional decline experienced by older people in the HITH program:

> *Randomised controlled trials (RCTs) that remove the role of the hospital in treating acute or sub-acute illness in older people have absolutely demonstrated that this phenomenon exists. It was previously shown that people randomised to treatment in Hospital in the Home had greater improvement in instrumental activities of daily living (IADLs) (0.65 ± 0.23) than those randomised to treatment in the hospital (−0.08 ± 0.26) (P = .04). The greater improvement in IADL scores for Hospital in the Home participants remained significant after adjusting for age, sex, living arrangements, development of confusion, and length of stay.*
>
> *In another trial, frail older adults randomised to Hospital in the Home for rehabilitation completed their rehabilitation 7 days earlier (16.0 ± 9.4 days) than those randomised to institutional rehabilitation (23.1 ± 19.4 days) (P = .02), while achieving the same functional improvement on their Functional Independence Measure score (105.5 ± 17.1 vs 103.7 ± 20.3; P = .66).*
>
> *Functional decline is associated with mortality, so it is no surprise that a recent meta-analysis of 62 RCTs demonstrated that treatment in Hospital in the Home leads to 19% lower mortality* (Caplan, 2015, p. 1724).

In 2009-2010, $11.9 million dollars was allocated to Area Health Service Agreements to provide an additional 7,900 Hospital in the Home and Community Acute Post-Acute Care (CAPAC) services (NSW Department of Health, 2010, p. 38). The CAPAC program will be expanded upon as a case study at the end of the chapter, as it is the only model of care that threatens the role of ‘Professional Monopolists’ in the hospital. In spite of strong evidence of the efficacy and validity of the HITH program, it took several years to become established in NSW.

ComPacks

ComPacks are packages of care that support older people, or people with complex needs, when they are discharged from hospital after which they are supported in the community for a period of six weeks. The ComPacks program assesses the patient and then facilitates referral to services for ongoing care needs. The ComPacks program began as a pilot project at the Royal North Shore Hospital in 2003. Bronwyn Wilkinson, who was a Senior Manager at Royal North Shore Hospital, wrote a business case to the hospital management arguing that if short-term support (six weeks) could be provided to older people to facilitate their discharge from hospital, long-term supports would then be established. At the time of the interviews, Community Options was the sole service provider for ComPacks within NSW.

The respondents commented that funds redirected into ComPacks and CAPACs presented a significant policy shift because of the perceived movement of funding from the hospital into community-based care to either reduce the length of stay in hospital, or to replace hospitalisation. The private sector had also shifted resources to create rehabilitation programs in orthopeadics. As one ‘Corporate Rationalist’ noted:

> *There has been a significant movement already in the system’s understanding where the centre of the health system is, and so people are – you know, if management at the health level are saying we're putting money back into acute community care, that decision's been made. We've been talking about it for 20 years. We're actually doing it now. We've actually got people saying yes, use the money, put it into acute community care. So, it is a significant change in position, obviously, and I think we're only just scratching the top of the surface* (Senior Manager NSW Health B, 2009).

Wilkinson and Lovitt (2005) demonstrated that ComPacks provided safe discharge for older people, as the community-based supports they required were available from their day of discharge. Overall, an average reduction in hospital length of stay of 7.9 days was achieved. In 2015, there were 145 referral hospitals and 10 service providers delivering ComPack services (NSW Ministry of Health, 2018). The NSW Ministry of Health Annual Report stated that 16,936 patients received ComPacks services to facilitate safe discharge from hospital with an annual investment of $24.8M (NSW Ministry of Health, 2018, p. 19).

Transitional Care Program (TCP)

The emergence of the Transitional Care Program (TCP) was judged as a positive policy step from the Federal Government with matched funding from the states. The program commenced in 2005 and was in the process of being established across Australia at the time of the research. Transition Care, as the name implies, is an opportunity for frail, aged, and disabled people to have restorative care either in a RACF setting or in their own home following a period of hospitalisation. It aimed to increase function over a 8-12 week program to avoid the need to prematurely go into permanent residential aged care. The program was instigated by the Federal Government, but the New South Wales State Government also put funding into the program which was managed by NSW Health. As one CEO noted:

> *… they are now looking at transition between hospitals and aged care a little bit more explicitly than was the case, the incoming government introduced a thing called 'Transitional Care Places,' and they've just announced another batch of a couple of hundred today. And the idea there is to provide a bit of a stepping stone between an acute hospital stay and something else, which could be going home or it could be residential care. I mean, I think the model could be a good deal stronger, but it's explicit recognition in the Act that there is that transition, it's small and it's new, but*

> *it's a chink if you like, it's a foot in the door* (CEO Aged Care Peak Body B, 2010).

Early evaluation by Cameron and Davies (2007) of the Transition Care model of care suggested that the participants they surveyed, who were placed within a residential program, were more frail and had a more severe disability that did not generally improve, and were less likely to return to their pre-morbid living environment. Importantly, some gains were made by people in residential care programs with the result being that they improved from high- to low-care needs. The authors acknowledged that their study was a limited audit (30 participants); however, they felt that the program was a substitute for existing services and was not homogeneous:

> *This limited audit suggests that the Australian TCP is not homogeneous and is substituting for other forms of treatment and care. Thus, there is provision of high-level residential care as a substitute for waiting for residential aged care in a hospital bed, and community rehabilitation as a substitute for rehabilitation services provided by state health departments* (Cameron & Davies, 2007, p. 198).

Transitional Care in NSW was jointly funded by the Commonwealth and the State Government, and in 2009/10, there were 41 TCP "… *services supporting 934 flexible care places in both community and residential settings*" (NSW Department of Health, 2010, p. 83). In July 2009, NSW added an extra 169 places to the program and provided services to 3,758 older people with 62 per cent being able to return home (NSW Department of Health, 2010). The NSW Ministry of Health Annual Report 2017-2018 cited the TCP as an important program bridging health and aged care, but did not cite the number of participants nor their rate of returning home.

Gray et al. (2012) explored the effectiveness of TCP and indicated the focus of the program in assisting older people to have therapies that restored their functional capacity, as older people can become deconditioned during hospitalisation. They reported that:

> *TCP targets older Australians at the conclusion of an acute hospital episode. The stated aims are to provide care that is goal-oriented, short-term, therapy-focused, and necessary to complete the care recipient's restorative process, optimise their functional capacity, and assist the older person and their families to make long-term arrangements for care [16]. The average duration of care is 7 weeks, with a maximum duration of 12 weeks, that may in some circumstances be extended by a further 6 weeks* (Gray et al., 2012, p. 2).

Gray et al. (2012) went on to state that the program had a high degree of acceptance by hospital staff and patients. It was well-targeted to older people at imminent risk of admission to residential care, and was designed to improve functional ability to allow successful transition back to home. The evidence to date (at the time of the article) was not robust in terms of providing either economic returns or positive patient outcomes as the studies were retrospective and did not include '*well matched historical or contemporary control groups*' (p. 4).

Advance Care Planning

Advance Care Planning (ACP) is a formal directive whereby a patient outlines their preferences for treatment in the event they no longer have the cognitive capacity to direct such treatments. There have been many initiatives to introduce ACP across Australia, including in legislation. Respecting Patient Choices is one such program which was funded by the Commonwealth Government in 2002 and grew out of the Austin Hospital in Melbourne (Lee, Heland, Romios, Naksook, & Silvester, 2003). It provided guidance on the implementation of Advance Care Directives (ACD) within the hospital setting. The respondents to the current study described many examples of ACP throughout NSW, including the 'My Wishes' program which was run in the western region of metroplitan NSW. ACP programs were funded for three years by NSW Health during the period the interviews were conducted. This funding came with the instruction that this activity would be installed 'within usual business' within this timeframe. The respondents noted that the ACP initiative commenced by NSW Health was seen as a policy which could shape practice; however, there was a stand-off between NSW Health and the Area Health Services who argued that they needed more resources to implement the program. The NSW Health position was that the program should be able to be implemented within existing resources as core business; this effectively created a stand-off (NSW Area Health Service Executive, 2010). The respondent below outlines the history:

> *… several of the Area Health services have been … doing projects, now there's been work done at South East Sydney, based around Prince of Wales Hospital by a person doing similar work to me there, although I think it's probably fair that her work has been a lot more focused on nursing home-level care* [Anne Mellor] *… , the other area is the Hunter and John Hunter was part of a, with this respecting patient's choices in Victoria, they did sort of like a pilot in several states in NSW, they did a pilot in NSW in the John Hunter in about 2004 or thereabouts. … Some of the GP divisions … had an interest in issues around advance care planning – … is the Southern Highlands division, so they've kind of like been doing workshops, they've got information on their website, they've been sort of encouraging GPs to incorporate a brief advance care planning as part of the 75+ health check. There's another group on the Central Coast … And I have a website called 'Planning What I Want' … the main emphasis in the literature about approaches to advance care planning being successful is that they have to take a real systems approach. They have to look at the way that systems are organised, such as things like, you know, documentation, patient assessment, inter-connections between like GPs and hospitals, rather than putting all the emphasis on individual patient change. This, like it's not about, if they put all the emphasis on trying to get individual patients to do certain things, it's not really going to work. … So things like … the electronic flagging – if someone's got an advance care plan, it will come up on their electronic medical record. So, those sort of changes and then, so it's partly the system changes, it's partly a collaboration across sectors. So, what we've*

> *tried to do very much with this work we're doing here, is to not just focus like on the hospitals, but to try to change practice in the hospitals, but also at the same time, to work with GPs and work with members of the community, and to try and promote members of the community to be advocates and to challenge the health system. You know because … what needs to happen is for people either as individual patients or as substitute decision-makers … is that they need to stand up to the system and insist on their rights, so part of what we're trying to do is to encourage that* (NSW Area Health Service Executive, 2010).

This quote from an interviewee highlights the 'system' requirements whereby GPs and hospital staff need to have common access to a patient's ACP when one is in place. It also highlights the work led by the Area Health Services at the time to increase the understanding and uptake of ACP. Importantly, this respondent described the potential role that 'Equal Health Advocates' can have on the system – that is, if the community demands that hospitals have a means to identify their ACP when they present to the Emergency Department, then it will put pressure on the hospitals to put this system in place.

Caplan and colleagues (2006) examined the impact of their ACP project in Residential Aged Care Facilities (RACFs). They used the 'Let me Decide' Advance Care Directive tool, led by a Clinical Nurse Consultant, with 21 RACFs and two hospitals. The authors conducted a controlled evaluation by monitoring Emergency Department admissions into hospital for patients who had an advance care plan. Calls to the ambulance service by the intervention RACF group decreased, as did the risk of admission (by 25 per cent), compared to the control group.

A systematic review on the impact of ACP among the residents of Residential Aged Care Facilities was also conducted by Marin et al. (2016). They found that a range of studies reported between a 9 per cent and 26 per cent decrease in hospitalisation rates. Two of the studies Marin and colleagues reviewed demonstrated a decrease in overall health costs.

The Respecting Patient Choices submission to the Productivity Commission Draft Report: Caring for Older Australians highlighted the need for ACP in Australia. The authors stated that approximately 85 per cent of Australians will die of a chronic disease rather than an acute event, and 50 per cent of people will be unable to make their own decisions near their time of death (Respecting Patient Choices (RPC) "Making Health Choices‟ Steering Committee, 2011, p. 3). These same authors cited the use of ACP in 17 Residential Aged Care Facilities with a significant reduction in length of stay in hospital and in hospital admission prior to death.

The NSW Health Annual Report 2017/2018 stated that they released an information package and form known as the 'Making an Advance Care Directive'. While ACP and Advance Care Directives (ACD) have been the subject of Commonwealth and state funding, there is no central repositiory to identify the number of Australians who have an ACD, nor do hospital information systems (patient records) consistenty identify when an ACD is in place. This is despite the known benefits that ACPs can provide, particularly to residents in Residential Aged Care Facilities (RACF). Martin, Hayes, Gregorevic, and Lim (2016) conducted a systematic review of the use of ACP for residents of RACFs and found that the use of ACPs decreased hospitalisation by between 9 and 26 per cent, and increased the number of residents dying within their RACF by between 29 and 40 per cent.

HealthOne

HealthOne is a model of care that expanded on the traditional notion of General Practice, whereby GPs are co-located with a varity of allied health and diagnostic and treatment services into one service. The NSW Government promotional materials state:

> *HealthOne NSW aims to create a stronger and more efficient primary healthcare system by bringing Commonwealth-funded general practice and state-funded primary and community healthcare services together. Other health and social care providers may also be involved in the HealthOne NSW model; for example, pharmacists, public dental services,*

> *private allied health professionals, other government agencies, and non-government organisations* (NSW Government Health, 2019).

The aim was for the services to work in collaboration, in particular, with patients with chronic and complex health needs. Two HealthOne clinics were mentioned by the respondents, namely Rouse Hill and Mt. Druitt. The GPs were still operating according to the Medicare Benefits Schedule (MBS), while the allied health teams were funded by NSW Health. Funds from NSW Health were injected into the operations to fund case conferencing and collaboration between GPs and the community teams (either co-located or in other community services) when MBS item numbers were not available. As the above statement from NSW Health suggests, the intention of the funding was to create a holistic model of care in which General Practice and community-based services would be co-located to facilitate improved co-ordinated care for people, particularly those with chronic conditions who were at risk of undue hospitalisation (as will be further demonstrated by the evaluation of this model). The efficiencies of this one-stop-shop model are outlined below:

> *So, in a Health One, which is a higher level than a super clinic ... pathology, imaging, and all the various medical and primary care, healthcare services that you need, and specialists come in on periodic basis ... they can manage consultations either by phone or computer …* (Medical Specialist and NSW Health Executive, 2009).

The significant, ongoing investment by the NSW Government in to the HealthOne model of care since 2006/07 is demonstrated in the following statement:

> *Since 2006/07, the NSW Government has committed almost $46 million to the capital development of integrated HealthOne NSW services across the state.*
>
> *In 2015, the Government committed an additional $100 million to develop new HealthOne facilities, enhance existing facilities, or develop information*

> *and communications technology. The new and updated facilities are currently in the planning phase* (NSW Government Health, 2019).

The South Western Sydney Area Health Service opened its second HealthOne Clinic at Rouse Hill which built on the commitment of shared care with local GPs to provide more co-ordinated care for people with chronic and complex health conditions (NSW Department of Health, 2010, p. 318).

NSW Health commissioned an evaluation of HealthOne and the authors, McNab and Gillespie (2015), concluded:

> *The vast majority of providers and all general practitioners involved agreed that HealthOne Mount Druitt had resulted in improved communication and information exchange between patients and providers, and that the programme enhanced care coordination and improved the planning and coordination for patients. Patients admitted to the programme had fewer Emergency Department visits and shorter lengths of stay compared to the 12 months prior to enrolment. Referrals to allied health services rose, but there were fewer referrals to less specialised community home nursing* (McNab & Gillespie, 2015, p. 2).

Section Two

In the workforce chapter (Chapter 7), it will be demonstrated that the ‘Professional Monopolists’ blocked any fundamental changes to the design of healthcare. In terms of traditional models of care, the argument is that doctors ran the model of care delivered in the hospitals, while in the community, models of healthcare were built around the GP. New models of care emerging from this study represent additions to the ways in which care is organised, and do not challenge the structural interests of the ‘Professional Monopolists’, apart from the Hospital in the Home and CAPAC programs. All of the models identified by the respondents outlined above came about via additional dedicated funding from either the state or Federal Government, and this funding did not make any radical changes to the role of the ‘Professional Monopolist’, with the exception of the HITH program.

The table below summarises how each model of care was established. The models with an asterisk were state-wide initiatives in 2008, but were not necessarily fully established in each Area Health Service (for example, in HealthOne). The year the program was identified as commencing is indicated in brackets.

Table 6.2: Models of Care and funding sources

Model of Care	Funding source
Care Navigation (2002)	New funding from NSW Health via clinical services redesign and embedded in Area Health Service Agreements.
*Medical Assessment Units (2008)	
*Advance Care Planning (2004)	
AARCS and ASET Teams in Emergency Departments (2002)	Commonwealth dedicated funding for long-stay older people.
Transitional Care Program (2005)	Commonwealth and State Government funding.
*Health One (2006)	
GRACE (2005)	Australian Better Health initiative grant, and later funded via the Area Health Service.
*ComPacks (2003)	Commenced via a business case to reduce long-stay older patients at Royal North Shore hospital and became a discrete funded state-wide model using NSW Health funds via Area Health Service Agreements.
*CAPAC (1994)	The model was first established in NSW in 1994 as a post-acute respiratory outreach service

(Brown & Caplan, 1997) which was funded via in-patient hospital equivalents from Commonwealth hospital funding (Medicare). In 2009, CAPACs were funded as a discreet program in Area Health Service Agreements via NSW Health.

‘Hospital in the Home’ (HITH) or CAPAC Case Study

The case study describes HITH within the context of New South Wales. It outlines the definition of the model and its evolution since the late 1980s. The focus is on the reluctance of the ‘Professional Monopolists’ to embrace the model, despite sound economic and health outcome benefits to patients which has been well established in the literature (Board, Brennan, & Caplan, 2000; Caplan, 2006; Caplan, 2015; Caplan et al., 2012; Caplan, Ward, et al., 1999; Deloitte Access Economics, 2011; Liu & Taylor, 2002; Marley, 2013; NSW Government, 2018; NSW Ministry of Health, 2012; Tran & Taylor, 2009). At the time the interviews were conducted, the ‘Corporate Rationalists’ were enforcing the expansion of HITH. The ‘Corporate Rationalists’ from NSW Health required each Area Health Service to establish a HITH program to provide an alternative to hospital admission despite the reluctance of the ‘Professional Monopolists’. The following statement from NSW Health supports this statement:

> *In 2009-10, Area Health Services were allocated $11.9 million state-wide to roll-out an additional 7,900 Hospital in the Home and* ***Community Acute Post Acute Care Services.*** *These provide selected types of acute/post acute care delivered to patients at their home or in an ambulatory clinic as an alternative to inpatient (hospital) care. This target was met in May 2010* (NSW Department of Health, 2010, p. 38).
>
> *The number of persons commencing Hospital in the Home/Community Acute Post Acute Care type services has increased over the past three*

> *years. In 2009-10, over 54,000 people were treated in Hospital in the Home/Community Acute Post Acute services. This is a 130 per cent increase over two years* (NSW Department of Health, 2010, p. 70).

The significant growth in the HITH program was only achieved through the dedicated funding directed towards it by the ‘Corporate Rationalists’ – previous attempts to systematise this model of care were not evident until the ‘Corporate Rationalists’ injected this dedicated funding.

HITH and CAPAC

In New South Wales, Community Acute/Post Acute Care (CAPAC) encompasses a range of models, including Hospital in the Home (HITH), Post Acute Care (PAC), Acute/Post Acute Care (APAC), Ambulatory Care in the Community (ACC), and Acute Care at Home (ACH) (NSW Department of Health, 2006). The models are as varied as their names suggest, but essentially, they all replace hospitalisation. The patient receives hospital-type care from their own home and is visited daily by a nurse and a multi-disciplinary team as required. In 2013, NSW Health standardised the nomenclature and opted for Hospital in the Home (HITH) as the standard title (Marley, 2013).

In describing CAPAC, one respondent spoke about how it challenged the fundamental power base of the hospital-based ‘Professional Monopolists’. In the hospitals, each specialty vies for the highest number of inpatient beds dedicated to their specialty – the number of inpatient beds under his or her control was traditionally the symbol of clinical power (Green & Armstrong, 1993). The HITH model moved the hospital bed out of the hospital, potentially destabilising the standard mode of power and control.

With the growth in medication efficacy and technology, the potential to move traditional inpatient activities into the community was perceived as a threat to the accepted model of healthcare delivery. Green and Armstrong (1993) noted that the ways in which hospitals operate has not fundamentally changed for nearly two centuries:

> *Hospitals emerged at the end of the 18th century as a place for the ill to be treated (Ackerknecht 1967, Foucault 1973). These hospitals were organised on the basis of large open wards which were run by a nursing team headed by the nursing 'sister'. The doctor visited the ward on a regular basis to go round the beds ('rounds') and see his or her patients. This particular configuration of medical work has remained the dominant mode of hospital clinical practice for the last two centuries* (p. 337).

Challenging this model, that is, challenging which activities can only be delivered in a hospital setting, proved to be a threat to the ‘Professional Monopolists’. HITH proved to be a model of care that was a radical shift from nearly two centuries of tradition in relation to the location in which acute care treatments can be performed. The increases in technology, medication, and sophisticated homecare services placed the ‘expensive’ model of inpatient care under the spotlight. Note too, that this respondent referred to the hospital as a ‘business’, and recall from an earlier chapter that the hospital is the domain of the ‘Professional Monopolists’, but the ‘Corporate Rationalist’ views it as a business:

> *But this goes back to the way we, well number one, which is where we deliver it [healthcare], and the fact that an inpatient setting is an expensive delivery model for a whole range of things, so it was completely appropriate for a large part of the business, but it’s an unnecessarily expensive way to deliver what is oftentimes these other things in terms of self-management that can best be done in another setting.*
>
> *We [NSW Health] funded all of our growth money this year when we took CAPAC services, not other than a MAU beds, there was not any inpatient bed growth in the system; as a ministerial commitment, MAU got 60 of those, the other equivalent went into, and they ended up being about a hundred … all the rest went into CAPACs and a lot of the tip-off money, the taking pressure off public hospital commonwealth money, have gone into CAPACs as well and funded took up the shortfall for ComPacks. …*

> *But CAPACs have been around since 1988 with the national demonstration hospitals ...* (Senior Manager NSW Health A, 2009).

Challenging the 'Professional Monopolists'

Associate Professor Gideon Caplan was the instigator of CAPAC at the Prince of Wales Hospital and is the current Director of Geriatric Medicine. He formed the Hospital in the Home Society of Australasia (Hospital in the Home HITH Society Australisia Ltd, 2015) in 2006 and served as its President from 2006-2012 and is a life member. Caplan has produced numerous evidence-based peer-reviewed publications that prove the economic and clinical patient benefits of CAPAC (Caplan, Board, et al., 1999; Caplan, 2000; Caplan, 2006; Caplan, 2015; Caplan et al., 2012; Caplan, Ward, et al., 1999). In 2012, he co-authored a systematic review which appeared in the Medical Journal of Australia which concluded that HITH is safer than hospitalisation, as it reduced mortality by 19 per cent, readmissions by 25 per cent, and was preferred by patients in 21 out of 22 studies and carers in 6 out of 8 studies. It was also more cost-effective by 26.5 per cent on average (Caplan et al., 2012).

Despite the compelling evidence supporting the benefits of the model, medical staff were reluctant to refer patients to A/Professor Caplan's services. One respondent commented on this issue:

> *Gideon [Caplan] … he's got the longest running probably most mature CAPAC service in the State, and … his fellow physician's still don't refer to it, after twenty years of it* (Senior Manager NSW Health A, 2009).

This is an example where one 'Professional Monopolist' embraced an alternative model of care and pioneered this model as well as researching the model and providing sound evidence of the validity of the model in health outcomes as well as patient and carer experience. Despite this, the model did not spread throughout NSW until NSW Health (the 'Corporate Rationalists') provided dedicated funding and specified the activity targets for each Area Health Service.

The Royal North Shore Hospital (RNS) was the second CAPAC service to be established in NSW. At the time the interviews were being conducted, the RNS was expanding its service to allow GPs to directly refer into it rather than requiring the patient to go via the Emergency Department. One respondent who was involved in this initiative indicated that GPs were happy to follow the clinical protocols that had been developed within the RNS as they had been established by the physicians within the hospital. They felt that this physician-to-physician engagement was critical in getting the GPs to comply with the clinical protocols. To expand on this, if a GP wished to refer a patient with Community Acquired Pneumonia into the HITH service at the RNS, they had to agree to prescribe the specified antibiotics used by the service. These antibiotics were part of the clinical protocols upon which the service operated and had been developed by the Respiratory Physicians at the RNS. Because the GPs knew their specialist colleagues in respiratory medicine had developed these protocols, they were happy to adopt them and did not seek to develop their own (Operational Manager NSW NSCC Area Health Service, 2009).

One of the major challenges of HITH was whether it would be led by a group of specialists or would take on a generalist approach. HITH services had various names prior to standardisation of the term to Hospital in the Home in 2013 in NSW – this was because each model was developed at a hospital with a particular medical specialist lead. For example, Post Acute Care (PAC) services only provided in-home post-acute care services for patients recovering from specific types of surgery, and was under the supervision of a group of surgeons. The challenge at the time the interviews were conducted was to encourage Area Health Services to adopt more generalist models that could cater to a broad range of conditions, rather than developing the model to cater for discreet diseases and medical specialties.

> *Now, there’s another model at Prince of Wales or St. George which is a respiratory outreach model … it’s got good results. Well, of course it would have good results in the context that you’ve got a specialist driving a medical model; however, if the patient doesn’t fit … they’ve just got COPD or they’ve just got bronchiectasis, which very rarely they do, they have diabetes or … heart failure, and when they come into ED, sometimes they’ll be ... if they come into a major tertiary hospital, they’ll come under*

> *cardiology, not respiratory. … So, you've got a cardiac group, a respiratory group, and you've got clinicians saying, oh these are my … patient load, you're saying hang on, how stable is that for one clinician with 500 patients and they're all different degrees. … my model and which I've tried to instill in … Coffs Harbour, … Northern Sydney, Central Coast, … Western Sydney, is have a generalist model, embed in haematology, respiratory, cardiology, surgery, whatever. Go to the clinicians, go to the doctors, and get their agreement on clinical protocols …* (Operational Manager NSW NSCC Area Health Service, 2009).

This respondent also noted that specialist teams by discreet disease types were not financially sustainable, and therefore, more generalist models were required.

The 'Corporate Rationalists' and their role in New Models of care

In 2009, the then Deputy Director General, Health System Quality, Performance and Innovation from NSW Health, presented his case to support the adoption of new models of care that better provided alternative strategies to hospital admission to the executives of each Area Health Service (Smyth, 2009). In this presentation, hospital admissions were demonstrated to be at a record high with an annualised rate of nearly 1,550,000 in 2007/08 compared to the 2001/02 rate of just under 1,350,000 (Smyth, 2009). In their report on Australia's hospital activity in the 2009/2010 year, the AIHW found that hospital separations increased by 2.8 per cent (Australian Institute of Health and Welfare, 2011, p. viii).

The NSW Health 2009/2010 Annual Report cited the increasing demand on the system:

> *Demand … continues to grow, with more presentations to our Emergency Departments, increased demand for both non-elective and elective surgery, and for renal dialysis and cancer services. And although our life expectancy levels are amongst the highest in the world, the proportion of adults who were either overweight or obese has risen from 41.8 per cent in 1997 to 52.5 per cent. We are also seeing increasing incidences of chronic disease, and it is expected that 80 per cent of the disease burden in*

> *Australia will be due to chronic disease by 2020* (NSW Department of Health, 2010, p. 2).

The Institute for Health Metrics and Evaluation (2013) found that in Australia and New Zealand chronic conditions caused 85% of the total burden of disease with 90% of the burden due to deaths alone from chronic conditions.

The continued increase in demand for hospital services was attributed to the increasing rates of chronic disease. In 2009/2010, NSW had lower than the Australian average of hospital admissions and higher use of ambulatory care strategies, and yet the system was struggling under an ever-increasing demand, as noted in the annual report:

> *NSW has the largest number of hospitals of any state or territory, and also has the greatest number of hospital beds, reflecting its population. … The number of admissions per head of population is below the national rate; however, the level of non-admitted patient services is well above that of other states. NSW accounts for over 46% of non-admitted patient services in Australia. This in part is attributed to policies that aim to provide the right care to people in the right place. For example, many clinical services previously requiring admission to hospital are now being provided in alternative settings. This is not only better for the patient, but a more appropriate use of health resources. … NSW provided more elective surgery than the national average, at 28.3 admissions per 1,000, almost 3% above the national provision* (NSW Department of Health, 2010, p. 39).

In the previous year in his report, Peter Garling had summarised the impact of the ageing population on the acute care system in New South Wales:

> *Demographic changes mean that Australia has an ageing population which will require proportionately more care as the age groups survive through their 70s and well into their 80s. In 2006-07, one-third of all public hospital patients were aged over 65 years, although that group made up*

> *only 13.5% of the state's population. By now, those aged over 65 years make up 45%, nearly one-half, of all public hospital patients* (Garling, 2008, p. 6).

Smyth (2009) echoed Garling's analysis, stating that half of all hospital beds were occupied by people aged over 65 years and that hospital presentations were growing annually by 20 per cent for the over 75 age group. He also reported that in the over 75 age group, the average length of stay was 9 days compared to 4 days in other age groups. He further noted that an analysis from 2007 projected that the current growth in demand would require additional beds into the system at the rate of one small hospital per year (Smyth, 2009). The longer stays in hospital increase the chances of the older patient experiencing an adverse event. Wilson et al. (1995) reviewed medical records from New South Wales and South Australia of 14,000 admissions. They found that 16.6 per cent of those admissions resulted in an adverse event, while 51 per cent of these were considered preventable. Altogether, 80 per cent of the adverse events that resulted in death were patients who were aged over 65 years (Wilson et al., 1995, p. 470).

As previously stated, in the 2009 Area Health Service Agreements, the only in-patient hospital increases were for Medical Assessment Unit beds and all other resources went into HITH and ComPacks which could replace an inpatient activity or reduce the length of stay by facilitating early discharge to the home. In 2013, the Ministry of Health issued guidelines that included eight targeted DRGs that would be the focus of HITH services (Marley, 2013). This paper presented the case for increasing the activity of HITH services:

> *In the current climate of state and national health reform, NSW is leveraging key strategies to drive change for HITH:*
>
> - *Local Health District Service Agreement measures*
> - *NSW 2021 Goal 11 – Keeping people healthy and out of hospital*

- *National Emergency Access/Elective Surgery Targets (NEAT/NEST)*
- *Activity Based Funding (ABF)* (Marley, 2013, p. 4).

The paper went on to quote the increase in HITH activity since 2007/08, rising from 33,902 episodes to 52,505 episodes in 2011/12 (Marley, 2013). The latest Adult and Paediatric Guide for Hospital in the Home, released on the 8th August 2018, noted:

> *HITH services have operated in NSW for more than two decades under different names and with different responses according to patient needs, resourcing, and geography. In 2016-17, there were over 22,000 HITH separations in NSW, provided by over 50 adult and paediatric HITH services. The range of treatments provided is increasingly complex, with 80 per cent of HITH separations spread across 81 Diagnosis-Related Group (DRG) codes. Every District and Network provides adult and/or paediatric services, but not every hospital has a HITH service. …*
>
> *HITH services are an effective use of resources. They can improve:*
>
> - *use of hospital bed capacity*
> - *choice for patients on the setting of their hospital care*
> - *safety and quality outcomes, particularly a reduced risk of infection.*
>
> *Adult and Paediatric Hospital in the Home Models of Care for HITH are also evolving. With new drugs, technologies, and minimally invasive surgical procedures, many conditions once treated in hospital can be safely and easily treated in the community* (NSW Government, 2018, pp. 10 - 11).

The systematic growth and expansion of this model was extremely slow and took in excess of 20 years to become a statewide service. This situation highlighted that it was only when the 'Corporate Rationalists' were effectively supported by some 'Professional Monopolists' who chose to embrace the model, that its expansion was possible. As Alford (1975) concluded, this alignment of two structural interest groups led to a significant system change, but sadly for our health system, it was a rare event and one that could have been advanced at a greater pace. Or is this the realistic pace of change in healthcare, given the inherent ownership and political clout of the 'Professional Monopolists'? Can change only occur over several decades? Are ideas of 'reform' and 'transformational change' over short-time periods a utopian fable? Quoting economist Eli Ginzberg, Alford noted that a pluralist system favours incremental change rather than fast-paced, large-scale reform.

> *As economist Eli Ginzberg put it, "Each of the major parties insists that its essential owner remain undiminished as a result of any contemplated large-scale change. … Inherent in pluralism is an overwhelming presumption in favour of incremental rather than large-scale reforms* (Alford, 1975, p. 254).

Conclusion

The models of care discussed in this chapter operated at the edges of health system design. For the most part, they did not challenge the role of 'Professional Monopolists', and in order to be introduced, had to come with new funding via the 'Corporate Rationalists' who did not challenge the 'Professional Monopolists' mode of operation. It was only through the efforts of a small number of 'Professional Monopolists', despite a lack of support from their own colleagues, that these models succeeded. This required doctors to refer to alternative models of healthcare, and to gather evidence on the effectiveness of the model. In the face of ever-increasing hospital bed days and the move to the National Efficient Price for hospital funding, NSW Health was forced to intervene and directly fund the expansion of the program over the decade covered by the course of this study.

As Garling (2008) concluded in his review of the Acute Care Services in New South Wales:

> *It would surprise many in the public to know that, as a rule, a person with an illness is often better off being treated outside rather than inside a hospital. Of course this does not apply to someone who suffered a serious*

> *accident or has taken the wrong medication or is suddenly struck with chest pains. But the bulk of chronic conditions are better dealt with in the home or in the community than in an acute care bed* (Garling, 2008, p. 13).

The models of care highlighted in this chapter all involved skilled health professionals in their execution, and that is the focus of the next chapter, the health workforce and how the rules governing professional roles both allow for, and stymie, health reform.

CHAPTER SEVEN WORKFORCE

This chapter presents a thematic analysis of the respondents’ views about the workforce, and the challenges of workforce design to meet the needs of older people with chronic disease. The major themes are the:

1. Status of gerontology
2. Ageing workforce
3. Problem of specialisation for patients with multiple morbidities
4. Professional control over skills – in practice and structurally
5. Failure to work inter- and intra-professionally

The ensuing analysis contrasted Alford’s theoretical framework to the views of the respondents – the analysis demonstrated how ‘Professional Monopolists’ maintained control of an area of work, even though there was not enough of their own number (i.e. GPs and specialists) to meet the needs of the ageing population. This ‘area of work’ dictated how healthcare in Australia operated, as it was (and still is) dominated by the medical model and the ‘Professional Monopolists’ who protect this construct. The low numbers of GPs and specialists was particularly evident in rural and remote Australia in 2008, and was recognised as a key problem in the Health and Hospital Reform Commission Report (Commonwealth of Australia, 2009, p. 23). However, strategies to address these gaps in access via the employment of health professionals with extended skills, such as Nurse Practitioners, were met with opposition (Kidd, 2009; Royal Australian College of General Practitioners, 2018).

Following this analysis, possible solutions in the multidisciplinary sharing of care, including the up-skilling of nursing and allied health professionals for community and holistic care, are explored. In the final section of this chapter, a case study is presented on the position of Nurse Practitioners. The case study is used to illustrate the role that ‘Professional Monopolists’ play in blocking workforce reform.

A note on context

In a letter to the editor of the Australian Health Review, Playford et al. (2008) highlighted that one of the critical issues required of the Australian healthcare system was a “*health workforce that is able to “more rationally match … health professional skills to healthcare needs*” (p. 6). This quote provided an important context to the period in which the interviews were conducted in 2009/2010. The Health and Hospital Reform Commission (Commonwealth of Australia, 2009) recommendations were released giving rise to considerable discussion about the kind of workforce reform needed for the ageing population with increasing rates of chronic disease. A number of interview respondents’ acknowledged that the current design of the workforce did not match present or projected population needs. The Reform Commission Report (Commonwealth of Australia, 2009) recommended key changes in workforce composition (i.e. an increase in the number of Nurse Practitioners) and enrolment into a “Health Care Home” (i.e. enrolment to General Practices for chronic disease management). The other significant report was the release of Australia’s Health Workforce in 2005 which outlined the changes required to achieve a more effective and efficient design of the Australian Health Workforce (Australian Government Productivity Commission, 2005). This report was discussed in the Introduction. Of relevance here is the different status of the work areas; care of the older person was classified as ‘low status’ work, as noted by the Productivity Commission:

> *Entrenched workplace behaviours can increase resistance to worthwhile innovation, and cultural attitudes can reinforce notions of ‘high status’ and ‘low status’ work areas, exacerbating the recruitment and retention difficulties faced by mental health, disability services, and aged care. Inflexible hospital management practices also affect workplace productivity* (Australian Government Productivity Commission, 2005, p. XIX).

The respondents pondered the question of “What would the health workforce look like given the greatest need for long-term care is older people with chronic conditions?” This was a pertinent question given that the current design of professional specialisations are oriented towards single organ, single episode interventions with a ‘cure’ as the end product. As one senior executive noted:

> *… what should a workforce for an older population look like and … what's the capacity and capability elements of that workforce and then how do we start developing and continuing to develop that workforce? … and that spans chronic and aged care … So, that's a whole gamut of work that we're trying to work on ourselves, and there are pockets of other work going on around the nation, but it's really not a coordinated effort (Operational Senior Executive NSW Area Health Service, 2010).*

The difficulties in addressing these workforce issues are explored throughout this chapter, commencing with the lack of gerontological skills and the low status attributed to gerontology.

Status of Gerontology

Through various examples, the respondents identified the need for gerontological skills in all areas of the health workforce. There was an acknowledgement of ageism within healthcare, so that working with older people was not seen as 'sexy' or attractive in the hierarchy of health professional status. This is despite the fact that the majority of healthcare is delivered to older people. The 2009/2010 NSW Health Department Annual Report found that there were a total of 6,429,314 total bed days in 2009/10 compared with 5,887,535 in 2001/2002, demonstrating an overall increase over the seven year period (NSW Department of Health, 2010, p. 271). These increased numbers of bed days were attributed to older people, with half of all hospital beds occupied by people over 65 years and the number of people aged over 75 years presenting to hospital growing by 20 per cent per annum. Dr. Tim Smyth, the then Deputy Director General for Health System, Quality, Performance, and Innovation at NSW Health presented an analysis of this increased demand on the 17th March 2009. He stated in his presentation that:

- *Half of all hospital beds were occupied by people aged over 65.*
- *Hospital presentations by the over 75 age group were growing by 20% per annum.*
- *Average length of stay in hospital was 4 days. For people aged over 75, this jumped to 9 days.*

> - *77% of Australians over the age of 65 have at least one chronic condition. …*
> - *Incidence of chronic disease increases with ageing.*
> - *Current models of hospital-based care do not adequately cater for the needs of older people or people with chronic diseases.*
> - *An external report in 2007 projected that growth in demand would require additional beds equivalent to a small hospital each year* (Smyth, 2009, pp. 6-7).

Given the increased use of hospitals by older people with chronic conditions, the need for skills in gerontology seems obvious. The respondents emphasised the need for expertise in gerontology across all health disciplines, rather than being treated as a specialty:

> *I'd like to see a much stronger emphasis on social gerontology across healthcare education, I think we're still very acute-care dominant … I did my research for my PhD, I was amazed like in the medical division … where they mostly have older people … the nurses that I interviewed right from the Nursing Director down, none of them had qualifications beyond … their general educational preparation – was in the care of older people, gerontology … what they valued was acute care, so what they had was qualifications in acute medical nursing and … it was about dealing with acute medical conditions, it didn't … include the social kind of stuff that you need … with older people; now I know hospitals aren't necessarily the right place to deliver that kind of stuff, but if an older person gets admitted to hospital, the difference it can make to … recovery to having some of their social needs met can have a huge difference* (Nursing Academic, 2010).

This was extended to suggest that there was a range of skills used in assessing older people that should be generically known across all professions. These included skills in mobility, and brief cognitive and continence assessments. The respondents did not suggest that all health professionals needed to be experts in these areas, but that they should have the ability to screen, and to determine if there was an issue and then refer to a specialist as required. The need to keep older people as active as possible in the hospital setting was also recognised as a way to avoid de-conditioning – hence, skills to assess and support continued mobility were seen as being critical to achieving that outcome.

> *… frontline staff … they need to be able to understand … the importance and how to do a brief cognitive screen on patients … Understand the importance and how to do a mobility assessment … Understand the importance of … recognising different forms of incontinence … how to treat it and assess it, and how to refer it on even if you're in hospital for three point three days, you need to recognise that that's a problem. … I don't expect them to be incontinence experts … I don't expect them to be mobility experts, but I'd expect frontline staff to be able to say, this person's got a gait problem or they haven't got a gait problem, and therefore, we will walk them, okay, we don't need a physio to tell us they haven't got a gait problem* (Operational Senior Manager NSW HNE Area Health Service, 2010).

The respondent's acknowledge, that regardless of the discipline, an understanding of home and community services (e.g. Home and Community Care funded programs) were crucial to the effective flow of older patients with chronic disease into and out of hospital. One respondent went further to suggest that if there were more rotation of health professional roles from hospital to the community and back again, that clinicians would develop an understanding of the issues and the range of services available in both settings, and that this insight would ultimately benefit patients.

In summary, the respondents felt that gerontological skills were not valued and did not attract as high a status as acute medicine. Health professionals were drawn to acute technical knowledge rather than knowledge of gerontology and community services that assist older people to return safely to their homes after hospitalisation. Keeping older people healthy within the hospital walls takes skills including cognitive, physical, and psychosocial assessment skills as well as ensuring that if issues are identified, they are referred to the appropriate discipline such as continence nurses and physiotherapists. It also requires doctors and nurses to understand the range of skills that allied health professionals can bring to ensuring the safe and effective care of the older person. Closely allied to this was concern over the ageing health workforce, a second factor raised by the respondents.

Ageing workforce

The Australian health workforce is ageing, and this signals the end of a generation of staff who were happy to be on call and to work extended hours. As noted by the Productivity Commission in 2005:

> *Although workforce numbers have increased significantly, several key trends are affecting workforce participation and availability. They include:*
>
> > *– workforce ageing;*
> >
> > *– feminisation across a wider range of professions;*
> >
> > *– lower average working hours;*
> >
> > *– increasing specialisation in a number of professions …*
>
> (Australian Government Productivity Commission, 2005, pp. 10-11).

One respondent, a former Area Health Service Senior Executive at a large NSW Area Health Service, noted that the average age of nurses in NSW was 47 years (Operational Manager NSW NSCC Area Health Service, 2009), while another reported on the age of GPs:

> *I read a journal today, Australian Doctor, where they were talking about the statistics … about General Practice … and the age breakdown of GPs between 2000 and 2009 and now GPs are much older significantly about … 15-20% older, and they're spending … less and less hours, so there's less people doing after hours stuff, less people doing home visits, I think it's from 60 down to 40% over that 9 years, and … but interestingly, they're doing as much work, they're seeing as many patients, and more patients*

> *who are older, and who are, and they're squeezing into less time, and there [are] more and more of them are working less hours* (Geriatrician and Executive NSW Health, 2009).

This respondent echoed the findings from the Australian Government Productivity Commission (2005) that examined the Australian Health Workforce, noting:

> *For the labour market as a whole, the ageing population will be a major influence on future workforce supply. Labour participation falls significantly after the age of 55 — many in this age group reduce their hours or move out of the labour force altogether. Thus, as the population ages in future, aggregate labour participation rates will decline, all other things being equal. Recent Commission projections suggest that, in 2044-45, the labour force participation rate will be 7 per cent lower, and average hours worked per person 10 per cent lower, than in the absence of population ageing* (Australian Government Productivity Commission, 2005, p. 23).

In 2008, Garling (2008) reported that 22 per cent of the nursing workforce would qualify for retirement in 2011. Doiran et al (2008) showed that in 1993, the average age of all nurses in NSW was 38.75 years, and for the Registered Nurse (RN) group alone, the average was 39.45 years. By 2000, the average age of all nurses had gone up to 42.16 and for RNs 40.91 years (Doiron, Hall, & Jones, 2008). Data from NSW Health from 2009 demonstrated that GPs in NSW aged 55 years and over comprised 30 per cent of the workforce in 2000-2001 and 39 per cent in 2005/2006 (Smyth, 2009, p. 8). This also correlated with a reduction in GPs aged less than 35 years from 7 per cent in 2000/2001 to 5 per cent in 2005/2006. In the same report, GPs were shown to be less likely to provide their own after hours services, with figures moving from 65 per cent in 2000-2001 to 47 per cent in 2005-2006 (Smyth, 2009, p. 9). This data from Smyth (2009) demonstrated an ageing General Practice workforce who were less likely to provide their own after hours services. In spite of this, Nurse Practitioners who could complement the work of a GP were viewed with a great deal of caution when their roles were proposed to be expanded in the 2009 Health and Hospital Reform Commission Report (Kidd, 2009), a caution that continues a decade later:

> *The RACGP supports the role of nurse practitioners within GP-led general practice teams, either collocated or external to the general practice location, but does not support nurse practitioners working autonomously in the primary healthcare sector. Independent nurse practitioners seeking the same level of authority, autonomy, and scope of practice as GPs will compromise the quality, safety, efficiency, and cost effectiveness of patient care* (Royal Australian College of General Practitioners, 2018).

The key message was that Nurse Practitioners could work ‘under the supervision’ of a GP, but not autonomously and not in place of them. This is a prime example of the ‘Professional Monopolist’ maintaining control over an area of work, when there was not enough of them to do the work. This argument will be expanded upon in the case study at the end of this chapter.

The respondents also expressed concern that with the ageing workforce, there would be challenges in recruiting personnel, particularly younger health professionals, needed for future work with patients with chronic illnesses and the elderly. With the anticipated influx of Generation Y graduates, it was acknowledged that changes to education and training would need to be made to cater for this generation; for example, “*… seven minute … video clips that’ll teach them what they need to know*” (Operational Senior Manager NSW HNE Area Health Service, 2010). This respondent had a nursing background and had worked in both acute and community services in managing older people with chronic disease, and he recognised the need to change the way they approached training with the younger generation coming into the health workforce.

Problem of specialisation for patients with multiple morbidities

To introduce this section, I remind the reader of the three interest groups that Alford identified in his theory of structural interests. These are the ‘Professional Monopolists’, ‘Corporate Rationalists’, and ‘Consumer Interest Groups’. The third group are the repressed 'Equal Health Advocates'. Alford's theory suggested that healthcare reform was not achieved over a nearly 20 year period (1957-1975) within New York City, because of the power of the 'Professional Monopolists' over the healthcare system. He asserted that healthcare must be understood from the perspective of the constant struggle between these three structural interest groups if reform was to ever be successful. Alford (1975) stated:

> *My general theoretical perspective is that healthcare institutions, whether described as "fragmented" or as "pluralistic," must be understood in terms of a continuing struggle between major structural interests operating within the context of a market society – "professional monopolists" controlling the major health resources, "corporate rationalisers" challenging their power, and the community population seeking better healthcare via the actions of equal health advocates* (p. xiv).

Alford's central argument was that 'Professional Monopolists' did not have to fight to maintain their control and power because the system was designed to do this for them – they control healthcare through legislation, regulation, funding rules, and through associations such as the Australian Medical Association and the 24 Royal Colleges of the medical specialties approved by the Medical Board of Australia (Australian Health Practitioner Regulation Agency, 2013). My argument is two-fold. Firstly, I believe that Australian 'Professional Monopolists' continue to hold power because they 'own' the Medicare rebate table. Secondly, attempts to reform healthcare by 'Corporate Rationalists' fail because this inherent power base, which is upheld by legislation, regulation, Medical Boards, AHPRA, and the Royal Colleges, does not effectively engage in the reform process. In Australia, medical dominance is also upheld in our Constitution (Commonwealth of Australia, 1975), an argument that again will be expanded upon in the conclusing chapter.

Membership within the three structural interest groups is not homogenous. The majority of respondents in this study have a professional background in medicine, nursing, or allied health; however, a number of them were working in leadership roles for either the

Federal or State Governments, or for large not-for-profit or for-profit health companies. Some held dual roles incorporating their clinical practice in medicine, a bureaucratic role within NSW Health, along with adjunct academic status within a university. In Alford's paradigm, medical doctors are the 'Professional Monopolists'.

The theme that emerged in this section is that both the 'Professional Monopolists' and the 'Corporate Rationalists' agreed that medicine had become too specialised and sub-specialised, and that this did not reflect the needs of the population, who were ageing with increasing rates of chronic disease. They identified that older people needed holistic care rather than specialisation, and there was frustration that medicine had evolved into ever smaller specialties, when what older people needed was someone to look at their overall health and wellbeing as well as considering organ-specific disease processes that may be occurring, particularly in relation to chronic conditions such as cardiac and respiratory diseases. A consultant with an allied health background for multiple state governments around Australia, including NSW Health, is quoted below along with a geriatrician who echo each other in the dilemma of increasing sub-specialisation in the context of increased demand for skill to treat older people with chronic conditions:

> *[The] older person … in essence, what they need is more time, they need a more integrated response to their management, so it's not about a specialty, it's about a collection of specialties, what we don't have is a … capability or skill in that ...* (Consultant, 2009).
>
> *In medical practice, the sub-specialties are becoming more and more sub-specialised, and they're getting better and better at looking after smaller and smaller bits of people, and again, that's excellent if you're requiring procedures and it's not very good if you require overall care* (Geriatrician and Hospital Executive, 2010).

This notion of increased specialisation is not new. In 1961, Bucher and Strauss described the emergence of urology and proctology as emerging specialties that were struggling to differentiate themselves from that of general surgery (Bucher & Strauss, 1961). At the time, doctors in these new specialties argued that these particular areas of anatomy required ‘special attention’ and only doctors with their unique skills were ‘competent’ to provide it. The intent was to claim an area of the body as their own and to exclude others from practicing within this domain (Bucher & Strauss, 1961, pp. 326-327).

The specialisation of medicine was also felt to have affected secondary prevention programs which lead to bespoke respiratory, cardiac, and stroke rehabilitation programs, and while there may be some elements of these programs that need to be disease-specific, there are generic components such as smoking cessation, adhering to nutrition guidelines, responsible alcohol consumption, physical activity, immunisation, and falls prevention. This over-specialisation has generated capacity issues as well as excluding people with multiple disease assessments. The complexity for patients to manage these appointments was outlined by one respondent:

> *I think the generalist model is absolutely crucial I, we haven’t got the workforce to maintain specialist … rehab clinics etc. You currently have a system that has a respiratory clinic on a Tuesday morning at 10 o’clock and a cardiovascular at two o’clock and … there’s a diabetes education, God forbid we have all three, but increasingly, people have all three and the other thing is that we don’t tell them the same … information* (Senior Bureacrat NSW Health, 2009).

The response of this senior bureaucrat highlighted that when we consider older people with chronic conditions, we are not talking about one chronic condition, but multiple conditions, therefore further stressing the importance of holistic care with skill to manage the complexity of an ageing person with multiple chronic conditions.

In his report, Garling (2008) made two important observations about the role of the ‘Professional Monopolists’ within the hospital setting. The first was that specialists do not do their ward rounds before 10am, and if they were to do this, it would enable discharges to occur by noon and thus free up beds for new admissions. The question needs to be asked why specialists set the schedule of rounds rather than the needs of the patients and the system dictating the timing. This would require the 'Corporate Rationalists' to direct the 'Professional Monopolists' in relation to the timing of their ward rounds. The second point he made in relation to this theme was the need for overall care beyond the procedure-based approach of the specialists:

> *The doctors, nurses, and allied health professionals will need to replace the old system where different specialists would see the patient, but no one person would necessarily take complete charge of the patient's care. A new model of teamwork will be required to replace the old individual and independent "silos" of professional care* (Garling, 2008, pp. 3-4).

The Royal Colleges who are responsible for the training of medical specialists reinforce and perpetuate the dominance of the 'Professional Monopolists' and their single disease focus. The Colleges were leading this ever-increasing trend of medical specialisation and were acknowledged by the respondents, and this is exemplified in the following quotation from a respondent who is a medical specialist:

> *I think what's happened over the last decade or two is that we've seen a significant increased specialisation, particularly amongst the Colleges, but what we know is, rarely does a person have a single chronic disease that the nature of what's occurring is that people have … a number of chronic diseases and the concept of having specialists treat each different morbidity … is unrealistic and … certainly not … helpful, and I think that it's how do we develop a system that provides that more generalist management … framework … with … access to particular specialists when the generalists is unable* (Medical Specialist and Academic, 2010).

The impact this process of specialisation has had on the ability of medical professionals to feel competent in the care of older people was observed by one respondent.

> *So, some of my physician colleagues shy away from looking after old people because they don't like old people, and some of them shy away*

> *from it because they don't feel competent to look after the whole person because their training is very narrowly focused* (Geriatrician and Hospital Executive, 2010).

One of the reasons respondents attributed to the increased numbers of doctors choosing specialty work were the greater fiscal rewards provided by the Medicare Benefits Schedule for procedural work. The following observation made by Peter Garling in his 2008 Inquiry into acute care in New South Wales also provided support for this claim:

> *Increasingly, newly qualified practitioners have been attracted into work as proceduralists, where the rewards (which are in part driven by the Medicare schedule of fees) are greater, and away from work as generalists, where the need is greatest, but rewards are considerably less* (Garling, 2008, p. 3).

'Procedures' attract greater remuneration in the Medicare Benefits Schedule than does comprehensive healthcare, such as activities like the 'over 75 year old health check'. Using this as an example, the 'over 75 year old health check' takes longer than the average six minute consult, and the uptake of this activity was quite slow in 2009. Blakeman, Comino, Zwar, and Harris (2001) evaluated the use of the over 75 year old health check in the South West Sydney Area Health Service which included 890 GPs. They found that only 27 per cent of GPs reported having used the item number for this procedure. When they were used, the authors concluded that "*Health assessments are unlikely to improve clinical outcomes if they do not result in multidisciplinary care, including care plans, for patients with psychological and functional needs*" (Blakeman et al., 2001, p. 1004). In their evaluation of the uptake of the 45-49 year old health check, Chan, Harris, and Amoroso (2008) noted a faster uptake of the use of this item number than that of the over 75 year old health check.

As part of their submission into the 2005 Productivity Commission Inquiry into the Australian Health Workforce, the Committee of Deans of Australian Medical Schools argued for the importance of inter-professional and team-based care as the fundamental requirement for looking after older people and those with chronic conditions, and yet the ‘different paradigm’ of medical practice, which is more community-based and more generalist, had not been achieved.

> *… the growing provision of healthcare by teams rather than individuals, particularly for the aged and chronically ill, has presented the as yet largely unrealised challenge of interprofessional education and learning … suggested a different paradigm of medical practice, one which was more community-based and more generalist* (Australian Government Productivity Commission, 2005, p. 19).

The importance of reconceptualising workforce design to meet the demographic changes in the Australian population was also highlighted by Duckett (2005) who argued that future workforce planning should not be focused on ‘more of the same’, rather it should focus on ‘workforce substitution’; that is, a different mix of responsibilities held by various health professionals.

Professional control over skills – in practice and structurally

As Alford (1975) observed, other professional groups are capable of performing some of the tasks undertaken by doctors, but are blocked as it is seen as encroaching on the medical domain. Respondents noted that doctors took on tasks they did not need to do, but which they got paid to do under the Medicare Benefits Schedule (MBS). The MBS dictates that only doctors can perform certain tasks and that they are therefore the **only** profession that can be paid to undertake those tasks. For example, Livingston and Dunning (2010) described the role that practice nurses undertook in rural and remote Australia, and McMurray and Cooper (2017) described the important role that nurses took in navigating patient care for those with chronic conditions. The respondents also felt that the role nurses could take was influenced by industrial rules and regulations. I assert that this is the fundamental barrier to changing the dominance of the ‘Professional Monopolists’ in healthcare, because they control the vast majority of the work funded by the MBS. The MBS rules determine that only a doctor can perform certain tasks, which then makes it impossible for another profession to perform that task even if they are qualified and capable to do so. This is what Alford refers to as the pluralist system protecting the interests of one group over the other. The MBS protects the role of the 'Professional Monopolists', and until the rules change to allow other professions to directly access item numbers restricted to doctors, real change in the function of the health system will not be achieved. Furthermore, industrial restrictions, particularly in hospitals, similarly dictate which professions can perform particular tasks.

> *Doctors do work that they don't need to do because they get paid for it, not because somebody else couldn't do it. Nurses do work that they don't need to do. I mean, there's those industrial complications and probably financial where various people who are paid widgets won't be prepared to give it up for a collective, so that will be a problem* (Medical Specialist and NSW Health Executive, 2009).

Other authors such as Willis (2006) have described how the medical profession has restricted the activities of other health professions. He provided an example from 1935 when the Optometrist Registration Act passed in Victoria, the content of which was significantly influenced by organised medicine to restrict what optometrists could and could not do, and they were blocked in being able to treat health conditions of the eye which had to remain the domain of the doctor. Beadnell (2019) explored the role of Nurse Practitioners (NP) in Australia by examining the practice of one NP working in women's health. The restrictions imposed by the Medicare Benefits Schedule (MBS) and the Pharmaceutical Benefits Schedule (PBS) limited what the NP could and could not do and/or prescribe. These limitations led to inefficiencies and unnecessary consultations with a GP.

> *"It feels like women's health was overlooked when deciding on MBS and PBS access for NPs back in 2010," Jo says. "If the barriers we face in women's health were addressed, I feel we could provide a timely and streamlined approach to the care we give. And I think it would be cost-effective in the long run if my clients didn't have to go to a GP who doesn't need to see them"* (Beadnell, 2019, p. 16).

In Beadnell's study, the reason why a patient had to see a GP after seeing a NP was largely due to the need for medication that the NP could not prescribe.

In 2005, the Productivity Commission highlighted that the skills of many healthcare workers were not being fully utilised, and they cited "systemic impairments" that restricted the use of the full range of their skills, a situation reflective of the insistence of doctors to own all aspects of health treatment.

> *And though health workforce arrangements have evolved in response to changing healthcare needs, including through greater reliance on multidisciplinary care, the skills of many health workers are not being used to full advantage. To a large extent, this is because of various systemic impediments that prevent their competencies being fully developed, assessed, recognised, and utilised* (Australian Government Productivity Commission, 2005, p. xvii).

These systemic impairments represent the restrictions that the MBS imposes as well as the industrial activities of organisations such as the Australian Medical Association and the Royal Australian College of General Practitioners. Health Workforce Australia and the establishment of the Australian Health Practitioner Regulation Agency also provide strict guidelines regarding scope of practice and police clearance (Australian Health Practitioner Regulation Agency, 2013, 2017).

Failure to work inter- and intra-professionally

Playford et al. (2008) highlighted the importance of inter-professional practice as an element of health professional skill that was required to match the healthcare needs of an ageing population with chronic conditions, and while universities are taking up this challenge, health policy funding is not. Inter-disciplinary practice is when a group of health professionals come together from different disciplines to discuss their respective assessment findings and develop comprehensive, holistic care plans (Cashman, Reidy, Cody, & Lemay, 2004). An example of this kind of practice is that of rehabilitation after stroke, in which a team of allied health professionals will conduct various assessments, come together to discuss findings, define the goals with the patient, and then develop a rehabilitation plan. To take this a step further, intra-disciplinary practice would see the various professions, i.e., nurses and allied health professionals, find opportunities for the patient to develop their functional capabilities. For example, a nurse may follow the guidance of an occupational therapist during a showering routine to scaffold tasks whereby the patient is encouraged to perform as many of the tasks as possible. Another example in relation to the Medical Assessment Unit (MAU) model of care discussed in the previous chapter is the intra-disciplinary practices developed by the physiotherapists, occupational therapists, and speech pathologists working in a MAU. They taught each other basic assessment skills so they could cover each other's roles over the weekend.

Failure to work inter-professionally has many causes. This might be due to a lack of consistency in allied health staffing numbers that enable interdisciplinary practice, or to the rostering of allied health that occurs mainly between 9am and 5pm, Monday to Friday. Allied health professionals are critical in assisting older people to maintain and improve function. However, it was noted that allied health practitioners are an 'easy target' for reductions when budget savings are on the table, and furthermore, the numbers are lower than stated due to uncovered extended leave; for example, maternity leave. For a hospital to function, it requires doctors, nurses, and hotel service staff. Allied health staff can be seen as being 'nice to have' rather than being a 'need to have'. However, as noted by the respondent below, in rehabilitation settings, the skills of the allied health team are critical in patients regaining function. Allied health staff were seen as easy targets when there were budgetary problems, as noted by this respondent:

> *It still happens … the allied health staff … complement is officially there, you've got people away on maternity leave and things, so that effectively … the fairly barren staffing levels are even less than they appear to be. You know in rehab settings, there's a relationship between input and outcome, and we could be doing a lot more a lot more quickly for some people if, but it's not their capacity to tolerate more therapy, it's the inability*

> *of, or the lack of therapists that provide that therapy. We … basically stop from Friday afternoon to Monday morning – that's got to be wasteful* (Geriatrician and Hospital Executive, 2010).

As Alford (1975) described, a set of "problems" can be related to chronic understaffing, not only by quantity of staff but also by skill mix. Alford noted the same issue in 1975, "*Although 6,157 positions were actually budgeted for staff nurses, only 1,756 were employed. But 8,451 nurses' aids were employed*" (Alford, 1975, p. 36). Chronic under-staffing of the full range of allied health professionals was also noted, "… *for example, 298 positions were budgeted, but 157 of these were vacant*" (Alford, 1975, p. 36). The importance of access to Allied Health was noted in the 2009/2010 NSW Health Annual Report with the establishment of Medical Assessment Units (MAU).

> *MAUs are designed to conduct rapid multidisciplinary assessment and provide earlier initiation of treatment. They are staffed by experienced doctors, nurses, and allied health staff who are specialists in caring for older people and/or people of all ages with chronic conditions* (NSW Department of Health, 2010, p. 38).

Medical Assessment Units (MAUs) were developed to assist hospitals to meet their Emergency Department benchmarks. In 2008, the benchmark was that once a patient had been assessed in the Emergency Department, they had to either be discharged home or moved to an inpatient ward in less than 8 hours (NSW Department of Health, 2009). Older people were found to require more time for comprehensive assessment and to establish necessary discharge supports if they were to return home. This led to the establishment of MAUs to provide up to 48 hours of inpatient care which were staffed by doctors, nurses, and Allied Health professionals 7 days per week. The significant investment by NSW Health of $11.9M highlighted the crucial role the multi-disciplinary team played in assessing and treating older people. Effective multidisciplinary teamwork where there is strong interdisciplinary collaboration and cohesion have been linked to improved patient outcomes and satisfaction (Braithwaite et al., 2016).

A further challenge that can delay an older person's discharge from hospital is the lack of trust between hospital-based teams and community teams. Trust was seen as a barrier to multidisciplinary or intra-professional teamwork. Trust between treating teams is an element that spans all disciplines, but one respondent who was an occupational therapist working in the community provided a particularly pertinent example of the mistrust between hospital-based clinicians and community clinicians.

> *As a community occupational therapist (OT), we had a respiratory team outreach from the hospital and the occupational therapist in hospital would not refer the patient to us because we didn't know how to use a pulse oximeter, so she insisted that she maintain the patient and the outreach for their respiratory work conditioning, but because she was a specialist, she didn't do the home mods* [modifications] *or the equipment prescription … it was an OT saying you're not qualified to look after this person …* (Senior Bureacrat NSW Health, 2009).

Thirdly, these two barriers can be overcome. One respondent gave an example where intra-disciplinary collaboration had come about due to practical limitations when setting up the Medical Assessment Units (MAUs). As previously stated, this respondent noted that allied health professionals taught each other critical assessment skills in the Emergency Department to ensure that these assessments were available to patients over the weekends and in the evenings.

> *MAUs that have really worked and evolved – because they haven't all bought the extra Allied Health they should have, they came up with the first thing – you can't have three [disciplines] 24 hours a day … so the essential ones all got together and it doesn't matter who's on call, they will do exactly what you've described. You know, so the OT who happens to be there, they'll do the swallow test if someone comes through with a stroke, and they will follow that. And they work really well and they are really impressive teams … and there's a lot of confidence between them and they trust each other and there's no professional … there's none of the professional baggage bullshit around it and … it's just really good, and*

> *there's others who say oh no, we won't do that unless we've got a physio three days a week …* (Senior Manager NSW Health A, 2009).

These brief interventions were then followed up as required by the most appropriate discipline. This point could be framed as 'generalist gerontological skills' that all health professionals would benefit from understanding. For example, the ability to conduct a brief cognitive assessment is critical in Emergency Departments. Delirium in an older person remains one of the most unrecognised conditions in the Emergency Department. Hare, Wynaden, McGowan, and Speed (2008, p. 74) examined elderly patients in Emergency Departments in Australia and found that delirium occurred in 7 to 9.6 per cent of elderly patients, but the literature indicated that only one-sixth to one-third of these presentations were diagnosed.

In summary, the central themes that emerged in relation to workforce issues highlighted the low status of gerontological skills, despite these skills being an essential requirement to optimally care for the older person, particularly in in-patient settings, to reduce the risk of iatrogenic events, such as falls and delirium. The increasing age of the Australian health workforce was also highlighted along with the increasing rise of specialisation within the medical profession, when there is a need for holistic care. The tight grip the 'Professional Monopolists' hold over the Medicare Benefits Schedule (MBS) was also discussed and the failure to work inter- and intra-professionally.

Introduction to the case study on Nurse Practitioners

Through working with 'Corporate Rationalists', 'Professional Monopolists' block the expansion of the role of Nurse Practitioners, resulting in their functions being determined by the team they work within rather than by their skills, experience, competence, and capabilities. Scanlon, Cashin, Bryce, Kelly, and Buckely (2016) examined the roles of Nurse Practitioners in Australia from the time they were introduced in 2001, and concluded that:

> *There remain many barriers to full expression of the scope of practice for nurse practitioners … Often the reasons are political, while at other times economic. In both scenarios, there is little objective justification for the*

> *regulatory restriction. Nurse practitioner clinical practice must be performed within the confines of existing healthcare service delivery systems. Change within these existing systems can be slow … Nurse practitioners must continue to collect the evidence to persuade decision-makers that a lessening of the regulatory burden for this health practitioner group would enhance healthcare delivery and effective health outcomes in a cost-effective manner. These restrictions continue to hinder nurse practitioner practice. They make working to full scope of practice by nurse practitioners and growing nurse practitioner numbers in this country, a far greater challenge* (p. 140).

‘Equal Health Advocates’ will always demand the best healthcare available and that includes access to medical services in hospitals and in the community through General Practice as we have been socialised into believing in the importance of medicine and the medical model. As Alford (1975) described, we believe that when we are ‘sick’, we must go to a doctor who is paid to diagnose and treat our illness with a ‘cure’ as the end product. This idea is symbolised by hospitals, and elections are fought, won, and lost on access to Emergency Department care and hospital beds.

Alford (1975) described how ‘Professional Monopolists’ assert their superiority over governments and bureaucracies:

> *… it must not be thought that government financing and bureaucratic control – even to the point of socialized medicine – will inevitably eliminate the special power of the professions. A recent review of the literature on the factors affecting the method of payment of physicians in ten countries concluded that “the economic power of physicians is an overriding political resource which washes away the effects of both the bargaining styles employed by physician organizations and the attributes of the political culture …”. This observation is telling evidence of the consequences of the professional monopoly of physicians for their control over the method of*

> *their payment, even in countries which have nearly completely socialized health care delivery* (Alford, 1975, p. 200).

Nurse Practitioners – A case study in how Professional Monopolists block health reform

The role the Medicare Benefits Schedule (MBS) plays in blocking health reform

The ‘Professional Monopolists’ restrict other disciplines from gaining access to the MBS and maintain a vice-like grip on tasks even if they could be competently completed by other health professionals, especially Nurse Practitioners. This occurs in a context in which GPs themselves are ageing and do fewer after hours call-outs. The restricted supply in General Practice is confounded by hospital staff that have few or little skills in gerontology or the core assessments that older people need, particularly in cognitive, mobility, and continence screening. The majority of item numbers in the MBS are for procedures conducted by GPs and specialists. It has also been argued that the design of the MBS not only restricts activities that can only be performed by a doctor, but that it also favours episodic or procedural, rather than holistic or long-term interventions. As the Productivity Commission noted:

> *Funding and payment arrangements detract from efficient outcomes. For example, the focus of Medicare Benefits Schedule (MBS) subsidies on services provided by medical practitioners can lead to inefficient use of the workforce, as can the bias in MBS rebates in favour of procedural services* (Australian Government Productivity Commission, 2005, p. XIX).

The respondents highlighted the underutilisation of Nurse Practitioners, particularly when compared with the United Kingdom and New Zealand. Nurse Practitioners were first introduced in Australia in 2000 (MacLellan, Higgins, & Levett-Jones, 2015). Gardner, Gardner, Middleton, and Della (2009) sent a questionnaire to the 234 Nurse Practitioners in Australia and had an 85 per cent return rate. From this sample, they were able to identify that 145 were employed as Nurse Practitioners and that the most common location was in Emergency Departments (26.9 per cent). Nearly one-third of them were waiting to be given permission to prescribe medications, and over 70 per cent stated that the lack of being issued a Medicare Provider number and the authority to prescribe limited their practice. In 2018, there were 1,500 Nurse Practitioners registered in Australia, with the majority employed in the public health system and 28 per cent in the private sector. In the public sector, 46 per cent worked in hospitals and 13 per cent in community health (Scanlon, Murphy, Tori, & Poghosyan, 2018). In the hospital environment, the vast majority worked in Emergency Departments. However, what Scanlon and colleagues highlighted was that the role of the Nurse Practitioner was still dictated by the environment they worked within as well as the medical doctors they collaborated with. Scanlon et al. (2018) wrote:

> *Organizational climate directly effects NP practice within employment settings, in terms of determining the level of collegial interactions between the NP and practicing medical doctors (MD) and the support the NP receives for delivery of care, as well as how visible the NP role is within the organization. Thus, fundamental to the development and ongoing practice of NPs within Australia, is the local organizational climate* (Scanlon, Murphy, Tori, & Poghosyan, 2018, p. 414).

These restrictions on NP functions occur in a context where research has demonstrated the unique input the doctor and the NP have when they collaborate to achieve high quality patient care. Cashman et al. (2004) confirmed the value of inter-disciplinary practice when NPs and physicians collaborate:

> *… it has been noted that physicians and Nurse Practitioners (NPs) bring different perspectives and skills to patient care; when intertwined, these different practice paradigms result in additional value for patients in terms of quality, cost, and satisfaction* (Flesner & Clawson, 1998; Mundinger, 2002, p. 184).

‘Professional Monopolists’ block the expansion of Nurse Practitioners (NPs)

The power of doctors to determine the scope of practice of NPs occurs despite the rigorous educational, legislative, and regulatory context. Elsom, Happell, and Manias

(2009) described the response by the Australian Medical Association regarding the perceived encroachment by nurses into domains traditionally held by medicine:

> *The AMA has clearly articulated opposition to the expansion of nursing roles into areas that are traditionally the domain of medicine, such as prescribing medication and referring to medical specialists. The AMA position that NPs are doctor substitutes has been expressed through an official position statement (AMA, 2005a) and via the media (Pollard, 2006a). In response, the Premier of the Australian state of New South Wales accused the AMA of fighting an old turf war (Pollard, 2006b,* p. 10).

The rigid demarcation between the role of a doctor and that of a Nurse Practitioner is one of great conjecture, and indeed, could be described as a 'turf war'. The Inquiry into acute care in New South Wales led Garling (2008) to make the following recommendation.

> *… the rigid demarcation between what a doctor's job is, and what a nurse's job is, needs to be consigned to history. Once the concept of teamwork is accepted as the norm in treating a patient, it is easier to see why a qualified nurse practitioner should be able to do many jobs once reserved for doctors* (Garling, 2008, p. 4).

The Australian Medical Association (AMA) lobbied for amendments to be made to the Midwives and Nurse Practitioners Bill 2009 which required Nurse Practitioners to have a collaborative agreement with a medical practitioner – this diminished their autonomy and effectively relegated power over their scope of practice to the doctor who supervises their clinical practice. As the AMA noted:

> *The AMA was pleased with the government's recent amendment to the Health Legislation Amendment (Midwives and Nurse Practitioners) Bill 2009. The amendment specifies a formal requirement that midwives and nurse practitioners must work in collaboration with medical practitioners. The AMA had been negotiating with the government for this vital change*

> *to the legislation for some time. We made it clear to the government that without a requirement in law that there be collaborative arrangements between midwives, nurse practitioners and doctors then the legislation did not have any safeguards to ensure continuity of patient care, nor did it have any protections against the fragmentation of patient care services. The change creates a framework of quality primary care delivery that supports team-based care and ensures that the role of medical practitioners, particularly the patient's usual General Practitioner, is not undermined* (Dr Andrew Pesce, 2009).

These amendments to the Midwives and Nurse Practitioners Bill 2009 have resulted in restrictions to the role of NPs and limitations to their scope of practice.

Impact of collaborative agreements

Doctors have been given the authority to dictate what the NP can and cannot do as a result of the MNP 2009 Bill. Furthermore, the 'Corporate Rationalists' have maintained a vigilant hold on the Medicare Benefits Schedule (MBS) and the Pharmaceutical Benefits Scheme (PBS) limiting access to item numbers to procedures that a NP could perform, but are not allowed to, or medications they could prescribe but are blocked from doing so.

The 'Professional Monopolists' have successfully lobbied the 'Corporate Rationalists' to gain control of the scope of work of the NP, with claims of safety and fragmentation if the role was allowed to continue as it was formulated in 2000. In 2009, the Australian Medical Association President Dr. Andrew Pesce made the following statements:

> *"There is no substitute for a GP. The AMA supports a coordinated care model based around GP-led multidisciplinary primary care teams. We are pleased that the Minister has clearly articulated that the government recognises the centrality of general practice in providing primary care services to the Australian community. We now call on the Minister to state clearly that the government's primary care reforms, especially those regarding nurse practitioners and midwives, are genuinely about*

> *collaborative care with doctors, and not about primary care being provided independent of doctors. Such an assurance would be met with relief by the Australian community," Dr Pesce said* (Australian Medical Association, 2009).

Hillege, Coulon, Swann, and Wilson (2005) examined the issue of collaboration between doctors and NPs and concluded that most NPs were dissatisfied and were working within ineffective collaborative relationships. Gardner et al. (2010) examined the activities undertaken by NPs in Australia. They found that Australian NPs were not using their clinical skills as much as their international counterparts. The authors also stated that there remained significant barriers to NPs being able to work in accordance with their scope of practice, particularly in prescribing. They also found that the NP's inability to apply their clinical skills led them to spend time on administrative and co-ordination tasks.

Opposition by the medical profession in Australia is highlighted by Elsom et al. (2009) who stated that "*The medical profession in Australia has expressed concern about the expansion of nursing practice into areas that are traditionally the domain of medicine."* However, their analysis found that there was little evidence that the quality of services provided by a NP was inferior to that offered by a GP, and concluded that the evidence suggested that NP consultations in primary healthcare are equal to that provided by medical practitioners. However, despite this evidence, 'Professional Monopolists' continue to block expansion of the NP role.

Residential Aged Care

In response to the government's 2010 budget announcements, the Australian Medical Association released the following press statement in regards to additional funding for NPs within Residential Aged Care. Note the caveat by which this proposal was met: this funding must come with sufficient funding for the doctors as well, in addition to tethering the practice of the NP through the collaborative arrangement:

> *In regard to the proposal to fund nurse practitioners in residential aged care facilities, Dr Pesce said residents in nursing homes must have access to the safety net of a medical diagnosis. "The AMA has been an advocate for team-based care for patients. For this measure to work, the government must ensure that nurse practitioners in nursing homes work in legislated collaborative care arrangements with the resident's usual GP. However, access to nurse practitioners in collaborative arrangements is not enough. It is vital that the government provides sufficient funding so that doctors are available to provide medical services to nursing home residents"* (Australian Medical Association, 2010).

Note also the view of these 'Professional Monopolists' who agree that NPs are important in providing care to residents in Residential Aged Care Facilities – but they want funding to ensure there are enough doctors to do this work. The implication here is that the NP cannot do this work, and that it is the work and domain of the doctor. The role of the NP has been stymied in Australia with GPs and specialists fearful of the role, arguing that it could replace or encroach on the role of the Junior Medical Officer (Elsom et al., 2009).

Summary

The ability of the Australian workforce to meet the needs of the ageing population with increasing rates of chronic disease is stymied by a number of limitations. These limitations range from the lack of attractiveness and low status and value attributed to gerontology and gerontological skills, along with the ageing of the health workforce itself. The consequences of this include reduced hours of practice and type of practice (e.g. provision of after-hours care by GPs). The increased specialisation of the medical workforce contradicts the need for the holistic care required by an ageing population. Despite the shortages in adequately trained medical professionals to meet the needs of older chronically ill patients, the medical profession has used its power to restrict any role substitution. The case of the NP illustrates the power of medicine to use the regulatory system to restrict autonomy. The 'Professional Monopoly' of the Medical Benefits Schedule also restricts the ability of other healthcare professionals to perform tasks they are qualified to do, and this is played out in the examination of the role of the NP. As a consequence, inter- and intra- professional practice is also stymied by ‘Corporate Rationalists’ in the form of regulatory, industrial, and policy-based restrictions. If the needs of the ageing population with increasing rates of chronic disease are to be met, serious consideration needs to be applied to the structural interests, namely the ‘Professional Monopolists’, that block reform within the health system.

CHAPTER EIGHT FUNDING AND THE PROBLEM WITH MEDICARE

Introduction

This chapter outlines the problems associated with the design of the Medicare Benefits Schedule (MBS), as identified by the respondents. Before discussing these points, I first remind the reader about Alford's theory and describe the funding 'crisis' that the Australian healthcare system was undergoing in 2009. I then discuss the following five arguments that centre on the problems of the Medicare Benefits Schedule (MBS):

1. Fee-for-service, or the episodic paradigm of the MBS, does not optimally meet the needs of older people with chronic conditions.
2. Episodic care drives outputs not outcomes, and does not promote multi-disciplinary team care. This led to an argument by the respondents for general practice enrolment, as per the model in the United Kingdom. However, the 'Professional Monopolists' blocked the enrolment initiative.
3. Medicare facilitates clinical and economic autonomy for doctors; therefore, they are highly resistive to proposed changes to Medicare.
4. As doctors are business owners, there is pressure on them to engage in high-rebate, quick procedures, rather than low-rebate, long episodes of care which are often required by older people with chronic conditions.
5. Medicare design allows doctors to deliver outputs without accountability for patient outcomes.

In addition, two further arguments focus on increased healthcare costs, with hospitals often being the epicenter of health debate, when in fact, effective primary care is what older people with chronic conditions need. Finally, I argue that the lack of synergy between programs funded by the Commonwealth and the states has led to inefficiencies and fragmentation.

In Part Two of the chapter, these arguments are discussed in relation to Alford's theories of structural interests, including the 'Professional Monopolists', 'Corporate Rationalists', and 'Equal Health Advocates'. By way of introduction, I revisit Alford to remind the reader of his theory.

Alford: a brief reminder

The three structural interest groups Alford (1975) identified are ‘Professional Monopolists’, ‘Corporate Rationalists’ and ‘Equal Health Advocates’. These three groups represent firstly, doctors; secondly, government, managers, and bureaucrats in the public or private sectors; and thirdly, health consumers. Particularly for the ‘Equal Health Advocates’, the membership of this group is often not homogeneous. Tension exists between these three groups as they vie in different ways to either preserve or change health systems. The ‘Professional Monopolists’ operate from a position of power where legislation, regulation, and MBS design protect and maintain the status quo, or ensure any adaptation maintains their privilege – they are the dominant structural interest and, as such, do not have to mobilise to challenge the system. The ‘Corporate Rationalists’ take on the role of the challenging structural interest as they seek to change and improve the effectiveness and efficiency of the health system, in this case the public system, but are often met with rebuttal from the ‘Professional Monopolists’. The ‘Equal Health Advocates’ are the repressed structural interest group, and their voice is often quashed. Temporary coalitions can be formed between two of the interest groups, most notably the ‘Corporate Rationalists’ and the ‘Equal Health Advocates’.

The respondents recognised the health system ‘crisis’ that led to bipartisan support for the bold reform agenda and recommendations from the National Health and Hospitals Reform Commission Report in 2009 (Commonwealth of Australia, 2009). However, some respondents alluded to the fact that the notion of ‘crisis’ was not a new ‘crisis’, and that there had, in fact, been long-standing claims of ‘crisis’ in the health system. Alford (1975) observed the same phenomenon in relation to the health ‘crisis’ documented in the 1930s, and the continued dialogue of ‘crisis’ decades later:

> *If health care is in “crisis” now, then it was in crisis ten, twenty, and forty years ago as well. Several qualified observers have commented on the similarity between the 1932 analysis by the Committee on the Costs of Medical Care and reports issued thirty-five or more years later* (Alford, 1975, p. xi).

The perpetual ‘crisis’ in healthcare was also an observation made by the respondent below:

> *I have a newspaper article pinned to my wall about the crisis in the health system, and we don’t have access to beds and people are dying from 1967 ... so it ain’t new* (Senior Bureacrat NSW Health, 2009).

Rising health costs

With rising health costs, which can in part be attributed to the ageing population with increased rates of chronic disease (Armstrong, Gillespie, Leeder, Rubin, & Russell, 2007), there was a need to focus efforts on ensuring that health funding went into effective services and programs that would meet the needs of older people, not in terms of ‘cure’, but in achieving and maintaining ‘wellness’. Chronic disease requires ‘effective’ treatments that prevent unplanned acute exacerbations that require ‘expensive’ hospital treatments. Duckett et al. (2014) stated that public hospital spending was the fastest growing area of government expenditure, and every year, one billion dollars (of the $140 billion total cost) was spent on activities in public hospitals that achieved ‘little or no benefit’. The government pays for 70 per cent of health spending, and unless ‘reforms’ were made “*… health spending is predicted to rise by another three per cent of GDP over the next 20 years*” (Duckett et al., 2014, p. 3). Also note that the funding for Medicare is uncapped because we pay for Medicare through the Medicare levy via the taxation system (Duckett, 1995).

Medicare design – episodic fee-for-service favours procedural medicine

The Medicare Benefits Schedule (MBS) in Australia is designed to recompense GPs and specialists for providing individual specified services, described as item numbers to a patient. This makes the Australian health system ‘episodic’ in nature, whereby a health intervention is quantified by the completion of a task and the time allocated, after which payment ensues. GPs and specialists have exclusive access to the majority of item numbers within the MBS which focuses on discreet ‘procedures’ rather than holistic long-term care required by older people with chronic conditions. The Commonwealth noted:

> *... the needs of people living with chronic diseases … and older, increasingly frail people are less well met. When we consider the … organisation of our health services, it is evident that our health system has not been designed around the needs of such people with more complex and long-term health problems* (Commonwealth of Australia, 2009, p. 85).

This observation is not new. Duckett (1995) wrote of the need for coordinated care for people with long-term health conditions, providing an example whereby a patient with diabetes would be able to enroll in a program that would stabilise their condition and which would give them access to medications and allied health professionals such as dietitians and podiatrists to ensure that their care was in line with ‘state-of-the-art clinical protocols’ (p. 123).

The respondents felt that the episodic design of the MBS led to inefficient care for older people with chronic disease. The challenge was two-fold; firstly, chronic diseases and diseases associated with ageing are not curable – they require long-term care and management. Secondly, older patients with chronic conditions often respond best to multi-disciplinary care provided by nurses and allied health professionals in partnership with GPs and specialists (Bould & Wieland, 2010; Epping-Jordan, Pruitt, Bengoa, & Wagner, 2004; Gilbert et al., 2013; Litaker et al., 2003). In particular, specialised nursing roles, such as care coordinators, diabetic educators, cardiac nurses and NPs are part of this care (Litaker et al., 2003; McMurray & Cooper, 2017). However, the ability to access specialised nursing and allied health services requires authorisation by the GP who must engage in another ‘episode’ of care to release item numbers attached to Enhanced Primary Care (EPC) or Mental Health Care Plans. As one specialist noted:

> *Where we remain on episode funding, there’s no incentive in aggregating teams for care … where the funding is paid episodic for a condition that is in essence never-ending … I think that’s inefficient. So, the funding needs*

> *to be in some form packaged and managed* (Medical Specialist and NSW Health Executive, 2009).
>
> *… if there's any area that is of greatest disadvantage, it is this chronic disease and the ageing population where … the current system works essentially for single episode illness* (Senior Bureacrat SA Health and former NHS Executive, 2009).

For effective chronic disease management, the funding needs to allow direct funding for allied health interventions or for nurse-led interventions. The respondent below highlighted the observations made by the Australia's Health Workforce Report (Australian Government Productivity Commission, 2005), The Garling Report (Garling, 2008), and the recommendations of the National Health and Hospital Reform Commission (Commonwealth of Australia, 2009). The recommendations of all three reports pointed to the need for all health professionals to be able to work to the full extent of their skills and knowledge base, and that the unnecessary restrictions placed upon their practice be lifted. This was also echoed by a respondent, who said:

> *... you could actually get: a) better care, b) more care, and c) cheaper care if you could more directly engage through nurse practitioners ... [and] further down the tree to undertake the chronic disease management rather than always having to go back to the doctor as the primary point of reference (Operational Senior Manager NSW HNE Area Health Service, 2010).*

Alford also reminded us that doing more of the same does not equate to improved outcomes for patients.

> *… the mere citation of expansion of facilities – programs, buildings – is not evidence at all that there has been any advance toward meeting the "important health problems in the community"* (Alford, 1975, p. 177).

This point was raised by Professor Ian Hickie speaking in relation to mental health services in Australia. He noted that additional services do not necessarily improve health outcomes; rather, what is required is the best design of care:

> *More it is not better; this is one of these great furphies. If you need a particular type of care, you need to make sure you are getting it for the right condition and that delivers the right outcome. Health is driven … by activity. We pay for every activity, as if more is better.* ***More is not better****. In fact, you can do more harm. There's a lot of good evidence both with pharmacotherapy and psychological therapy that more is not necessarily better. It depends what's wrong with you* [emphasis added] (Professor Ian Hickie, 2019).

Episodic vs. packaged care via enrolment

Building on my initial argument outlined above, the respondents believed that episodic funding led to care that was fragmented and did not optimise opportunities to proactively prevent unnecessary chronic disease exacerbation, or unnecessary hospitalisation. They noted that the remuneration model for GPs needed to change so they had time to do care coordination and that this work should be funded. The respondents argued that there was a need to get the economic incentives right to sustain long-term community care; for example, patients with diabetes would benefit from an enrolment system.

> *... what shapes what people get is what you pay for and how you pay for it … So, the recent changes which are paying doctors to enrol people for diabetes will clearly make a fundamental change in the way in which people with chronic diseases get assistance, because they'll actually be enrolled with somebody who's actually paid to actually think about them on an ongoing basis rather than on an episodic basis. You know, and that's the key to chronic disease management in that people have to be thought about in their entirety, but always rather than when they just front up at the front door* (Bureaucrat, 2010).

The acknowledgement of the poor design of the MBS for chronic conditions is not a new observation. Duckett (1995) stated that:

> *Medicare needs to be enhanced by improving its ability to meet the diverse and varying needs of patients with long-term illnesses: improvement in 'coordinated care' is necessary* (p. 117).

The final report of the National Health and Hospitals Reform Commission (Commonwealth of Australia, 2009) proposed that patients have a ‘Health Care Home’, and therefore be enrolled with a General Practice so that:

> *... there will be grant funding to support multidisciplinary services and care coordination for that service tied to levels of enrolment of … people with chronic and complex conditions; … payments will be developed that bundle the cost of packages of primary healthcare* (p. 15).

The argument for enrolment (or Health Care Homes) in Australia

The Medicare Benefits Schedule (MBS) is not designed to efficiently serve the older person with chronic disease. The respondents believed that the United Kingdom’s (UK) NHS enrolment model was intuitively aligned to the needs of the individual with a chronic condition. In summary, the UK model requires each patient to register with a General Practice which becomes their ‘Health Care Home’. Due to models of commissioning in the United Kingdom, GPs can offer a range of services including community nursing (North & Peckham, 2001). There have also been enhancements to the enrolment model whereby patients at risk of hospital admission are targeted for increased services which include case management, assistance with self-care, and care co-ordination (Parry, Wolters, Brine, & Steventon, 2019). These services are designed to reduce fragmentation and generally to serve older and more complex patients effectively (Parry et al., 2019). All of these services are organised and delivered at the General Practice the patient is enrolled in, allowing the care team to have oversight of all services being provided to the patient.

Some of the respondents went further to suggest that if Australia adopted the enrolment model (Health Care Home), that the GP should be penalised in some way if the patient was hospitalised. This would promote adoption of 'best practice' in chronic disease management and proactive interventions, rather than waiting for an escalating symptom or exacerbation to prompt an episode of care. This is also a critical point as older people tend to wait to see their GP until they are very unwell (Chenoweth & Sheriff, 2003).

> *I would structure the funding in New South Wales so that the centrality of care was around the patient in the community, and that hospital care was penalised if it was avoidable. That would mean that the GP would get less incentive or, I think you can't take away income, but you can reduce incentive. So, if people are well-managed and people who don't need to go to hospital don't go to hospital because they can't get into their doctor, or the doctor has made an error in judgement, but then that would be a penalty stroke against the GP* (Medical Specialist and NSW Health Executive, 2009).

The respondent was referring to the inherent tension at the time in relation to the disconnect between GPs funded by the Commonwealth Government and the states who operated the hospitals. This respondent believed that this disconnect resulted in a lack of accountability by GPs for preventable hospital admissions. The proposal to 'enrol' patients with diabetes to GPs was viewed as an effective initiative as it would make the GP focus on long-term wellbeing as opposed to episodic care; however, this model of care did not eventuate, as the Australian Medical Association lobbied against the introduction of the program and sucessfully **blocked this initiative, stating that**:

> *The AMA opposes the move away from a fee-for-service model to a model that introduces fund-holding, fund-capping, and patient enrolment. This is because it removes patient choice, limits access to services, compromises the independence of doctors' clinical decision-making (financial considerations versus clinical need), creates perverse incentives that may*

> *diminish access to, and the quality of care, and adds to the red-tape burden on GPs* (Australian Medical Association, 2010).

And yet, one respondent, a former Health Minister, could see the implicit logic in enrolment to facilitiate long-term holistic care. They also acknowledged the strong resistance to any 'weakening' of the fee-for-service model inherent to Medicare, suggesting that:

> *... there is some professional resistance to it ... particularly the medical profession is very concerned about ... what they would see as a weakening of what they'd see as the fee for service model, but I think it's absolutely crucial that we do find a different mechanism for chronic illness, and particularly, for older people* (Former Health Minister, 2010).

Another respondent stated clearly that in their view, the Australian Medical Association viewed enrolment as a form of control; "… *Doctors see … enrolment as some sort of control over them*" (Bureaucrat, 2010).

It was further noted by the respondents that effective chronic disease management requires patients to be managed holistically and on a long-term basis rather than episodically. Episodic funding does not generate the imperative for continuity of care. As the executive below noted:

> *… the AMA is still very strongly pushing for fee for service … The diabetes packages that went out, very, very strong backlash by many medicos talking … for the fee for service notion and against the notion of a package of care. I think for people with chronic illness, that shift to a package of care is going to become increasingly important and shifting from the fee for service model …* (Executive Sydney West Area Health Service, 2010).

The diabetes care this respondent is referring to was the trial of packaged care for diabetes that is described in the quote below. This trial was instigated in response to recommendations from the National Health and Hospital Reform Commission 2009. Its history is described in the evaluation report:

> *Australia's Coordinated Care for Diabetes Health Reform measure was originally announced in March 2010 … It was intended to fund the flexible delivery of primary healthcare services through general practice for the treatment and ongoing management of people with diabetes who voluntarily enrolled with their general practice. Following this announcement, a range of concerns were raised by stakeholder groups such as the Australian Medical Association (AMA) and the Royal Australian College of General Practitioners (RACGP) in both media commentary and informal stakeholder discussions. Key areas of concern included the 'fundholding' arrangements (over- and under- expenditure), 'capitation' concerns, 'cherry-picking' by practices only enrolling the 'least sick' patients with diabetes, and the pay-for-performance targets for general practice. On 12 November 2010, the then Minister for Health and Ageing announced—in response to these stakeholder concerns—that a pilot of the Coordinated Care for Diabetes reform would commence in July 2011 (this pilot would subsequently be renamed the Diabetes Care Project)* (McKinsey & Company, 2014, p. 12).

The National Health and Hospital Reform Commission Report (Commonwealth of Australia, 2009) recommended the establishment of 'Health Care Homes' for people with chronic conditions. The rationale was to improve co-ordinated care in the community and to halt unnecessary Emergency Department presentations and hospitalisation. This also represented a fundamental change to the funding design of the Medicare Benefits Scheme for GPs (from episodic fee-for-basis to packaged care funding) (Jackson & Hambleton, 2017), a move that was ultimately quashed by the 'Professional Monopolists'[1]. Notwithstanding, there was an appetite for this change

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[1] Health Care Homes is currently being trialed by the Federal Government https://www1.health.gov.au/internet/main/publishing.nsf/Content/health-care-homes

given the highly publicised examples of poor care leading to harm or death and rising costs (Jackson & Hambleton, 2017; Wells & Jackson, 2016), and so a pilot was the compromise. In summary, the government had planned to roll out Health Care Homes and then packaged care for diabetes (a form of enrolment); however, it met strong opposition from the 'Professional Monopolists' (that is, the Australian Medical Association'). The compromise was for the government to announce a pilot.

Medicare facilitates clinical and economic autonomy for doctors

The core intractable reality of the Medicare Benefits Schedule (MBS), and various legislation such as the Health Insurances Act 1973 (the origins of which can be found in the Constitution s.51) (Mendelson, 1999), prevents the government from civil conscription of doctors. Amendments made to the Australian Constitution (Section 51) in 1975 preserved the private contractual relationship between a doctor and their patient, and prohibited the Commonwealth and the states from the civil conscription of the services of doctors (Mendelson, 1999). Commenting on this, a respondent noted that this inherent fact embedded in our Constitution was often passed over in conversations on health reform "… *and so the reforms have to be mindful that there are obviously financial gains and losses from reform, and in some ways, there's going to be losses, financial losses for some of our clinicians if these major reforms are tackled*" (Operational Manager NSW NSCC Area Health Service, 2009).

The MBS rules also led to inequity of supply and lack of choice, with another participant who compared the overwhelming numbers of GPs in the eastern suburbs of Sydney unfavourably to the scarcity of doctors in Dubbo or other regional and rural towns (Senior Bureacrat NSW Health, 2009).

GPs have complete autonomy over what they can and cannot do. If they do not wish to engage with a Medicare Benefits Schedule (MBS) item number, there is no imperative or consequence for them to do so, as was highlighted by this respondent:

> *… a GP is a businessman (sic), that's not an indictment on them, it's basically [how] they have to operate … if you've got a GP that doesn't see … the enhanced primary care stuff is important, then they won't do it,*

> *they're not driven by policy to do [it] … they're not required to … they can get extra funding if they do … if they don't want to, they don't have to …"* (Operational Senior Manager NSW HNE Area Health Service, 2010).

In support of this view, the uptake of the over 75 year old health check was extremely slow in Australia (Blakeman et al., 2001). A comprehensive health assessment takes significant time and may not adequately compensate the GP for the time they spend completing the assessment.

Timed consultations are also a consequence of MBS design according to the following respondent, who was a medical specialist, who quoted feedback from their patients: "*I mean, people come into me and they say no-one has ever sat down and talked to me about what my problem is, because they've only got six minutes, they don't want the patient to open their mouth*" (Medical Specialist and NSW Health Executive, 2009). Another specialist reported:

> *... I think the whole way we drive care, which is fee for service cannot work … if I've got two patients in front of me ... [one] is to prick a boil and I get a certain amount of money and the other person is, I have to do a hard slog for an hour and a half ... every time a person who's been paid with those two people, he's going to choose the boil to prick – and that's the way we run medicine ... the whole thing is fee for service ... there is something, intrinsically very badly wrong ... and it doesn't sit with the sorts of people we're talking about [older people with chronic disease], fee for service is where we're doomed* (Geriatrician and Executive NSW Health, 2009).

Compounding these reimbursement issues linked to the MBS, another respondent, who was a geriatrician, indicated that the financial compensation provided for a geriatric review in a patient's home did not cover the amount of time required to meet the patient's needs – when physical assessment, case history, consultation with family members, liaison with other medical and allied health professionals were taken into account. The remuneration is based on a single episode of care rather than a continuum of care (Geriatrician and Executive NSW Health, 2009). The in-home and long consult Medicare benefits were too low to be attractive to geriatricians and GPs, as there was considerable documentation required from the consultation that was effectively unfunded. However, funding for this work was not available to other professionals who could do the long consult and comprehensively assess the client, and then provide the report for the GP or geriatrician to review.

In summary, the argument is that the episodic fee-for-service design of the Medicare Benefits Scheme promotes single episodes of care and favours procedures. Due to the economic realities of running their own businesses, medical practitioners may favour the high-rebate quick procedures rather than the low-rebate longer episodes of care associated with older people and their chronic conditions.

Medicare facilitates a focus on outputs not patient outcomes

Another perceived problem of the Medicare Benefits Schedule (MBS) was the lack of accountability on doctors for patient outcomes. One respondent had practical experience with reviewing the outputs from one item number (a Comprehensive Geriatric Assessment). In their view, the product did not produce better outcomes for the patient, but rather generated the production of more episodes (or outputs) for the GP. This echoed Alford’s argument that more of the same does not equate to improved outcomes for patients. As this geriatrician noted:

> *... comprehensive geriatric comprehensive assessment ... if you [GP] do that, you get $180 dollars … I get this form that was generated by a computer program, that basically is this enhanced primary care item thing that the GP sent me … and all I have to do is sign at the bottom and then he gets ... the enhanced Medicare primary item right? … I honestly don’t believe after seeing these forms a million [times], I don’t believe it helps that person’s care one single iota ... it’s just a form … but the clinical care hasn’t improved ...* (Geriatrician and Executive NSW Health, 2009).

Increasing healthcare costs require genuine reform

In 2009, the Productivity Commission stated that Australia spends nine per cent of its gross domestic product (GDP) on healthcare which demonstrated a rise of one per cent over the previous decade (Productivity Commission, 2009), and one-third of this funding was spent on hospitals. The concern from government, or the 'Corporate Rationalists', was that this trend would continue. As stated in the National Health and Hospital Reform Commission Final Report, the reforms that were proposed would reduce projected health and aged care expenditure by $4 billion dollars by 2032-33 (Commonwealth of Australia, 2009, p. 152). However, to achieve this result, all the recommendations they proposed would need to be implemented.

The National Health and Hospitals Reform Commission (Commonwealth of Australia, 2009) was equally concerned with efficiency, and the pursuit of sustainability and quality. It also used the language of the 'Corporate Rationalists' with an acknowledgement of 'waste', 'duplication', 'ineffectiveness', and 'inefficiencies' to rally a call to action for change in healthcare:

> *... the importance of efficiency in the healthcare system ... not only because it is key to delivering an affordable and sustainable health system, but also because it can be an ethical issue in terms of equity and fairness. If waste occurs – whether through duplication, poor processes, unnecessarily high cost inputs, errors, high administrative costs, or spending on ineffective treatments – it will adversely impact other people's access to healthcare in a system with finite financial, capital, and human resources ...* (Commonwealth of Australia, 2009, p. 42).

In a system of finite financial and human capital, the effectiveness of treatment is always paramount. There is no doubt that the cost of acute exacerbation of chronic diseases places a high burden on the hospital system and also has negative impacts on the quality of life of the individual and their family and friends, and on productivity costs through lost time at work or in a person's usual daily activities (Hutchinson et al., 2015; Islam, McRae, Yen, Jowsey, & Valderas, 2015). If the management of a chronic condition is not effective, there is a high likelihood of an unplanned admission to hospital and this admission could be classed as preventable (NSW Agency for Clinical Innovation, 2013). Using diabetes as an example, the respondent below highlighted the productivity costs and the costs to informal carers that have a huge impact on the overall cost and burden to the community.

> *... in Australia, we now have nearly a million Australians with type 2 ... diabetes as a major chronic disease burden in Australia ... for each one of those people, there's another Australian everyday who ... has to live and cope with that chronic disease impact on that person's life as a carer or family supporter ... the cost impacts on those people are very significant … the impacts on productivity and employment both for the person with chronic disease and often for their carer and family supports are significant* (Senior Manager NSW Health A, 2009).

Another cost is that of adverse events in hospitals, which were estimated to cost between $1-2 billion dollars annually (Armstrong et al., 2007, p. 486). The older person is at greater risk of adverse events than younger patients, as noted by Shanley et al. (2009): "*The older person presenting to the emergency department has a high risk of adverse outcomes, including death, functional decline, and institutionalization*" (p. 129). The rising cost of pharmaceuticals and technological advances are also considerable, and were estimated to be one-third of the cost of the growth in healthcare (Commonwealth of Australia, 2009).

Hospitals are often the focus

The hospital is the most expensive element in the health system and as I have previously stated, the community is often focused on access to, and funding for, hospitals, yet the vast majority of the time, the community requires access to primary care:

> *... the principle driver … remains too much shifted towards the acute system, a hospital system, the treatment system ... rather than ... prevention, rather than out-of-hospital systems, there's still too much emphasis on the acute sector in both a policy and a funding sense* (Academic and CEO peak body, 2010).

It was observed that in-patient care is an expensive service delivery model, and "... *it's an unnecessarily expensive way to deliver what is often times ... things [like] ... self-management that can best be done in another setting*" (Rehabilitation Physician and Hospital Executive, 2009). These factors were further reinforced with respondents commenting on the Health and Hospital Reform Commission Report (Commonwealth of Australia, 2009) which suggested the introduction of local hospital networks. The respondents felt that it would be more appropriate to have primary care networks, with the hospital being one part of that network rather than being the central point of the network. The Commission (Commonwealth of Australia, 2009) also recommended the move to a 'national efficient price' for hospital procedures, and a shift from the casemix model. However, this move would not address the current issues with casemix funding. Funding based on an efficient price ignores the questions of how quality of care is maintained and what the outcomes are for the patient. There was general concern that the move to an 'efficient' price would create perverse incentives that would see hospitals increase or limit their activities if they believed that a patient cohort (such as older people) would not meet 'efficient' price allocation. The concern that has been raised previously also appeared within this theme, that is, that in acute care, care of the older person is not valued:

> *There's this kind of headset that in acute care, it's acute care and I don't want to look after older people, that's why I'm working in acute care; well actually, the majority of people in acute care are older people and, you know, it's just like, it's a very strange, but a lot of this is driven by this mentality that we've got to make our hospital performance indicators look good ... the Manager of the Division was lamenting the fact on the surgical wards sometimes, they get to nurse empty beds and they don't in the medical division because they're always got people lined up waiting and they would really would like sometimes to be nursing empty beds, how's that?* (Nursing Academic, 2010).

This observation of the importance of community-based healthcare was reiterated by many respondents, with one observing that 90 per cent of the time, healthcare received was delivered in the community, and therefore, that 90 per cent of the funding should reside in this domain.

> *I'd increase ... the number of resources available in the community to ... do home visits, follow-up care … I'd allocate ... a specific bucket of funding from the Commonwealth* (Former Executive NSW Area Health Service B, 2010).

> *Most healthcare occurs in the community, and certainly from a federal perspective where we've got hospital networks, I would make them primary care networks and the hospital would be a component of that service* (Operational Senior Manager NSW HNE Area Health Service, 2010).

Another respondent commented that in Australia, we often fund and build the hospital first and then whatever is left over gets allocated to community services. It is also the hospital 'crisis' that makes the front page of the newspapers rather than a perceived or real decrease in community-based health services. As previously outlined, community concerns and elections are often fuelled by either the threat of a hospital or ward closure, particularly in rural and remote communities, or access to a GP.

One respondent (Operational Senior Manager NSW NSCC Area Health Service, 2010) made the observation that a significant increase in community-based services was required (primary care, rehabilitation, case management, care coordination, transition care) in order to encourage decreased length of stay in hospitals, the challenge being that this sustained investment has not occurred, but there had been significant pressure applied to hospitals to decrease their length of stay without the increased funding to expand community-based services to support discharge of these patients. In 2009, hospitals were decreasing length of stay and this placed extra burden on community services and outpatients, and thus, highlighted the importance of communication between GPs, health staff, community teams, and the patient.

> *… my concern is that the policy direction around the ... shift away from hospital care, it's not being supported with the shift of resourcing, or with*

> *appropriate infrastructure at a community level, to provide viable, good quality alternatives to hospital care and that the, that focus on shifting away from in-patient or hospital care has, as I said, almost, is almost bubbling up as a bit of a, well, witch-hunt's probably a harsh word, but, but it's almost like these people [older people] aren't entitled to be unwell and go to hospital* (Operational Senior Executive NSW Area Health Service, 2010).

The respondents acknowledged the absolute dependency hospitals have on community-based services when it comes to discharging older people safely back into the home. But these services often struggle to provide the necessary services due to lack of adequate funding:

> *You need to put a whole heap of money into primary care, into rehab, into case management, into GPs, into care coordination, into transition care programs for the four years before you stop the push to hospital care. But people expect the instant response. They expect a response within twelve months and it's not going to happen within twelve months because the change itself has taken so long … And if you, if people were willing to put the money in for the three years, then you would get your impact, and you get long-term impact because then you'd be building the programs in the community to keep people out of hospital permanently* (Operational Senior Manager NSW NSCC Area Health Service, 2010).

The respondents acknowledged that there had been some additional funding to community-based programs by NSW Health via the Area Health Service Agreements. This had resulted in the growth of the state-funded CAPAC and ComPacks programs. The funding into ComPacks and CAPACs (Community Acute Post Acute Care or commonly known as Hospital in the Home) was noted as a significant policy shift because it allocated funding to community-based care. Recall in Chapter Six in the discussion about models of care, that the only growth in funding by NSW Health in 2009/2010 Area Health Service budgets for 'beds' was given for the Medical

Assessment Units, while the rest was dedicated to the Hospital in the Home and ComPacks programs. It is important to note that this was new funding, rather than the movement of funding from one program to another. The movement of funding to the community was also observed in the private sector through the creation of rehabilitation programs in orthopaedics.

> *There has been a significant movement already in the systems understanding where the centre of the health system is and so people are – you know, if management at the health level are saying we're putting money back into acute community care, that decision's been made. We've been talking about it for 20 years. We're actually doing it now. We've actually got people saying yes, use the money, put it into acute community care. So, it is a significant change in position obviously, and I think we're only just scratching the top of the surface* (Academic and not-for-profit Executive, 2010).

The importance of effective programs that promote health literacy was recognised in the NSW Annual Report 2018-2019. The report described the introduction of the NSW Health Literacy Framework which as released in April 2019 with four priority areas:

> - *All patients, their families and carers are active partners in their healthcare.*
> - *Staff communicate with patients, families and carers in ways they understand.*
> - *Health facilities and centres are easy to access and navigate.*
> - *Our health systems are built to be sustainable and reliable for every patient, every time.*(NSW Ministry of Health, 2019, p. 24)

Uncoordinated care because of state and Commonwealth misalignment

The fragmentation of the health system, with funding coming from state and Commonwealth Governments, has resulted in a number of disconnects, as one respondent stated:

> *Well, part of our problem is that, that the Commonwealth funding the PBS and the MBS items, and that's shaping the medical care and some allied health, and the state funding Community Health. And they're going in two different directions, so that doesn't help [older people]* (Operational Senior Manager NSW NSCC Area Health Service, 2010).

Older people receive support services in their home, including a range of nursing and allied health interventions, primarily through the Commonwealth-funded Home and Community Care program (HaCC). However, because of the separate funding silos that exist (hospital, primary care, and HaCC), clinicians at the coalface can be frustrated by the inability to connect these separate pieces of funding to work for the benefit of the patient. For example, one of the barriers to discharge from hospital can be home modifications that are required for the patient to safely return home – these home modifications were assessed by, and actioned through, the HaCC program. However, HaCC programs were not designed to fast-track assessment and interventions based on the needs of the acute sector. To access a HaCC service, a patient must be assessed by an Aged Care Assessment Team (ACAT). One respondent spoke of the perverse situation occuring at the time, where the Commonwealth were considering banning ACAT assessors from being part of hospital-based teams. This would have meant that the community teams would have to come into the hospitals to assess patients waiting for discharge. The rationale behind this move was that the Commonwealth were concerned that there was potential cost shifting happening, and that patients were being inappropriately referred to HaCC services to save the hospital money. Cost shifting is when a program funded by one jurisdiction absorbs activity which is the responsibility of another jurisdiction. In this case, the Commonwealth would have argued that the HaCC program should not do the work that the hospital is funded to do.

> *… because of the nexus between the impact of the aged person on the health system and that cohort in terms of demand for resources with …*

> *other forms of crises, what we get is this mish-mash of arrangements that doesn't serve anyone particularly well* (Consultant, 2009).

Other observations about HaCC services were that they needed to be more flexible and responsive. In 2009, HaCC services were designed in NSW so that if a person was assessed by the ACAT team as requiring the service and they obtained the service, they were basically set up with a 'service for life'. There were huge inequities and inefficiencies in this construct, and by 2019, this situation had changed significantly through the introduction of Consumer Directed Care and far more flexibility in the application of HaCC services; however, in 2009, this was not the case.

> *Well, you might not need four and six hours like for the rest of your life, but you might need … eight hours for the first six months, because you're recovering from something, or you may need towards 15 towards the end of – … the end of your life, because of increased clinical need … So it – I just think there needs to be more fluidity in … hours that actually suit the client's needs* (NSW not-for-profit Executive, 2009).

Part Two: Discussion – What would Alford say?

Introduction

At the time the interviews were conducted, the Australian Government had just released the report of the National Health and Hospitals Reform Commission – A healthier future for all Australians (Commonwealth of Australia, 2009). Four of the 10 commissioners were interviewed out of the total of 30 interviews undertaken in this research. In its opening pages, the Report stated the raison d'être of the Commission:

> *While the Australian health system has many strengths, it is a system* ***under growing pressure, particularly as the health needs of our population change****. We face significant challenges, including* ***large increases in demand for, and expenditure on, healthcare****, unacceptable inequities in health outcomes and access to services, growing concerns about safety and quality, workforce shortages, and*

> ***inefficiency.*** *Further, we have a* ***fragmented health system*** *with a complex division of funding responsibilities and performance accountabilities between different levels of government. It is ill-equipped to respond to these challenges* (p. 3, emphasis added).

Juxtapose this statement with Alford (1975), who opened his analysis of the New York health systems major reviews with:

> *The purpose of this detailed analysis is to evaluate the reports with respect to their consideration of the causes, characteristics, and consequences of, and their policy recommendations on, the* ***"fragmentation"*** *and lack of "coordination" of the New York City health system* (p. 26).

Alford went on to say:

> *This picture is restated in every diagnosis of the "crisis" of the health system. The figures portray dynamics without change: a rapid increase in almost every index of growth-dollars, manpower, programs – except those pertaining to quality, distribution, accessibility, and reasonable cost to the consumer* (p. 181).

The health systems 'under pressure' in New York in 1975 and Australia in 2009 bear striking similarities. The seven reports analysed by Alford to construct his theory of structural interests led him to conclude that if major health reform was ever to be achieved, the structural interests at the system's core must be identified and methods to align the divergent views articulated. As outlined in Chapter Three, the three structural interest groups Alford identified are 'Professional Monopolisers', 'Corporate Rationalists', and 'Equal Health Advocates'. Importantly for the dominant structural interest group, Alford (1975) stated:

> *Dominant structural interests are those served by the structure of social, economic, and political institutions as they exist at any given time. Precisely because of this, the interests involved do not continuously have*

> *to organize and act to defend their interests; other institutions do that for them* (p. 14).

Here, Alford is referring to the doctors (GPs and specialists). When the Australian Government proposes changes to healthcare, either to the Medicare Benefits Schedule or in relation to hospital beds, this directly challenges the professional monopoly of this group including their income. A central argument in this thesis is that health reform in Australia has failed because the power, status, and income of 'Professional Monopolists' were not addressed when reform recommendations were made. I stress that I do not wish to assign 'blame' to individual professional groups for the failure of health reform; rather, I assert that Alford's taxonomy of structural interest groups provides a framework to understand why health reform fails.

The other key concept in Alford's theory is the position that interest groups take. Alford argued that the 'Professional Monopolists' rarely have to take the stance of a 'challenging' interest', as their interests are inherently protected by health system design and the power built by medical schools, professional associations, and Royal Colleges. The 'power' of doctors, their schools, and the Royal Colleges is enshrined in national legislation in the form of the Health Practitioner National Law (2009) (Forrester & Griffiths, 2014). In Australia, once a doctor has been accepted into their profession by the relevant Specialist College, they have the right to practice their chosen specialty, gain a Medicare provider number which gives them the right to claim benefits through the Medicare Benefits Schedule, and to prescribe medications from the Pharmaceutical Benefits Scheme. Their collective power is also derived from their professional associations such as the Australian Medical Association and the Australian Divisions of General Practice.

'Professional Monopolists'

One of the recommendations of the National Health and Hospital Reform Commission (Commonwealth of Australia, 2009) was to introduce the notion of a 'Health Care Home' for identified high risk groups.

> *… encouraging better continuity and coordinated care for people with more complex health problems – including people with chronic diseases and disabilities, families with young children, and Aboriginal and Torres Strait Islander people – under voluntary enrolment with a* ***'Health Care Home'*** *that can help coordinate, guide, and navigate access to the right range of multidisciplinary health service providers (p. 6).*

A 'Health Care Home' was a form of enrolment in primary care as per the United Kingdom's National Health Insurance model, and was highly topical at the time of the interviews. The Australian Government proposed that a trial would take place with people with Type 2 diabetes, a trial opposed by and highly scrutinised and stymied by the Australian Medical Association (Australian Medical Association, 2016). This is a highly relevant example whereby 'Corporate Rationalists' proposed the enrolment system while the 'Professional Monopolists' rejected and ultimately blocked its implementation. A key pillar in the argument was that the implementation of this model could lead to capitation. The Medicare Benefits Schedule (MBS) was in 2009, and remains in 2020, a completely uncapped form of health funding. To understand the elements of enrolment in primary care vs. the current operation of primary care, it is important to go back to the foundation of the MBS.

The MBS was designed by 'Corporate Rationalists' and firmly entrenched the role of the 'Professional Monopolists'. In Australia, these 'Professional Monopolists', namely the GPs and medical specialists are compensated on a fee-for-service basis through both the MBS and in some instances through private health insurance rebates. Much of the debate raised by the respondents is that the fee-for-service paradigm does not create incentives for long-term care, the formation of care teams, or for a system that uses the full capacity of nurses and allied health professionals. However, as Alford (1975) noted, there are those who advocate its superiority.

> *Schwartz argues that the pluralistic market system in the U.S. not only* ***"provides choices for both physicians and patients," but also "gives [the physician] an economic interest in satisfying the patient",***

> *because of the "intimate, long-term, and humane" contact between physician and patient. He argues that to "nationalise and bureaucratize" the American health system like that in Britain will reduce the amount of choice, reduce the incentives to please the patient, and thus depersonalise treatment* [emphasis added] (Alford, 1975, p. 3).

Compare this with the 2010 response from the Australian Medical Association (AMA) when the National Health and Hospital Reform Commission Report proposed the establishment of Medicare Locals.

> *The AMA believes that ... the need to preserve and support the role of GPs, and focus on areas of unmet need. GP engagement would ensure that patient care is* ***not fragmented****. Medicare Locals* ***must not interfere in the doctor-patient relationship*** *and patients must maintain choice of GP or other medical practitioners* [emphasis added] (Australian Medical Association, 2010).

My argument is that the long-held belief of the sanctity of the doctor-patient relationship must be questioned, when a number of other professions could successfully undertake tasks that are performed by doctors, and particularly, for those tasks of which the only reason doctors undertake them is that they are the only ones for whom funds are released from the Medicare Benefits Schedule (MBS). For example, recall the examples given in the previous chapter in relation to Nurse Practitioners (NPs). The study by Dierick-van Daele, Metsemakers, Derckx, Spreeuwenberg, and Vrijhoef (2009) using a randomised controlled trial method, demonstrated the effectiveness of NPs in primary care settings, delivering care equal to that of GPs. In Australia, Beadnell (2019) highlighted an example where the only need to see the GP was because the NP could not prescribe the necessary medications, as NPs were not given access to the PBS.

As was noted in the review of Australia's health workforce (Australian Government Productivity Commission, 2005), the full capacity of all health professionals must be utilised if the health needs of the ageing population with increased rates of chronic disease are to be met. These concepts are not new, as was The Rockefeller

Committee’s (1971) observation, cited by Alford (1975), that noted that physician assistants were perfectly capable of completing a number of tasks performed by doctors, but were not permitted to do so – a common factor with the respondents’ views of healthcare in Australia at the time of the interviews. Australian healthcare will remain as it is until there is an alignment with the political will to change access to the Medicare Benefits Schedule (MBS) packages of care, through which GPs, nurses, and allied health professionals should be able to work together to effectively manage a patient’s chronic condition/s in the community. The National Health and Hospitals Reform Commission (Commonwealth of Australia, 2009) obviously felt that there were advantages of ‘Health Care Homes’, and three of the 10 commissioners were doctors, including the chair; however, the ‘Professional Monopolists’ fought this recommendation.

The other consequence of any changes to the MBS is that they would have an impact on the personal income of the GP or specialist. This fiscal reality is ignored in analysis, debate, and discussion about healthcare reform. In the United Kingdom, the inherent duplicity of being a GP and a provider of medical services vs. a commissioner was identified as an area of potential conflict more than two decades ago (North, 1995).

Alford went on to argue that critics of the pluralistic system observed that it leads to “*over-doctoring, over hospitalisation, and over-operating, and that the alleged intimate and humane quality of most doctor-patient relationships is a myth*” (Alford, 1975, p. 3). As I have previously stated, the sanctity of the doctor-patient relationship is upheld in the Constitution of Australia, section 51 (Commonwealth of Australia, 1975).

The respondents also identified similarities with Alford’s descriptions of “over hospitalisation”, referring to the fact that hospitals consume vast amounts of health funding and the interventions they conduct are costly. Not only do hospitals consume large quantities of health funding (Duckett et al., 2014), but also the funding for the activity they conduct via casemix was viewed to be inequitable when compared to community-based activity; for example, the average cost for a Hospital in the Home separation, was on average $1,764; compared to a hospital separation of $3,614 for matched acute medical patients with no difference in clinical outcomes and equal or better patient satisfaction (Board et al., 2000). Hospitals appear to have become the epicentre of healthcare delivery, which was viewed by the respondents as being inefficient and unnecessarily expensive (for example, chronic disease rehabilitation programs being hosted in hospital outpatient settings when they could be, and are, effectively hosted in the community).

The other fiscal reality of the MBS is the drive for outputs – that is, the higher the number of consultations a GP can deliver in one day, the higher will be their income. Recall the comment by one of the respondents who is a practicing medical specialist – he was often struck by how little patients had been told by the time they got to see him, and how much time he needed to invest to educate them on their chronic conditions and management options. This doctor's practice was influenced by the six minutes some GPs were spending with their patients, and the respondent who shared this story recalled that patients told him that: *"... they don't want them to open their mouths*"; this spoke volumes about the fast-paced GP consultations that occur in some practices (Geriatrician and Executive NSW Health, 2009).

Alford (1975) quoted the Rockefeller committee who stated similarly that:

> *"Most clinics serving poor people are structured for the convenience of the doctor, not the patient …"* (Alford, 1975, p. 182).

Consider, Dr. Kidd's comments about the release of the National Health and Hospital Commission Report (Commonwealth of Australia, 2009). He recognised General Practice as the critical cornerstone of the health system and its future, as acknowledged in the Commission Report (Commonwealth of Australia, 2009) and its role in meeting the growing needs of our ageing and "*... increasingly informed population*" (Kidd, 2009, p. 448). In commenting on proposals to further integrate primary care (or general practice) and community healthcare services, the latter typically funded via state and territory Departments of Health, he wrote:

> *The lack of specific focus on in the report on the role of the GP in leading the primary care team is disappointing ... The evidence is clear that multidisciplinary planning of care to improve outcomes for people with*

> *chronic conditions needs to involve GPs; this is more specific than the recommendation in the report about enrolment with a "principal healthcare home". Any move to remove Australians' direct access to "my GP" will not be popular with the electorate* (Kidd, 2009, p. 448).

Two powerful messages were inherent in this statement – one is if one wishes to integrate community health and primary care, the GP needs to be in charge of those teams, and secondly – if one messes with General Practice, there will be a strong political backlash. These sentiments were echoed by Dr. Pesce, the President of the Australian Medical Association, in 2009:

> *Above all, the central and leading role of the GP in primary care must be protected and promoted* (Dr Andrew Pesce, 2009).

Dr. Pesce was later quoted responding to a speech by the then Federal Health Minister, Nicola Roxon, who by then had backed down on the proposed enrolment system recommended by the Commission Report and opposed by the AMA.

> *"To most Australians, general practice is primary care", Dr Pesce said. "When people get sick or injured or require care for a chronic ailment, they want to see a GP. People trust their GPs and know they will get the highest quality care every time. So any policy that seeks to reform primary care must preserve the role of the GP as the leader and coordinator of primary care. There is no substitute for a GP. The AMA supports a coordinated care model based around GP-led multidisciplinary primary care teams"* (Australian Medical Association, 2009).

This statement went on to welcome the need to expand the role of NPs and other registered health professionals in rural and remote areas where often, GPs cannot be retained in their required numbers, with the important caveat that "... *care will be needed to ensure that the introduction of new practitioners does not lead to an exodus of those doctors who do work in remote locations*" (p. 449). Or is this an example of what the respondents referred to as 'patch protection'? What was clear was that while the GP was a vital team member in the care of older people with chronic conditions, the fast-paced episodic care environment of General Practice left little incentive for care co-ordination.

> *There are currently no formal mechanisms in place to encourage continuity of care. While many patients have a usual GP, this does not discourage them from seeking care elsewhere and, in turn, fragmenting care. Recent research suggests that over 25% of patients attend multiple general practices* (Royal Australian College of General Practitioners, 2018, p. 10).

While the MBS makes provision for case conferencing, it is unlikely that the GPs skills and expertise would be needed for this activity, and this role could easily and effectively be taken up by a nurse if there was a stand-alone MBS item number for this activity, or alternatively, a method of enrolment financing that would allow provision for medical and nursing interventions.

An important point was also raised by respondents which highlighted the difficult communities in rural and remote Australia face in accessing doctors and specialists..

Inequity of supply

Alford observed a complete lack of systematic needs analysis in the New York health system. The system met the needs of the 'Professional Monopolists' within it, but it cannot be said that there was evidence that the system met the needs of the public. Given the lack of rigorous planning data on community needs, it was not possible to plan healthcare services effectively. "… *Conant defined … community health planning as the "effort to bring together and make rational use of private and public resources … in such a way as to meet all important health problems in the community*" (p. 173). What Alford uncovered in his comprehensive analysis of over two decades of inquiries was that there were significant inadequacies in the establishment of need in each community, let alone planning, to systematically meet these identified needs. The same was observed by the respondents in this study, in that equity of access to GPs and medical specialists was not equally distributed across New South Wales; in other words, one's choice of a GP if they live in the eastern suburbs of Sydney is vastly different from those who live in rural or remote New South Wales, for example, in Dubbo.

In its position statement on Geographic Provider Numbers, the Royal Australian College of General Practitioners stated:

> *The RACGP NRF strongly opposes the use of Geographic Provider Numbers as a solution to general practice workforce maldistribution. Restricting provider numbers as a means of forced redistribution of workforce poses significant risks for communities and their profession* (RACGP National Rural Faculty, 2014).

'Corporate Rationalists'

'Corporate Rationalists' are constantly looking for ways to increase effectiveness and efficiency, seeking to make the health dollar go further and to halt the ever-increasing costs of healthcare. There was recognition by the respondents of the role that governments play in planning for healthcare delivery, so that in theory at least, all Australians would have equitable access to healthcare. Alford (1975) observed a fundamental lack of needs assessment and planning in the New York health system and a frustration with programs that flourished as their funding window opened, and disappeared in a similar fashion when their funding ceased. Again, this was mirrored in the respondents' comments, with frustration at the Commonwealth programs based on three year funding cycles and the endless chasing of the latest funding fad:

> *... you shouldn't really get between a health professional and a bucket of money ... because what we do is ... we say we can do that, whatever it is you want us to do, we can do it ... mental health, diabetes, what would you like? ... And we become all singing and all dancing health professionals ... who just do what the money is there to do ...* (Academic and NSW Health Consultant, 2010).

Recall the quotation from Alford (1975) in Chapter Three in relation to 'hot' programs and their endless short-term funding cycles that had little overall impact on health care delivery or outcomes.

> *The history of the Neighborhood Family Care Centers illustrates the extreme dependence of local health programs upon the vicissitudes of federal legislation. The rise of a particular "hot" program such as the War on Poverty generates a flurry of activity – plans, proposals, meetings, new organizations – but this activity quickly dies down as another program appears which is advertised as solving the problems. However, the "crisis" continues, largely untouched, because no program which is politically feasible can also attack the causes of the problem and more than a few of the consequences* (p. 166).

Respondents felt the casemix funding method stymied efforts of staff at the coalface who may see a more efficient or effective treatment option for patients, but the casemix rules restricted their ability to act. An overarching observation Alford made about the New York health system was the dominance of 'in-hospital care' and the over-hospitalisation of patients, which led to system blockages in emergency rooms. One of the strategies of the Clinical Services Redesign Program was that each Area Health Service was required to have a Sustainable Access Plan (SAP). The SAP had funding attached and led to the implementation of hospital avoidance strategies such as Hospital in the Home (HiTH) and early discharge strategies such as ComPacks, which were discussed in Chapter Six. The respondents highlighted the incredible push from NSW Health to decrease the number of hospital bed days, which echoed the findings of the 1960 Heyman Commission analysed by Alford, where it was reported that between 15 and 20 per cent of patients did not need to be in hospital, and in which the "Homestead Plan" was introduced to increase the number of community-based ambulatory care services and home care. The respondents echoed this observation in NSW and noted that while some increased investments had been made in community-based services to meet the push for reduced hospital bed days, there had not been enough resources allocated or enough time given to allow these programs to work in synergy with hospitals to reduce bed days. There was also frustration that programs such as HaCC did not work to the timetable of the acute sector in being responsive enough to assist with timely discharge of patients, particularly when barriers to discharge were comprised mainly of home modifications.

As viewed by the respondents, a mistake made in the Health and Hospitals Commission Report (Commonwealth of Australia, 2009) was to make the hospital the centre of healthcare. This ignored the fact that the majority of the time, people receive care in the community and proportionally little time is spent in acute settings (Australian Government Department of Health, 2018, 2019; Australian Institute of Health and Welfare, 2010; Royal Australian College of General Practitioners, 2018). Alford (1975) noted the recommendations of the 1966 Haldeman Report, which concluded, without any evidence as to why the following recommendation had merit, that the "*general hospital should be the core service providing institution ...",* that is, the centre of health services, with all other services being either hospital-based or hospital-related (Alford, 1975, p. 45).

Australia has two powerful factions in the 'Professional Monopolists' group, GPs and specialists. The latter are generally clustered in acute environments and/or in private practice. So, while hospitals continue to have this powerful lobby group behind them, the predominance of the acute sector will remain. The community voice, most powerfully felt during the lead up to an election, may well start to be felt at the doors of General Practice and not just at the hospital door.

'Equal Health Advocates'

Overall, the respondents had the least to say about the equal health advocates, and therefore, I do not comprehensively explore the literature related to consumer involvement in healthcare design, which is an important issue, but beyond the scope of my discussion. The main role played by consumers is their ability to vote in elections, and in Australia, election campaigns typically feature healthcare issues. However, the importance of the consumer voice in seeking change in the healthcare system was noted by one respondent:

> *So it seems that ... how you get your funding ... by encouraging the community to be vocal, by not being afraid of the community, and by enabling them, enabling the community and patients to voice their concerns in the context, and have a situation where, if you go to show*

> *competition, for many, many, many moons the competition, that there has been no competition, the majority of the state dollar has been sucked into the hospital. Now this, the ageing and chronic disease stuff predominantly happens in the community* (Operational Manager NSW NSCC Area Health Service, 2009).

In the next chapter about leaders, the role of the consumer voice that was identified by the respondents will be discussed, particularly the role it played when the opportunity was provided for it to be heard, influencing change within the hospitals.

Summary

In summary, this chapter reminded the reader of the key tenets of Alford's theory of structural interests, and revisited the constant state of 'crisis' in both Alford's 1975 summary of the New York health system and the Australian healthcare landscape in 2009-2010. Hospitals were under immense scrutiny during the period the interviews were conducted in New South Wales, due to tragic failures which had led to unnecessary deaths. The perpetual economic crisis of health was also critiqued, which is a factor that is expected to continue as Australia's population ages with increased rates of chronic disease.

The major funding instrument, the Medicare Benefits Schedule (MBS), was examined through the commentary provided by the respondents. The impact of its fee-for-service design which leads to episodic care was explored. The centrality of hospitals and the concerns about inequity in funding when compared to community-based care was also discussed.

Finally, the two major structural interest groups identified by the respondents, which equated to Alford's 'Corporate Rationalists' and 'Professional Monopolists', and their role in playing a challenging interest in healthcare reform, was examined. Overwhelmingly during the period of this study, the 'Professional Monopolists' successfully held their ground in relation to proposed changes from the National Health and Hospital Reform Commission, with the Australian

Medical Association successfully blocking the introduction of ‘Health Care Homes’ for patients with diabetes. The ‘Corporate Rationalists’ continued this agenda, and in 2019, as presented in the previous chapter, the trial of ‘Health Care Homes’ continues in Australia.

CHAPTER NINE LEADING CHANGE IN HEALTHCARE

Introduction

This chapter focuses on the leadership required to implement new models of care, as outlined by the respondents. This discussion is framed within the taxonomy of Alford's three structural interest groups, namely the 'Professional Monopolists', the 'Corporate Rationalists', and the 'Equal Health Advocates' and the respective contribution the respondents felt that each group played in leading change or health reform. This chapter demonstrates that in order to introduce a new model of care, it needs to be lead by a 'Professional Monopolist' with new money from the 'Corporate Rationalists'. I also provide an example, through the Clinical Service Redesign Program of the influential role that 'Equal Health Advocates' can play in influencing change.

Evidence of the alignment of interest groups from the respondent's accounts are then examined, leading to a conclusion about the **conditions that are required** to achieve reform within the Australian health system. First of all, I argue that the issue of leading and achieving change in health is unique because health is unique.

Health is unique

In considering how to write this chapter, I took a step back and objectively considered healthcare as an industry and sought to find a parallel. I could not find one, but I argue that healthcare is **unique** because of the nature of the human condition. A fact of the human condition is that we will all die. As a society, we find it extremely difficult to talk about death and illness and to confront grief and loss because we all know that one day it will be us. For this reason, regardless of our position in society, doctors hold an entrenched position of power because we subscribe to the medical model through which they save lives. A doctor has the power to stand between us and death. This means that we all have 'skin in the game' when it comes to the topic of healthcare. It also means that if one subscribes to the medical model, doctors hold intrinsic power over us, and this key factor must be taken into consideration when considering 'change' in the context of health. Edwards and Saltman (2017) highlighted the patient's perspective in reinforcing the need for doctors to lead the delivery and management of healthcare:

> *From the patient's perspective, strong physician influence is often seen as a good thing: the last thing a sick patient wants is for a clinical decision to be influenced by, or worst of all, made by non-medically qualified administrators or lower-level medical staff. This patient support reinforces the particular physician-led character of decision-making … and with it the inevitable resistance to externally generated change – be it politically or managerially led – that could interfere with physician- and, more broadly, medical staff-led decision-making* (p. 5).

In their comprehensive book on leading and managing health services in Australia, Day and Leggat (2015) discussed the important role that leaders play in healthcare and described five domains of competency required to be an effective leader. I agree with their assertion that leadership in healthcare is challenging because of environmental factors such as regulations that are imposed which are outside the control of the leader including, as per their example, the way doctors are remunerated. Indeed, this factor is embedded in the Constitution of Australia, Section 51 as I have previously described. My discussion about leaders is at a system level and not about their individual competencies or characteristics. I focus on how their position within their structural interest group led to change through the introduction of a new model of care. I also describe the coalitions that lead to the statewide introduction of a model of care, such as Hospital in the Home, which required both the 'Professional Monopolists' and the 'Corporate Rationalists' to act in synergy. My argument about healthcare leadership is at the macro and systems level, as per Alford's analytical position. Recall also that my criteria for health 'reform' being realised in healthcare is the statewide implementation of a new model of care.

In 2009, the Australian Government's "A Healthier Future For All Australians – Final Report of the National Health and Hospitals Reform Commission" was released (referred to as the Reform Commission Report throughout this chapter): The opening pages of this report clearly articulated the Australian psyche regarding general views on healthcare.

> *Each of us implicitly values our health and wellbeing. It is often only when we are sick, injured, or the quality of our life is under threat, that we truly recognise its importance as we face up to the potential loss of wellbeing, mobility, or life itself. … Few of us can stand by and watch a child die if there is a chance of buying them a few more days or months, no matter the price. As a community, we would find it confronting to be asked to make a decision about rationing high cost healthcare, such as renal dialysis to the elderly, if it released resources to extend the lives of sick children. The so called 'rule of rescue' means that we feel a moral imperative to invest in the care of identifiable individuals, no matter what the economic metrics may show. But the reality is all healthcare costs money, and money is scarce, facing us all with 'tragic choices'* (Commonwealth of Australia, 2009, p. 34).

In 2008, and today in 2020, the medical model dominates, and nothing will bring about a top news story or the downfall of a politician than closing a hospital bed, a ward, or a hospital. This fact was reiterated in the Reform Commission Report "*… health care consistently rates as one of the most contentious and high profile political issues at election time"* (Commonwealth of Australia, 2009, p. 34).

As quoted in the Report, the 'rule of rescue' is that we, as a society will want to intervene between a person's morbidity or mortality if prevention is possible. This places doctors, the 'Professional Monopolists', in a truly unique position unparalleled in any other industry, and they know this, as one geriatrician respondent acknowledged, this power comes from caring for patients:

> *… one of the really good things … about being a Geriatrician and being around a lot, is that often you start looking after the parents of your*

> *colleagues or, or bosses, and if you do a good job that helps …* (Geriatrician and Hospital Executive, 2010).

The natural progression of our society's subscription to the medical model is the centrality of the hospital in the healthcare system. It is the Mecca of the medical model.

> *We haven't really shifted people's headsets about acute care and about, you know, as I said, the dominance is still the hospital in the system, it is kind of the centerpiece … I still don't think we've actually shifted enough in viewing the hospital as kind of the last point of call rather than the first* (Nursing Academic, 2010).

In summary, leadership in healthcare is unique because we all have 'skin in the game'. As a society we subscribe to the medical model and the importance of hospitals. Hospitals are a politically sensitive topic at times of election.

Centrality of the hospital in the healthcare debate

The history of the centrality of the hospital was noted by Alford (1975) going back to the 1930s in America, and its roots are found in the decisions of the 'Corporate Rationalists' rather than the 'Professional Monopolists' in designing the operation of these institutions:

> *Hospital-based group practice, advocated as far back as 1932 by the Committee on the Costs of Medical Care and opposed by the AMA [American Medical Association], was an early attempt to rationalize the health care system around a key institution potentially capable of integrating and coordinating the specialized skills and techniques now available. … The power of the hospital as the coordinator and controller of the health services and personnel provided within its boundaries* (Alford, 1975, p. 215).

From the 1930s in the USA, the 'Corporate Rationalists' sought to use the hospital as the vehicle to control the activity of the 'Professional Monopolists'. In Australia, this paradigm of the centrality of the hospital has created a political and community perception of its importance in maintaining the health of the community, rather than its role in a continuum of primary and secondary health services and timely access to a range of interventions that keep people well. The Australian Bureau of Statistics reported that 83 per cent of patients reported having visited their GP in the last year, while only 14 per cent reported visiting an Emergency Department and 13 per cent reported being hospitalised (Royal Australian College of General Practitioners, 2018, p. 7). As the report noted, the actual centre of the health system is General Practice:

> *A thriving, accessible and high-quality general practice sector is vital to the health of Australia. General practitioners (GPs) are the first point of contact for most Australians seeking medical attention, with more than 87.8% of the population seeing a GP at least once each year* (Royal Australian College of General Practitioners, 2018, p. 1).

In 2017/18, patients accessed almost 155 million GP services (Australian Government Department of Health, 2018). In the 2016-2017 financial year, there were 7.8 million Emergency Department attendances (Australian Institute of Health and Welfare, 2017). This clearly demonstrates that the majority of the time, the community accesses primary care rather than acute care. I do however, note that some primary care activity occurs in Emergency Departments. Anecdotally, it was viewed in NSW Health that triage category five patients could have been seen in a General Practice setting; however, I also remind the reader of my earlier point that older people with chronic conditions can be inappropriately allocated lower triage categories (Olofsson et al., 2012).

The importance of comprehensive primary and community care is also echoed by McNab and Gillespie (2015) who evaluated the impact of HealthOne in New South Wales and found that patients who had access to comprehensive services provided by HealthOne (medical, nursing, and allied health services) were able to reduce the number of times they accessed an Emergency Department compared to the 12 month period prior to their enrolment. These benefits had flow-on effects into the hospital environment, and the authors also found that if these patients were hospitalised, their length of stay was shorter.

As the three previous chapters have demonstrated, the majority of ‘Professional Monopolists’ block health reform if it challenges the tasks they are solely able to perform (recall the case study of the Nurse Practitioner) or the operation of the Medicare Benefits Schedule. Health reform was on the agenda in 2009, given that Prime Minister Rudd had been elected partly on a platform of reform and establishing a commission to address the issue. In his address to the Congress on Health Reform, Dr. Andrew Pesce (President of the Australian Medical Association in 2009) firmly upheld the place of ‘Professional Monopolists’ in decisions regarding reform.

> *If you want real reform that sticks and works operationally, and is supported, you have to bring along the key players in the health sector, including the doctors. This means* ***negotiating the changes with them*** *and working through the operational detail … This is the only way to get real reform embedded into the system and supported by those who have to implement and work within the system changes* [emphasis added] (Dr Andrew Pesce, 2009).

The second major barrier to reform is the dominance of the hospital, rather than health being part of a continuum of care, that is comprehensive primary care, performed by a range of medical, nursing, and allied health professionals best suited to the activity required by the patient. In 2009, Dr. Pesce was asked how to address the ‘crisis’ in New South Wales hospitals, where there was a $90 million deficit, and what advice he would give the new Health Minister, Carmel Tebbutt:

> *I'd say* ***talk to the doctors ...*** *Make sure you see what they need … But I'm afraid we need extra resources as well. There is no fat in the system. We need extra resourcing. And it's time that that was recognised … I think*

> *that, you know, the deficits are not due to wasteful practices* (Pesce, 2009).

However, research by Duckett et al. (2014) highlighted that one billion of the $140 billion of the healthcare budget was wasted on ineffective and inefficient public hospital activity. The clear message in this statement is ‘talking’ to the doctors and giving them what they need to provide patient care. The other unwritten assumption is that all patients who present to hospital need to be there. However, as the previously discussed alternative models of care, such as ‘Hospital in the Home’, which are more effective and safer particularly for older people, may be better than hospitalisation. It has also been established that patients presenting to hospital may not have needed to attend if their chronic condition had been managed in services such as HealthOne which had demonstrated reductions in Emergency Department presentations and hospital length of stay (McNab & Gillespie, 2015).

It has also been demonstrated that the ‘Professional Monopolists’ will block alternative models of care if their autonomy or funding is threatened. The concern therefore is that if governments must continue to ‘consult’ with doctors and give them what they need, this will perpetuate what is already in place and ignore opportunities to improve efficiency and effectiveness. Indeed, this is what is highlighted by Duckett (2005) in calling for a different approach to health workforce design for the 21st century. In Chapter Six, models of care such as Hospital in the Home were demonstrated to be a safer mode of care particularly for older people (Caplan, 2000, 2015; Caplan et al., 2012). Medicare costs continue to spiral upwards with no immediate solution, and with an ageing population with increased rates of chronic disease, solutions need to be found. There was a 6.3 per cent increase in Medicare Benefits paid in the 2017/18 financial year compared to the 2016/17 financial year alone (Australian Government Department of Health, 2018). So, in the context of increased costs, there is an urgent need to introduce models of care that better meet the needs of older Australians with chronic conditions.

Australia’s Healthcare Crisis: where are the leaders?

Alford (1975) questioned whether the healthcare ‘crisis’ he examined in New York was unique or if it was a universal challenge. His observations are equally applicable to the Australian narrative about a health ‘crisis’, with rising costs in healthcare expenditure as a major driver in the Reform Commission’s Report in 2009:

> *… the upward pressures on health spending are unrelenting, reflecting continued advances in healthcare and increased demand from ageing populations and shifting disease patterns* (Commonwealth of Australia, 2009, p. 35).

Once again, as observed by Alford, this ‘crisis’ in the Australian health system exists in an environment of numerous Inquiries, Royal Commissions, Taskforces, and Reviews as well as in highly publicised personal accounts of health system failures.

> *There is a growing disquiet in the Australian community about the viability of our health system, which is reflected in the many Inquiries, Royal Commissions, Taskforces, and Reviews. Frequent media stories of personal tragedies and commentary on system failures add fuel to public concerns. People are looking for leadership and effective solutions, now* (Commonwealth of Australia, 2009, p. 33).

So, where is the ‘leadership’ to drive the urgent and necessary health reforms? Where are the leaders who can take the Australian healthcare system out of crisis and into an era of effectiveness and efficiency? This chapter seeks to answer these questions through the respondents’ answers. What will be demonstrated from this exploration is that, as Alford argued, change is achieved when temporary coalitions are formed between two of the interest groups to drive change. Similar to examples discussed previously from the United Kingdom (UK) (North, 1995; North & Peckham, 2001), in 2008, there was evidence of ‘Corporate Rationalists’ and ‘Equal Health Advocates’ aligning to achieve change in the operational paradigms of the ‘Professional Monopolists’. However, this was a more localised event rather than a system-wide change as in the UK experience. The importance of ‘Professional Monopolist’ to ‘Professional Monopolist’ engagement in leading change was a strong theme as well as temporary coalitions between ‘Corporate Rationalists’ and ‘Equal Health Advocates’ that emerged and will be described later in this chapter.

It is also relevant to quote from the Garling Report (Garling, 2008). He noted that within New South Wales (NSW) public hospitals, there was a schism between the management (the ‘Corporate Rationalists’) and the doctors (the ‘Professional Monopolists’) at the time the interviews were conducted for this study. These observations are reflective of those provided earlier in the chapter in relation to those of Dr. Pesce, President of the Australian Medical Association:

> *During the course of this enquiry, I have identified one impediment to good, safe care which infects the whole public hospital system. … It is the breakdown of good working relations between clinicians and management which is very detrimental to patients. It is alienating the most skilled in the medical workforce from service in the public system* (Garling, 2008, p. 15).

‘Professional Monopolists’ who block change

While there are excellent examples of ‘Professional Monopolists’ who champion improved models of care that better meet the needs of the ageing population, as discussed in Chapter Six, these models did not achieve system-wide implementation until the ‘Corporate Rationalists’ intervened with new dedicated funding to support expansion. What was needed was ‘Professional Monopolists’ who led the new model of care because of the evidence of the benefits to patients. The respondents provided examples of ‘Professional Monopolists’ who were leading effective services across New South Wales or within their Area Health Service.

> *… having strong leaders, you know, clinical leaders who can actually push the way ahead so that others will actually come on board and stop the stupid talk out of that fee for service from AMA, that type of thing. You know, it’s like [Dr.] Di O’Halloran’s and that – you know, if you can get out*

> *there and lead the way, you know, for others to follow. It would really be good too if we could see some of our specialists in hospitals also being champions of the cause in that same [way] that we've got the Di O'Halloran* (Executive Sydney West Area Health Service, 2010).

The respondent cited above was referring to Dr. O'Halloran's advocacy of the HealthOne model of care and the GP super clinics. The Australian Medical Association successfully lobbied for GP super clinics to be abandoned after the Reform Commission Report recommended it as a key strategy. In providing the AMA's response to the Reform Commission Report, Dr. Pesce, stated:

> *Now the government has focused on GP super clinics. We would argue that the – you could get good results by improving infrastructure grants and payments to existing general practices, to help them upgrade and provide the multidisciplinary care that's necessary* (Pesce, 2009).

Dr. Di O'Halloran was a GP who was highly instrumental in the establishment of the first HealthOne in Western Sydney and an advocate for co-ordinated care. She was an advocate for Super Clinics or Health One as they were known in New South Wales. At the time the interviews were conducted, Dr. O'Halloran was leading the establishment of the Mt. Druitt HealthOne and championed the model with NSW Health and the Federal Government. This demonstrated that one well respected doctor can provide a forceful argument against the general trend advocated by the Australian Medical Association (AMA).

Similarly, Professor Ian Hickie stated that he is unpopular among his psychiatric colleagues as he challenged the position of the 'Professional Monopolists' not only in their role in the treatment of mental health conditions, but also in how psychologists are remunerated via the Medical Benefits Scheme:

> *I am a psychiatrist, let's be clear here, I am in more trouble with my psychiatrist colleagues than my psychologist colleagues because I am saying two things; pay the clinical psychologists as well to lead teams of*

> *psychiatrists and work together, and also there's no reason to see a psychiatrist endlessly. We are not endless psychotherapists. We have particular medical skills that should be used as well within these teams, so you get the right combination. We are highly skilled medical practitioners and need to work with highly skilled psychologists and others* (Professor Ian Hickie, 2019).

Dr. O'Halloran and Professor Hickie both advocated for similar constructs, albeit in different domains of healthcare, the former in general practice, the latter in mental health. Both advocated funding of team-based care to utilise the full range of doctors, nurses, and allied health professionals' skills to meet the needs of the community to maintain and improve their health and wellbeing. These 'Professional Monopolists' conducted themselves in a manner inconsistent with Alford's theory of structural interest, that is, they do not defend their territory, but take on the 'challenging' role to seek reform to improve patient care.

Dr. O'Halloran was not alone in her advocacy in this area, and others such as Dr. Ron Penny, a long-time leader in chronic disease in New South Wales, were also cited by respondents as important advocates for improved models of care for older people with chronic conditions. Their collective advocacy led NSW Health to fund the HealthOne program to be established throughout the state via a competitive tender process. This connected and collaborative thinking was noted by the respondents among the GPs, but the respondents felt they could not find similar examples within the hospitals.

> *I couldn't point in the same way to what I've seen happen in GP land with our specialists in that same level of joined up thinking. There's some there – there's some there, but not to that same level of intensity. So, getting the champions from within the hospital sector would be good* (Executive Sydney West Area Health Service, 2010).

> *Then I think you've had other GPs who have been quite leading like Di O'Halloran who is very, very strongly linked to Mt. Druitt Health One as well as WentWest, she's been very instrumental in, you know, putting*

> *forward views. And there has been a few other GP leaders … there have been senior GP leaders who have helped push that [new Model of Care] through their colleagues and been quite instrumental* (Executive Sydney West Area Health Service, 2010).

The respondent's acknowledged that doctor-led innovation was evident in pockets throughout the health system, but usually they were isolated within individual hospitals; for example, Acute Care of the Elderly led by Associate Professor Sue Kurrle at Hornsby Hospital and OPERA lead by Dr. Peter Landau at Westmead Hospital.

> *Well, in my mind, most of them [innovative Models of Care] are led by well-respected clinicians* (Senior Manager NSW Health B, 2009).

In fact, this was the model recommended by Garling (2008), where individuals and teams within the system would seek the best evidence-based models of care and implement them with local champions. Unfortunately, in 2008-9, champions of successful and evidence-based models of care were isolated and not systematically embedded in the hospital sector. To achieve systematic adoption of the various models of care identified in this study required a clinical champion, after which it then needed to be provided with additional funds by the bureaucrats (the 'Corporate Rationalists') without any disruption to the existing practices or income of the Corporate Rationalists.

Other examples of champion clinician doctors can be found. For example, in the aged care sector, new models of care were established to meet the needs of older people; for example, Dr. Stephen Judd and Dr. Penny Flett from Hammond Care (CEO Aged Care Peak Body B, 2010). Another example is the establishment of Medical Assessment Units (AMU). As noted in Chapter Six, MAUs received funding from NSW Health via Area Health Service Agreements.

> *In New South Wales, the Medical Assessment Units haven't been the revival of general medicine, general physicians run the units at North Shore and maybe Hornsby and maybe Campbelltown, but for Sutherland,*

> *St George, Prince of Wales, St Vincent's, Concord, Prince Alfred, Bankstown, Liverpool, maybe some other places, they're all run by geriatricians … I think some of, many of the other physicians weren't comfortable adopting a general focus. So, I think the, I think OPERA is an unusual MAU and it, you know, it would be worth talking to [Dr.] Peter Landau about that. Of the others, they're all sort of slightly different in the way they're established, so you could really pick any of them and get a different perspective* (Geriatrician and Hospital Executive, 2010).

The example given by this respondent about OPERA was that it was the foundation model that led to the statewide funding of the MAU initiative. It evolved from a 'crisis' in the Emergency Department at Westmead Hospital with high volumes of older people presenting, and the NSW Health imposed rule on each Area Health Service to adhere to the 8 hour rule (NSW Department of Health, 2009, p. 47). This example of a lone clinical champion who has the opportunity to establish a new way of working, such as Dr. Peter Landau, was not unique, and other respondents provided examples from elsewhere in Australia. The respondent below spoke about a lone clinical champion who significantly changed the profile of hospitalisation for older people by her individual practice in Tasmania.

> *An innovative leader who, well an innovative clinician who took it upon themselves to do something differently and serve people differently, and even if they are a leader or not, if they are leading in what they do, but they didn't have a team to lead, they just did it themselves, and I think you know in Tasmania, for example, they told us before she [a geriatrician] started and before she took these relationships and protocols which included ambulance, and when they don't come through, they had something like 47 people in the hospital beds at any given time who shouldn't be there, they got it down to 17* (Doctor and Private Health Insurance Executive, 2009).

Examples were provided of forums in which GPs and specialists came together with consumers and management. In these forums, doctors not only heard the problems with existing practices from the consumers, but also the GPs and the specialists in the hospitals challenged each other. Again as a reminder to the reader, at the time the interviews were conducted, many leaders in New South Wales had either worked within, or had heard about the work of, the Clinical Services Redesign Program (CSRP) which, as part of the standard methodology adopted in each Area Health Service, advocated for the inclusion of consumers in the redesign process (O'Connell et al., 2008).

> *… coming back to those consumer voices all the time, I think was really a powerful way to get change, and, and as I said, having the GP-to-specialist to debate themselves was also a clear way to get change* (Operational Manager NSW NSCC Area Health Service, 2009).

This was a strong theme in that getting doctor’s to change their practice relied heavily on doctor-to-doctor engagement – ‘Professional Monopolists’ challenging other ‘Professional Monopolists’, in this case, the GPs in an Area Health Service challenging the specialists in the hospitals. The quote from one respondent below describes their experience of leading change within an Area Health Service.

> *… we had a fair amount of clinical engagement from the GPs who led our initial process, and participated. I think it would have had a different outcome if we hadn’t had that. We had GPs who were strong enough themselves to tackle the specialists, so it was a doctor/doctor argument, not a manager or a nurse trying to argue with the specialist. So, when it got down to the sticky issues, having some key champions from that professional group helped* (Operational Senior Manager NSW NSCC Area Health Service, 2010).

Another theme was the importance of the doctor or specialist and the nurse who worked with them. There were many examples of powerful collaborations that achieved strong change in areas such as Advance Care Planning (Dr. Peter Saul and nurse Lisa Shaw; Dr. Gideon Caplan and nurse Anne Mellor) (NSW Area Health Service Executive, 2010).

In summary, ‘Professional Monopolists’ can and do challenge the ‘status quo’ with innovative models of care; however, these innovations are generally introduced at an individual hospital level, and later, if supported by evidence and best practice, the ‘Corporate Rationalists’ play an important role in systematising the model of care by providing dedicated new funding to roll it out across the state. ‘Medical Assessment Units’, ‘HealthOne’, and ‘Hospital in the Home’ are all examples of models of care which had a ‘Professional Monopolist’ champion that were later systematised by the ‘Corporate Rationalists’. I will now expand on the role that the ‘Corporate Rationalists’ play in leading change in healthcare.

‘Corporate Rationalists’ and their role in leading change

Leadership from ‘the top’ was seen as absolutely critical in achieving change, with alignment between the Chief Executive Officer from within the Area Health Service and the Executive of the Area Health Service being actively needed to engage and lead the changes. In 2008-9, each Area Health Service had a Chief Executive Officer and an executive comprised of the CEO with the Director of Clinical Operations (DCO) and the Director of Population Health, Planning, and Performance. These three key executive roles were seen as critical in leading change within an Area Health Service.

> *… when we first started, it really, really helped that we had the CE and the Director of Clinical, so we had really senior exec support who basically turned up to meetings themselves, participated in workshops, and were really interested, and made it really clear to some of the specialty clinicians that things were going to change* (Operational Senior Manager NSW NSCC Area Health Service, 2010).

Furthermore, what was seen as necessary was for all the managers to support and lead the change. This was a consistently strong theme.

> *Yes look, engaging the Senior Managers … unless you’ve got commitment at the top of the organization, then um, or a significant leader … then I don’t believe … it was a significant commitment by leaders in the organization to try to deal with this … because the pressures were*

> *enormous … we had a cluster structure, so both the managers, the general managers of clusters, and the general managers of the larger facilities and the smaller facilities (Former Executive NSW Area Health Service B, 2010).*

Garling (2008) summarised the situation in Area Health Services regarding the roles of both managers (the Corporate Rationalists) and doctors (the Professional Monopolists). He stated that managerial skills are required in order to achieve an efficient operating model in healthcare, and that these skills should be acquired through necessary qualifications and training. However, managers (the Corporate Rationalists) need to understand medicine sufficiently in order to effectively resolve issues they are confronted with, and they need to work in partnership with the doctors:

> *A change of the present culture of division between clinicians and managers is required. It should be replaced by a collaborative partnership between administrators and clinicians* (Garling, 2008, p. 31).

Garling went on to state that the greatest barrier to healthcare reform is the divide between managers and clinicians (doctors). Through the course of his Inquiry, he stated that he heard time and again that data was the key to informing the adoption of evidenced-based innovation.

> *Statistically, it is established that Models of Care can be standardised for more than 80% of patients who suffer from a condition in common. The data already proves that patients are safer and have better health outcomes where best practice is used. The point about best practice is not that it is "standardised" care, but that it is "best" care* (Garling, 2008, p. 31).

The challenge however was that despite strong compelling evidence of superior outcomes for the patient, if the remuneration of the 'Professional Monopolists' was at stake, there was a backlash. As Professor Ian Hickie described in early 2019:

> *This fee-for-service stuff doesn't work for us [mental health], it doesn't work in cancer, it doesn't work in complex heart disease, let's stop it, or at least explore alternatives. This thing has gone back and said, no, let's expand it and do more of it because, guess what, we love it, the providers, we love it. We make more money, we charge more out of pocket, we actually set up more practices in eastern Melbourne and eastern Sydney, and you come and find us* (Professor Ian Hickie, 2019).

Professor Hickie was not acting in a fashion that typified the behaviour of ‘Professional Monopolists’, as identified by Alford. He was in fact taking a ‘challenging’ stance, proposing shifts in both the funding arrangements of the MBS and also the autonomy of the ‘Professional Monopolists’ in terms of where and how they practiced.

Smith (2008) highlighted what occurs when the ‘Professional Monopolists’ are challenged, as was the case in 2008 when the then Federal Labor Health Minister Nicola Roxon challenged General Practice by proposing the establishment of ‘HealthCare Homes’, and later, the Commission’s recommendation to trial enrolment (i.e. Health Care Homes as described in Chapter Eight) was strongly opposed by the then President of the Royal Australian College of General Practitioners.

> *The change in Federal Government a year ago has meant the future of the health system, the future of the medical profession, and the future of general practice has monopolised debate. With wholesale change expected under Federal Health Minister Ms Nicola Roxon, who is ready to fight what she believes are the medical profession's vested interests … to trial patient enrolment, a move that will allow patients to voluntarily sign up with practice or doctors to deliver their care. It's intended to prevent the fragmentation of care. The AMA is wary, saying it is a short step to capitation funding and fund holding* (Smith, 2008, p. 2).

The majority of ‘Professional Monopolists’ will block any move by the ‘Corporate Rationalists’ that threaten their professional autonomy or their fee-for-service mode of remuneration, in which more activity equals more cash, and any hint of capitation is met with violent opposition. It can also be stated that while the GPs were willing to tackle the specialists working in the hospitals, they were not prepared to challenge themselves and consider new models of care in the form of a ‘Health Care Home’ (enrolment). The conclusion is that a new model of care can be supported by the ‘Corporate Rationalists’ and the ‘Equal Health Advocates’; however, if it challenged the remuneration model of a ‘Professional Monopolist’, no change occurred. This is why, in the face of numerous reviews, reports, commissions, and ‘crisis’, the Australian health system fundamentally stays the same, because the debate does not address the fiscal realities for the ‘Professional Monopolists’.

‘Equal Health Advocates’ and the role they can play in change when given the opportunity

The Clinical Services Redesign Program (CSRP) (2005-2008) was led by the NSW Health Department under the stewardship of Deputy Director General Professor Katherine McGrath (McGrath et al., 2008). The focus of the program was to improve the performance of Emergency Departments, elective surgery, and older people with chronic conditions (Ben-Tovim. et al., 2008; MacLellan et al., 2008; McGrath et al., 2008; O'Connell et al., 2008). As part of the program, each Area Health Service received dedicated funding to conduct projects to deliver improved outcomes both in prescribed metrics, such as Emergency Department waiting times and patient outcomes (e.g. reduction in unplanned presentations to Emergency Departments due to preventable exacerbation of chronic conditions). A fundamental element of the CSRP methodology was to track and capture poor patient journeys and use them to create a ‘burning platform’ for reform (Ben-Tovim. et al., 2008). Consumer voices, or the ‘Equal Health Advocates’, were evident in the respondents’ views, as many had been involved with CSRP across the state of New South Wales. The CSRP was a ‘one of a kind’ program and has not been replicated to date.

The respondents recognised the importance of the collaboration of ‘Corporate Rationalists’ and ‘Equal Health Advocates’ in challenging ‘Professional Monopolists’ during the Clinical Service Redesign Program. As one executive noted:

> *Having senior executives and senior community members brave enough to say listen, this doesn't work and we have to change …* (Operational Senior Executive NSW Area Health Service, 2010).

The power of the consumer was most beneficial when the doctors were present and heard firsthand their account of how the 'system' had let them down. Doctors thought they were doing a 'great job' and this was challenged by consumers, as identified by the following respondent:

> *I guess we also started off with some really strong consumers who had a voice in our workshops that was heard by clinical staff [doctors], who thought that they were delivering really good care, but the feedback wasn't so great* (Operational Senior Manager NSW NSCC Area Health Service, 2010).

This respondent highlighted the impact of having the consumer voice in workshops with doctors present. It allowed them to hear first-hand what challenges patients faced in getting their healthcare needs met. The doctors were confronted with the evidence from patients about how the current models of care had failed, creating an incentive for them to engage in the changes required to fix these issues.

> *I think doing … the twenty or odd patient journeys that we did in detail, and the two hundred consumer surveys we did, all of which said the same thing … it challenged staff … they're just saying … every patient gets a discharge summary, while our file audits and the consumers said no, only a third did. And, so when you come back with that kind of information that clearly said no, you're not, and the clinicians say, "Oh no, we all follow the guidelines so that they're getting the same care," and the consumers kept coming back, "Well no, we've been admitted three times and we got a different medication each time, and we only got … one discharge summary and we never knew what the medication was". When people*

> *were saying that over and over again, it's just a bit hard to ignore. And in the end, you know, developing the principal with the consumers there, and with the GPs there, when staff themselves wanted to have the workshop without those people, I think it was a challenge to run, but in the end, meant that it's a bit hard to start to argue back that we needed to change some of the things we needed to change when you've got consumers saying to your face* (Operational Senior Manager NSW NSCC Area Health Service, 2010).

The specific conditions required to establish new models of care to better meet the needs of older people with chronic conditions

The respondents in this study identified that when there was dedicated funding given to an Area Health Service (from the 'Corporate Rationalists' at NSW Health central office or from the Commonwealth), change was possible, but it needed executive leadership and 'buy in'. However, this was not enough. The leadership of the 'Professional Monopolists' had to be aligned to the intent of the 'Corporate Rationalists', otherwise the change could not be achieved. Consumers were a powerful voice in making the case for change and for impressing on the 'Professional Monopolists' failures in the delivery of care, and the Corporate Rationalists used this ploy on a number of occasions. However, if the model of care challenged the financial rewards offered by the current system, the change would be opposed by the 'Professional Monopolists'.

The inherent power of the 'Professional Monopolists' was evident in the formation of the Medical Assessment Units (MAU) outlined in Chapter Six. Funding was provided by NSW Health. These were additional funds, with no funds taken from existing services or programs, but new money to Area Health Services (AHS) which targeted 19 major hospitals.

The respondents reinforced Alford (1975) theory that there needed to be a coalition between 'Corporate Rationalists' and 'Professional Monopolists' in order to deliver change to a health system. In the case of the Medical Assessment Units in New South Wales in 2008, the number of patients assessed and treated increased by 72 per cent, but this came with an annual investment of over $100 million dollars (NSW Ministry of

Health, 2013). However, what is not known is if a similar result could have been achieved with additional Emergency Department beds or with greater numbers of Nurse Practitioners attending to older people with chronic conditions in the community. Claims of system improvements in the context of increased funding do not permit a systematic comparison of one model of care against another. In this case, the evaluation compared Average Length of Stay (ALOS) for patients with a medical Diagnosis Related Group (DRG) prior to the implementation of the MAU, and then post-MAU implementation. Improvements in ALOS were observed; however, this does not preclude the argument that this reduction could not have been achieved by other means, or indeed, if it was the most cost-effective solution to the issue of the increasing numbers of complex older people presenting to Emergency Departments.

> *The NSW MAUs have produced system-wide changes on implementation of 17,429 bed days or $13,124,338. This was demonstrated through the efficiency benefit produced by comparing ALOS for patients with a medical DRG prior to the MAUs being implemented to ALOS for patients with a medical DRG and had a proportion of their treatment in a MAU after MAU implementation. This change has been sustained as demonstrated with the efficiency benefit of 6,111 bed days or $5,225,076 in 2011/12. This benefit was produced by the reduction in ALOS of MAU patients that were transferred to a ward and the increasing quantity of services provided by MAUs* (NSW Ministry of Health, 2013, p. 90).

What is evident however, is that MAUs came about because of the leadership in one Area Health Service led by the CEO (Professor Stephen Boyages) and a well-respected clinical champion and geriatrician, Dr. Peter Landau. Together, they established OPERA which was the foundation upon which the MAUs were established. OPERA was seen as a favourable solution within NSW Health, as it demonstrated improved metrics for the hospital in which it operated (Westmead Hospital) in average Emergency Department waiting times, off-stretcher times, and bed block. All of these metrics were Key Performance Indicators in every Area Health Service agreement at the time the interviews for this study were conducted.

What was also evident from the respondents was the role that consumers played in getting the doctors (the ‘Professional Monopolists’) to hear first-hand their experiences and how the current models of care were failing them. Many respondents felt that this was a key factor in getting the doctors on board in the change program, as they could not argue with the status quo in the face of direct patient feedback. However, engagement by and leadership of medical doctors and specialists occurred only if their remuneration and autonomy was not altered in any way.

Summary

This chapter has focused on leadership in the unique field of healthcare. Leadership in healthcare is different from other industries because it is one in which we all have ‘skin in the game’. Debate is often focused on one aspect of it (hospitals), rather than recognising the continuum of healthcare. I have also established that healthcare is in a constant state of ‘crisis’ with the increased numbers of older people and increased rates of chronic conditions which will require a fundamental shift in how care is delivered if we are to halt the ever increasing costs of healthcare. Yet, despite this ‘crisis’, leaders that embed genuine change in the system are hard to find.

The respondents were able to find examples of ‘Professional Monopolists’ who were able to implement a new model of care that better met the needs of older people. ‘Professional Monopolists’ typically act in ways that reflect Alford’s theory of structural interests, that is, they merely defend their territory. However, through this chapter, a new category of ‘Professional Monopolists’ emerged who take on the role of a challenging structural interest, a role typically held by the ‘Corporate Rationalists’. These ‘Professional Monopolists’ introduce new models of care at a local level and when proven, are adopted by the ‘Corporate Rationalists’ to be implemented via new funding. I argue in the final chapter that these ‘Professional Monopolists’ are different than what Alford described, and I label them as ‘Professional Advocates’. ‘Equal Health Advocates’ can play a powerful role in improving the health system and can take on a role to challenge the ‘Professional Monopolists’. In the examples provided, this opportunity was provided by the ‘Corporate Rationalists’ through the Clinical Services Redesign Program. In this unique context, the ‘Equal Health Advocates’ voices were heard through patient journeys and were involved in shaping improvements in healthcare.

Change was achieved when there was alignment with the ‘Professional Monopolists’ and ‘Corporate Rationalists’, and there were new funds available to implement proven models of care. These powerful coalitions led to significant improvements in the care of older people with chronic conditions in New South Wales, with the Medical Assessment Units being an example of this.

CHAPTER TEN CONCLUSION

Introduction

This chapter presents three arguments that combine the themes outlined in the four discussion chapters. In order to provide context for my arguments, I provide a summary of Alford's theory of structural interests and how these interests represent 'dominant', 'challenging', or 'repressed' positions in the struggle to reform or change the healthcare system. I then recap the context of 'health reform' that existed when the interviews were conducted in 2009-2010.

The first of my two arguments confirm Alford's theory of structural interests, most strongly in the evidence the respondents provided for the role that the 'Professional Monopolists' and 'Corporate Rationalists' play in healthcare. I also found evidence of the 'temporary alliances' that were formed when small improvements were made in the form of the introduction of new models of care.

The second argument outlines the case for the emergence of a fourth structural interest group operating in the Australian healthcare system, a group I have named the 'Professional Advocates'. I provide examples of the actions of this group and how they differ from both the 'Professional Monopolists' and the 'Corporate Rationalists'. I believe that harnessing the power and influence of this fourth group is the key to improving the healthcare system in Australia through the introduction of new models of care that better meet the needs of older people with chronic conditions. I also postulate that Alford's dichotomy of market versus bureaucratic reform in the Australian context may involve a third paradigm emerging from the 'Professional Advocates' who lead health improvements based on evidence-based medicine, but who also strongly argue the case for team-based packaged care which moves beyond the fee-for-service design of the Medicare Benefits Schedule (MBS). The argument for this shift is not one of market conditions or a bureaucratically imposed construct; rather, it uses evidence drawn from the effective management of chronic conditions to argue the case for team-based care. Before outlining these arguments in full, I will recap the thesis below.

Recapping the thesis

Chapter One introduced the thesis and my research questions. I then provided the context for these research questions, including an overview of the ageing population, and how models of care are described in the literature in Chapter Two, and an overview of chronic disease in Chapter Three.

My original research questions were to understand why the health system is so resistant to change or ‘reform’. My research focused on the highly topical issue of older people with increased rates of chronic disease. I have argued that increased rates of hospitalisation represent the system’s failure to change to meet their needs. To examine system inertia, I examined models of care from the major areas of healthcare in Australia, that is General Practice (or primary care) and the acute hospital sector. I assert that models of care are an expression of health policy (as they dictate the way health care is delivered). Because an emergent theory was not evident from my original coding and thematic analysis of my data I then applied Alford’s theory of structural interests to answer the following three research questions:

1. ***Does Alford’s theory explain why reform within the Australian healthcare system is difficult to achieve?***
2. ***Was there evidence of Alford’s three structural interest groups in the themes that emerged from respondents?***
3. ***Did these interest groups behave in a manner consistent with what Alford described?***

Alford’s theory of structural interests was summarised in Chapter Four, and I described his three structural interest groups, the ‘Professional Monopolists’, the ‘Corporate Rationalists’, and the ‘Equal Health Advocates’. These three groups have different positions within the healthcare system. The ‘Professional Monopolists’ hold the position of the dominant structural interest, because their position is protected by the system itself. In Australia, the position of the ‘Professional Monopolists’ is upheld by the Constitution (Commonwealth of Australia, 1975), and through legislation, regulation, and the funding rules in the Medicare Benefits Schedule (MBS). The role that the ‘Professional Monopolists’ perform, and the tasks that only they are allowed to undertake, are protected by these regulations. The ‘Corporate Rationalists’ take up the ‘challenging’ role, trying to change the system to allow others, such as Nurse Practitioners, to undertake episodes of care that are ‘owned’ by doctors. Chapter Six provided a case study of the Nurse Practitioner, as an example of role substitution that could provide less expensive and more comprehensive primary care. The reformers argued that doctors do tasks they do not need to perform, but have to perform, because under the existing MBS rules, they are the only ones permitted to claim these item numbers. The ‘Corporate Rationalists’ are focused on *“… breaking the professional monopoly of physicians over the production and distribution of health care*” (Alford, 1975, p. 15).

‘Equal Health Advocates’ are consumers who may collectively pursue a common agenda in order to lobby for improved access, quality, or cost of healthcare. ‘Equal Health Advocates’ form the repressed interest group. The key difference between these groups is that the dominant structural interest group merely has to maintain their position while enormous energy must be mobilised by challenging or repressed interest groups to impinge upon the role and function of the ‘Professional Monopolists’.

The dominance of the ‘Professional Monopolists’ has also gained societal consensus as we, as a society, have subscribed to the medical model, and therefore, are fully invested in the dominant role of the doctor. Alford (1975) asserted that it is not that we as a society give power to doctors because we all have ‘skin in the game’ when it comes to healthcare and the critical role doctor’s play in the provision of that healthcare, rather, it is our subscription to the existing design of the health system, which establishes the doctor as the dominant structural interest with a professional monopoly.

Alford believed that it was the *“… existence of a network of political, legal, and economic institutions which guarantees that certain dominant interests will be served comes to be taken for granted as legitimate, as the only possible way in which these health services can be provided*” (p. 17). These observations made by Alford in the 1970s are echoed in recent reports in Australia in the 21th century. Consider the commentary from Duckett (2005) and the Productivity Commission into Australia’s Health Workforce from 2005:

> *And though health workforce arrangements have evolved in response to changing healthcare needs, including through greater reliance on multidisciplinary care, the skills of many health workers are not being used to full advantage. To a large extent, this is because of various systemic impediments that prevent their competencies being fully developed, assessed, recognised, and utilised* (Australian Government Productivity Commission, 2005, p. xvii).

The dominant power of the 'Professional Monopolists' also allowed them to control the supply of doctors. Alford (1975) stated that "*Professional power over supply also results in a distortion of training toward specialization*" (p. 196). Again, this reinforced legitimacy where we have allowed the 'Professional Monopolists' to promulgate the specialisation of medicine, unabated, despite the greatest need for the ageing population being in holistic healthcare. Alford's theory of structural interests was formed in a context of constant inquiries within the city of New York … a situation consistent with Australia in 2009.

The Australian healthcare crisis and Commissions of Inquiry

The lack of team-based or connected care has been the basis upon which the Australian healthcare system arrived at recurrent crises whereby highly publicised failures of medicine led to the tragic deaths of patients. The notable example provided in this thesis is the death in 2008 that led to the Garling Inquiry in New South Wales. Garling (2008) described 'a system on the brink' with increased pressures due to the changing demographics of society, namely an ageing population with increased rates of chronic disease and increased demand. Using the language of the 'Corporate Rationalists', Garling also described a 'fragmented disconnected' system with rising costs and an overall environment of 'crisis'. He called for a radical change in how business was to be conducted, in particular, for a model in which teamwork and collaboration replaces individual and independent silos of healthcare (Garling, 2008, pp. 3-4).

Australia had also elected a new Prime Minister in 2007 with a mandate to ‘fix’ the health system. He instigated the National Health and Hospitals Reform Commission in February 2008 and made a commitment to tackle the long-term challenges in the Australian health system. The final report, ‘A Healthier Future for All – Final Report of the National Health and Hospitals Reform Commission’, released in 2009 came with 100 recommendations. One of the recommendations was for ‘Health Care Homes’, which faced powerful opposition by the Australian Medical Association, which was later watered down to become a trial.

These two Inquiries in response to the ‘crisis’ in health were major contextual issues at the time the interviews were conducted in 2009/2010, the first occurring at the state level, the second as a Commonwealth initiative, and I have discussed the key points from these reports that are relevant to this study throughout the thesis.

In support of Alford’s ‘Professional Monopolists’

‘Professional Monopolists’ maintain control over their scope of work, even though there are others who could perform these tasks. This control is dictated by the Australian Health Practitioner Regulation Agency (APHRA) and the Medicare Benefits Schedule (MBS), as was discussed in the workforce chapter (Chapter 7). The ‘Professional Monopolists’ in the form of GPs, supported by the Australian Medical Association (AMA) and the Royal Australian College of General Practitioners (RACGP), advocated to lead community-based teams and have dedicated funding and a position that would allow them to direct the care provided by nurses and allied health professionals in the community. I would argue that this would be a retrograde step further binding the work of healthcare to the ‘Professional Monopolists’ and take away from the skills, abilities, and capabilities of the nursing and allied health professions in the management of ageing and chronic conditions.

The RACGP and AMA succeeded in bringing the work of Nurse Practitioners (NPs) under the direct supervision of doctors in 2008 when their lobbying saw the government change the legislation such that NPs were required to have a collaborative agreement with a GP or specialist which curtailed their practice within a specified scope. As was presented in Chapter Seven on the workforce, this has been demonstrated to limit the potential of NPs, with the GP or specialist dictating what they can and cannot do – rather than their practice being defined by their qualifications, skills, and experience.

The Australian Medical Association (AMA) fiercely protects the fee-for-service paradigm of the MBS, and this was demonstrated in Chapter Eight (on funding), when the National Health and Hospital's Reform Commission (Commonwealth of Australia, 2009) recommended voluntary enrolment for people with chronic conditions into a 'Health Care Home' which was strongly opposed by the AMA. The 'Health Care Home' represented a fundamental change to the funding design of the MBS for GPs (from an episodic fee-for-service basis to packaged care funding) (Jackson & Hambleton, 2017), a move that was ultimately quashed by the 'Professional Monopolists'[2]. Notwithstanding this issue, there was an appetite for this change given the highly publicised examples of poor care leading to harm or death and rising costs (Jackson & Hambleton, 2017; Wells & Jackson, 2016), and so a pilot was the compromise. In summary, the government had planned to roll out 'Health Care Homes' and then packaged care for diabetes (a form of enrolment); however, these initiatives met strong opposition from the 'Professional Monopolists'. The compromise was for the government to announce a pilot; trials of 'Health Care Homes' commenced in 2016 and continue to the current day (2020). Jackson and Hambleton (2017) stated that the 'Equal Health Advocates' welcomed the concept. However, the 'Corporate Rationalists' backed down when pressure was applied by the 'Professional Monopolists' due to ongoing concerns related to funding:

> *Although consumer support for the initiative has been strong, professional organisations including the Australian Medical Association and the Royal Australian College of General Practitioners have voiced concern … Concerns include the size of the payment bundle, recompense for practice change …* (p. 1).

I argue that enrolment in 'Health Care Homes' is critical if Australia is to limit the increased costs of chronic disease and to achieve multi-disciplinary team-based and

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[2] Health Care Homes is currently being trialed by the Federal Government https://www1.health.gov.au/internet/main/publishing.nsf/Content/health-care-homes

coordinated care. Allocation of bundled payments to practices would require GPs to adopt a multi-disciplinary approach to primary care, as they would simply not have the time or skills to solely provide all of the care required. It would also provide a mechanism for government to monitor the outcomes of patients enrolled in these programs. However, the model is a direct threat to the clinical and fiscal autonomy of the ‘Professional Monopolists’, and it is no wonder it has been met with such resistance.

> *The Federal Government’s landmark Health Care Homes (HCH) reform is at risk of collapse because of a lack of funding, the AMA has warned. Earlier this year, the government announced the trial of the Health Care Homes initiative, involving 65,000 patients and 200 medical practices in 10 regions across the country. Under the government’s plans, practices will receive monthly bundled payments to manage patients with chronic and complex health conditions … But the details of the trial have reinforced suspicions that the government is undertaking Health Care Homes* ***primarily as a cost-cutting exercise*** [emphasis added] (Australian Medical Association, 2016).

On the 30 June 2019, the Department of Health announced that enrolment into the program closed, and over 10,000 patients were enrolled in ten Primary Health Networks across Australia (Australian Government Department of Health, 2019). Note that this number is significantly lower than the original estimates of 65,000 patients, and the trial will end on 30 June 2021.

As Alford stated, dominant structural interests do not have to take on the role of a challenging interest, rather they defend their position when challenged – and this defense worked and the plan for Health Care Homes was quashed. This was despite evidence that team-based care is effective, as demonstrated by the HealthOne model of care described in Chapter Six (McNab & Gillespie, 2015), which demonstrated improvements in Emergency Department visits and shorter lengths of stay for patients enrolled in the HealthOne.

As Alford (1975) stated, because dominant structural interests merely defend their territory, challenging interests must mobilise a significant co-ordinated effort to advocate for change:

> *Because these interests are, at present, the dominant ones, with their powers and resources safely embedded in law, custom, professional legitimacy, and the practices of the many public and private organizations, they do not need to be as visibly active or as cohesively organized as those groups seeking change* (Alford, 1975, p. 191).

Recall Bucher and Strauss (1961) who outlined the medical power asserted by the profession, and once a 'specialty' is claimed, no other profession can perform work related to this domain. This was also highlighted by Kenny and Duckett (2004) in the organisation of rural medicine and the dominant power doctors played in the delivery of medical care in rural Victoria. Medical dominance is preserved through the Constitution of Australia (Commonwealth of Australia, 1975), with various Acts that restrict what other health professionals can and cannot do, such as the Nurse Practitioners' Act (Dierick-van Daele et al., 2009; Gardner et al., 2010; Hillege et al., 2005; Scanlon et al., 2018) and the Optometrist Registration Act (Willis, 2006). These pieces of legislation and regulation preserve and protect the ownership and autonomy of doctors, which is further perpetuated through the design of the healthcare remuneration system in Australia through the Medicare Benefits Schedule (MBS).

'Professional Monopolists' restrict supply

'Professional Monopolists' resist changes to remuneration models as well as restrict supply in the numbers of graduates in specialties; for example, the discussion in Chapter Eight regarding Geographic Provider Numbers for doctors. The 'Professional Monopolists' block initiatives that threaten their autonomy, whether this is in the form of funding arrangements, or the location where they can practice. Access to GPs and specialists in rural and remote Australia has been a long-standing challenge, as noted by the National Health and Hospital Reform Commission Final Report.

> *The recommendations … are directed at addressing the problems for people living in remote and rural areas of having a universal health entitlement under Medicare, but not gaining universal access due to the limited availability of doctors in remote and rural communities* (Commonwealth of Australia, 2009, p. 4).

Efforts by the ‘Corporate Rationalists’ to address this concern have been opposed by the Royal Australian College of General Practitioners. In 2014, the government sought to establish Geographic Provider Numbers for GPs; however, this did not occur due to opposition from the RACGP. These ‘Professional Monopolists’ cited safety concerns and risks to patients, and then alleged breaches of civil liberties. ‘Professional Monopolists’ wish to maintain their autonomy to practice wherever they choose, regardless of the impact this has on the population, particularly in rural and remote Australia. This theme was echoed by the respondents who described vast choice if one lived in the eastern suburbs of Sydney as opposed to the paucity of choice if one lived, for example, in Dubbo.

This theme of geographical medical dominance has been observed by other authors such as Kenny and Duckett (2004) who examined the role of doctors in rural communities in Victoria. They concluded that the critical shortages of doctors in rural communities gave them the power, dominance, and a mandate to dictate how medical resources are provided. Their research concluded that “… *the power of medicine* [doctors] *is strengthened and institutionalized by geographically determined resource control*” (p. 1059).

In summary, there is clear evidence from the respondents that the role of the ‘Professional Monopolist’ as a dominant structural interest is evident in the Australian healthcare system. This has been observed by other authors such as Duckett (1984). Most notably, Duckett observed the powerful role that the Australian Medical Association played when it sought to block the Medibank legislation in 1974, a move that ultimately failed when it was passed.

Evidence in support of Alford's 'Corporate Rationalists'

The 'Corporate Rationalists' challenge the 'Professional Monopolists' as they seek to redress the system issues (such as increased Emergency Department demand) and rising health costs. In New South Wales during the time the interviews were conducted, the Clinical Services Redesign Program had dedicated its final year to the reduction in the length of stay in hospital by patients over 75 years of age (Smyth, 2009). There was also a dedicated focus by the 'Corporate Rationalists' on the utilisation of hospital beds by older people. Recall from Chapter Six (Models of Care), that in the NSW Health 2009/2010 Annual Report, for the first time, hospital activity tables separated out the occupancy for older people from other populations (NSW Department of Health (2010). This distinction highlighted the focus of the NSW Health Department on the utilisation of acute hospital beds by older people. Alford (1975) defined the 'Corporate Rationalists' as:

> *The structural interest of corporate rationalization is represented by persons in top positions in "health" organizations: hospital administrators … state and federal health officials.* ***Their ideology stresses a rational, efficient, cost-conscious, coordinated healthcare delivery system*** [emphasis added] (p. 204).

The Clinical Service Redesign Program (CSRP) sought to address health system challenges that were brought about due to increased demand by the ageing population with increased numbers of chronic conditions. In the years leading up to the CSRP, NSW had experienced significant access block, Emergency Department congestion, and long wait times for elective surgery. It was the job of the 'Corporate Rationalists' to fix these issues. As O'Connell and colleagues noted as part of their extensive work on unblocking Emergency Departments:

> *Health services across Australia are being challenged by rising demand caused by ageing populations, the high prevalence of chronic diseases and increasing patient expectations. Our public health services show many symptoms of strain, with growing queues and longer waiting times for*

> *access to care in Emergency Departments and for elective surgery* (O'Connell et al., 2008, p. S9).

A part of the methodology of the CSRP was to capture patient journeys (Ben-Tovim. et al., 2008) and to put consumers in redesign teams within the health services (O'Connell et al., 2008). Patients were given the opportunity to recount their experiences of poor care directly to the ‘Professional Monopolists’. The respondents provided examples of how the ‘Corporate Rationalists’ leveraged these poor patient journeys to create a platform upon which to seek improvements in the system. When given the opportunity, ‘Equal Health Advocates’ were able to support the ‘Corporate Rationalists’ to insist that the ‘Professional Monopolists’ participate in improvements in patient care; however, none of these improvements threatened the autonomy or remuneration of the ‘Professional Monopolists’.

Information provided by the respondents (and presented in Chapter Six) demonstrated that improved models of care were implemented within a hospital if there was new discreet funding for that model, and if the model did not threaten the role or autonomy of the ‘Professional Monopolists’. This is consistent with comments by Alford (1975), who quoted Hiestand thus:

> *The high order of pluralism which has been built into the health services complex may mean that there is a strong tendency toward the maintenance of the status quo. With many interest groups built into almost every decision system, each one tends to have a veto over any changes. These vetoes are likely to be exercised by any group which fears that a new departure may undermine or be adverse to its interests. A further implication, therefore, is that* ***innovations must almost inevitably be tailored so as not to threaten any interest groups*** *and, at the same time, to provide positive incentives for the acquiescence, indeed the active support, of each of them* [emphasis added] (p. 257).

The Model of Care chapter (Chapter Six) provided many examples of new models of care that were successfully established, but did not threaten the autonomy or roles of the ‘Professional Monopolists’. The models were derived from new funding and added new roles and functions into existing departments, such as Emergency Departments often staffed by senior nurses and allied health practitioners. These models included Care Navigation, Acute Aged Related Services (AARCS), Aged Services Emergency Teams (ASET), and Geriatric Rapid Assessment and Care for the Elderly (GRACE). The establishment of Medical Assessment Units was also described as an alternative to the Emergency Department environment, in which older and more complex patients had a dedicated multidisciplinary team that could comprehensively assess their needs for up to 48 hours. Models designed to substitute hospitalisation or to reduce the length of stay in a hospital included Hospital in the Home (HITH), ComPacks, and the Transitional Care Program. Models of care in relation to Advance Care Planning were also outlined.

Models of care that challenged the role of the ‘Professional Monopolists’, namely HITH, were met with resistance. The case study in Chapter Six demonstrated that despite the strong evidence for the effectiveness and safety of HITH, its widespread adoption did not occur until the ‘Corporate Rationalists’ intervened and mandated that each Area Health Service establish the model and provided funds for this to occur. Recall that the respondents who referenced the fact that other ‘Professional Monopolists’ in the same hospital as Professor Caplan would not refer into the HITH program, despite it having been established for over two decades with a wealth of evidence that validated its safety, and indeed, its superiority in the delivery of care to older people (Caplan, 2015; Liu & Taylor, 2002; Tran & Taylor, 2009). It was also shown to be more cost effective than hospitalisation (Board et al., 2000). However, HITH represented a model of care that challenged the role of the ‘Professional Monopolists’, and therefore, was met with opposition.

The language of the ‘Corporate Rationalists’ was also evident in the responses. Here, the respondents spoke of the ‘fragmentation’ between the Commonwealth and the state governments. This was often in relation to the perceived disconnect in the priorities of the Home and Community Care (HaCC) funded community services that supported older people and the hospitals. At the time the interviews were conducted, there was a strong push by the ‘Corporate Rationalists’ to decrease hospital bed days and avoidable admissions. The respondents noted the frustration with the need to get HaCC community-based supports in place to facilitate an older person’s timely discharge from hospital; however, the HaCC program did not prioritise access on the basis of hospital exit.

The role of clinical leaders

‘Corporate Rationalists’ tend to fail in the introduction of new models of care if they threaten the autonomy, remuneration, or dominance of the ‘Professional Monopolists’. However, as noted by Garling (Garling, 2008), the key to unlocking improvement is to be found in clinical leaders and medical doctors, or in clinical leadership as it has been referred to by other authors (Ham, 2003; McGrath et al., 2008). As Garling wrote:

> *I have seen, during the course of the Inquiry, that senior clinician involvement from the outset in devising clinical reform is critical to its success.* ***Clinical leaders*** *are needed to drive this reform through persuasion, negotiation, and clinician engagement. Non-clinicians have very little chance of successfully affecting change in clinical practice. Effective clinical leadership is essential and is the antidote to a system in which professionals operate independently. This involves building consensus around evidence-based models of care and requires ‘clinical champions’* [emphasis added] (Garling, 2008, p. 229).
>
> *The first step is to engage the dedication of clinicians in designing new Models of Care which are supported and actively* ***championed by clinical leaders*** *in the field, which are evidence-based best practice … The second step is to implement the changes required by the new models of care at the clinical unit level. This requires the active support of clinical leaders to be the champions of the changes* [emphasis added] (Garling, 2008, p. 4).

This was a strong theme emerging from the participants who were interviewed. Getting doctors to change their practice relied heavily on doctor-to-doctor engagement – that is, ‘Professional Monopolists’ challenging other ‘Professional Monopolists’. The quote from one respondent below described their experience of leading change within an Area Health Service.

> *… we had a fair amount of clinical engagement from the GPs who led our initial process and participated. I think it would have had a different outcome if we hadn’t had that. We had GPs who were strong enough themselves to tackle the specialists, so it was a doctor/doctor argument, not a manager or a nurse trying to argue with the specialist. So, when it got down to the sticky issues, having some key champions from that professional group helped* (Operational Senior Manager NSW NSCC Area Health Service, 2010).

I believe that what the respondents and Garling identified is in fact a fourth structural interest group, namely clinical leaders or clinical champions – that is medical doctors who lead change based on best clinical evidence. I call this group the ‘Professional Advocates’.

The case for ‘Professional Advocates’

As I explained in the Introduction (Chapter One), the Clinical Services Redesign Program (CSRP), which ran from 2005 to 2008, provided a unique opportunity in New South Wales prior to the time the interviews were conducted, whereby ‘Equal Health Advocates’ were noted by the respondents to have provided a strong influencing position in the creation of a ‘burning platform’ for change within the Area Health Services Redesign Projects. The respondents provided examples of the ‘Professional Monopolists’ (in Chapter Nine), who believed they were doing a good job, being challenged by patients who recounted their experiences of poor care. These patient journeys and patient stories (Ben-Tovim. et al., 2008), coupled with the ‘Corporate Rationalists’ mandated need to reduce patient length of stay and overall rates of hospitalisation (Smyth, 2009), provided the impetus for improved models of care to be established.

The CSRP was instigated by Professor Katherine McGrath, a medical doctor who was the Chief Executive of the Hunter New England Area Health Service who had improved the performance of the hospitals in the region as a result of the “Maggie Program”. I believe that Professor McGrath epitomises the ‘Professional Advocate’; that is, a medical doctor (haematologist) who was in a position of Chief Executive of an Area Health Service and later the Deputy Director General for NSW Health, who was able to lead and implement improvements. Her unique position as both member to the elite class of ‘Professional Monopolists’, coupled with her role as a ‘Corporate Rationalist’, led to the combination of these two roles enabling the implementation of improvements within the system. As noted by Masso et al. (2010), the Clinical Services Redesign Program was able to achieve significant improvement in the health system’s performance:

> *… performance improvements in both clinical areas since mid-2004 are impressive, particularly in light of the pattern of declining performance that had been evident previously, and the unprecedented growth in demand during the period. Furthermore, equity of access to both Emergency Department services and elective surgery improved markedly* (p. 353).

Another example drawn from the respondents was that of Professor Stephen Boyages who was the Chief Executive of the Sydney West Area Health Service. During the CSRP process, Sydney West established the OPERA model of care. This model later evolved into Medical Assessment Units which were implemented throughout the state. Funding was provided by NSW Health. This was new funding, rather than the funds being drawn from cutting another service or program, that went to Area Health Services targeting 21 major hospitals (NSW Department of Health, 2009). The respondents reinforced Alford’s theory that coalitions needed to be built between ‘Corporate Rationalists’ and ‘Professional Monopolists’ in order to deliver change to a health system.

Professor Steven Boyages is a medical doctor (endocrinologist) who held the role of Chief Executive of the Area Health Service. He was able to effectively lead improvements within the Area Health Service, and was able to lead the ‘Professional Monopolists’ into new ways of operating by virtue of his alignment to this group.

These two examples are ‘Professional Monopolists’ who were in ‘Corporate Rationalist’ positions, and therefore, took on the role of ‘Professional Advocates’. It was not their position that defined their membership of the ‘Professional Advocates’, it was how they behaved in taking on a challenging role and not seeking to maintain the status quo for the ‘Professional Monopolists’. ‘Professional Advocates’ may not hold a position traditionally held by a ‘Corporate Rationalist’, but they are able to introduce new, efficient, and effective models of care for older people with chronic conditions. The ‘Professional Advocates’ acted through ‘challenging’ structural interests and seeking to change existing models of healthcare not to further the position of the ‘Professional Monopolists’, but to ‘improve’ the system. A further three examples were Professor Gideon Caplan (HITH), Professor Sue Kurrle, and Professor Ian Hickie – as I highlighted, their innovative models and leadership are outlined in Chapter Nine.

Professor Gideon Caplan provided an excellent example of a ‘Professional Advocate’ leading the implementation of a new model of care. As outlined in the case study in Chapter Six, Professor Caplan led the implementation of Hospital in the Home that provided an evidence-based and valid alternative to hospitalisation. This evidence base was drawn not only from an economic perspective, but also from one of superior outcomes for older people. The ‘Professional Advocates’ believed in medicine, but they recognised that the current system was not optimal, and that there were opportunities to improve the patient’s treatment, in this case, as an alternative to hospitalisation.

GRACE was established by Associate Professor Sue Kurrle and was described in Chapter Six. The ‘Corporate Rationalists’ embraced the effectiveness of this model of care and it was established in each Area Health Service as the GREAT model, and was demonstrated to achieve significant reductions in hospital admissions for patients from Residential Aged Care Facilities. The NSW Ministry of Health Report for 2018 stated that GREAT had:

> *Achieved a 26.3 per cent decrease in hospital admissions and a 30 per cent reduction in in-hospital deaths by aged care facilities residents through the Geriatric Rapid Evaluation and Treatment (GREAT) service. GREAT is a nursing-based outreach program provided to local aged care facilities (ACFs) during working hours. It receives referral from ACFs and acute hospitals. Referred patients receive a face-to-face assessment at the ACF, and a management plan is developed in collaboration with the General Practitioner (GP), ACF staff, and the patient's family. This service also resulted in a significant cost-saving, estimated at $7.7 million per year* (NSW Ministry of Health, 2018, p. 227).

Professor Kurrle established the GRACE model in response to an identified need in the local community whereby patients from Residential Aged Care Facilities were being transferred to Emergency Departments, with low acuity triage ratings (NSW Government Agency for Clinical Innovation, 2013). She saw a 'better' way to deliver their care and established GRACE initially from funding via the Australian Better Health Initiatives grant scheme. The model was later adopted by NSW Health and rolled out across the state and renamed the GREAT model (NSW Ministry of Health, 2018).

Professor Ian Hickie is a long-term advocate for improvements in the mental health system in Australia. He is an advocate for the funding of team-based care and, by his own admission, is unpopular with his 'Professional Monopolist' colleagues (Professor Ian Hickie, 2019). He has advocated for team-based care funding through the Medicare Benefits Scheme for people with mental illnesses. He has stated that the fee-for-service model does not work for long-term conditions such as cancer and chronic disease, and the same is true for mental health conditions. In the statement below, Professor Hickie has also referenced the poor access that rural and remote communities across Australia have to mental health services, particularly to psychiatrists as I highlighted in Chapter Nine. He has also advocated for psychologists to be paid at the same rate as psychiatrists. This is clearly not the position of a person who is acting in a manner consistent with the 'Professional Monopolists'.

The ‘Professional Advocates’ represent a challenging interest which is based on clinical efficacy, evidence-based medicine, and economic efficiency. They recognise better ways to serve patients, and their motivation stems from evidence-based care. These models of care often have economic efficiencies built in because it is logical that effective care is economically efficient. I argue that the leaders described above do not qualify as belonging to the structural interest group of ‘Professional Monopolists’. These ‘Professional Advocates’ challenge the status quo and propose radical shifts in the health system, such as providing an alternative to hospitalisation and changing the fee-for-service paradigm of the Medicare Benefits Schedule:

> *The professional monopolists, by and large, are satisfied with the status quo and do not form part of the market reformers, who regard them as performing the core health functions. The physicians … are not in the vanguard proposing reforms, except when their powers and prerogatives are threatened by others* (Alford, 1975, p. 195).

Alford (1975) himself concluded that “*… change must come from within*” (p. 261). I believe the ‘Professional Advocates’ are this structural interest from within that has proven capacity to improve the system. They are not without their critics and opposers – but they provide the best opportunity to improve the health system through the introduction of new models of care that are better able to meet the needs of older people with chronic conditions.

A third reform method provided by ‘Professional Advocates’

Alford (1975) argued that change in the health system was achieved via two methods: through either market-based reform or bureaucratic reform. However, the ‘Professional Advocates’ offer a third method of reform, that is improving healthcare based on ‘best’ evidence. Best care was the terminology adopted by Garling in his recommendations for improvements in the hospital system:

> *Statistically, it is established that models of care can be standardised for more than 80% of patients who suffer from a condition in common. The data already proves that patients are safer and have better health*

> *outcomes where best practice is used. The point about best practice is not that it is "standardised" care, but that it is "best" care* (Garling, 2008, p. 31).

Recall the efficacy of the Hospital in the Home model of care, which demonstrated improved outcomes for older people compared to hospitalisation (Board et al., 2000; Caplan, 2006; Caplan, 2015; Caplan et al., 2012; Caplan, Ward, et al., 1999; Deloitte Access Economics, 2011; Liu & Taylor, 2002; Marley, 2013; NSW Government, 2018; NSW Ministry of Health, 2012; Tran & Taylor, 2009) for patients enrolled in HealthOne (McNab & Gillespie, 2015).

I have provided evidence that the Australian population is both ageing and that they have increasing rates of chronic conditions; these two factors will continue to challenge the health system. In order to meet these challenges, 'reform', 'redesign', or 'improvement' of our health system is essential, not only to ensure that Australians continue to access the 'best' care available, but that the systems of care are economically sustainable. An ideal system is one that is firmly entrenched in prevention, early intervention, self-management, and timely access to the right care. This care must be coordinated, and care teams need to communicate with each other so that is the care is consistent, well understood by the patient, and proactively managed. To ensure the effective delivery of health services to older people with chronic conditions, team-based care is 'best' practice in both acute and primary care settings. In order to move our health system beyond the fee-for-service paradigm, we need to embrace packaged care as is currently being trailed via 'Health Care Homes' around Australia.

As Dr. Hambleton stated, 'Health Care Homes' is the model of care that patients with chronic disease need to assist them to self-manage, and it has the potential to fundamentally change the way General Practice operates in Australia today:

> *We know the model is correct. We know our practice teams are underutilised today. We know we operate in silos. We know we operate in an information vacuum. We know we are inefficient. Our patients deserve a better deal and it's time for us to demand the conditions that we need to*

> *deliver it – and it's not more of the same!* (Department of Health, 2016, p. 2).

The under utilisation of Nurse Practitioners was also explored and the important contribution they make to the delivery and coordination of both primary and acute care. New models of care in the acute sector have been led by 'Professional Advocates', and I believe they have the best opportunity to achieve change. Putting the appropriately skilled 'Professional Advocates' in charge of hospitals, local health districts, and Primary Care Networks would achieve a greater pace of change than other modes of system improvement explored throughout this thesis, such as the Clinical Services Redesign Program.

Checkland's 'Corporate Monopolisers' and 'Professional Rationalisers'

In Chapter Four, in which I introduced Alford and other authors who had used his work, I noted that Checkland et al. (2009) had conducted a detailed qualitative analysis of the United Kingdom's National Health Service (NHS) and examined the introduction of practice-based commissioning that had come into play in 2002. They interrogated Alford's theory and identified the emergence of two new structural interest groups, who they termed 'Corporate Monopolisers' and 'Professional Rationalisers'. They believed that the introduction of Practice Based Commissioning (PBC) and Payment by Results (PbR), both new policies that changed the structural design of the National Health Service (NHS), had produced these two new structural interest groups. Alford's theory asserted that health service structures or policies privilege one group over another and placed them in a position of dominance. Checkland et al. (2009) argued that the introduction of Payment by Results placed the hospitals in a position of dominance which included a 'corporate monopoly', where they were in a position to compete with other hospitals and, in fact, to lure activity away from other hospitals to increase their revenue. The 'challenging' interest came in the form of the GPs as agents of PBC and Checkland et al. (2009) termed them 'Professional Rationalisers' . Checkland's 'Professional Rationalisers' challenged the activity undertaken by the hospitals and held them to account for the cost and quality of their care. As Checkland et al. (2009) noted, it was the government that had introduced and implemented the new structures that led to the formation of these new interest groups, and that the NHS fundamentally differs from the Alfordian New York, as the NHS is a state-funded system. Checkland's argument hinges on the behaviours that these two structural interest groups have adopted in response to commissioning.

Similar to Cho (2000) in his analysis of the Korean health system as discussed in Chapter Four, this could be perceived to be another argument 'over the rice bowl'; that is, an argument about health funding. The fight for funding was evident in the UK because the 'Corporate Rationalists' implemented a new system that put hospitals and community-based care in opposition to each other, thus splitting the 'Professional Monopolists' into two discreet interest groups (which Checkland called 'Professional Rationalisers' and 'Corporate Monopolisers').

What differs between Checkland's argument and my own is that I have demonstrated that in Australia, there is clear evidence of all three interest groups operating in the roles Alford described, 'dominant', 'challenging', and 'repressed'. However, my 'Professional Advocates' are challenging not only the dominant interest group of the 'Professional Monopolists', but also that of the 'Corporate Rationalists'. They seek to change the funding design of the Medicare Benefits Scheme (MBS) in order to introduce team-based care and 'Health Care Homes'. They challenge the traditional models of care by providing alternative treatment pathways to hospital admission. They are saying the population has changed and that the evidence demands that new models of care be implemented to meet the needs of the ageing population who suffer from increased rates of chronic disease.

Limitations of the Study

While I believe that using the methodology and methods of grounded theory allowed me to look beyond the initial data to find a deeper understanding of the respondents' answers, if I had been able to explore emergent themes with some of the respondents through further interviews with them, an emergent theory may have been reached. As I noted in the methods chapter, a repeat interview was not possible given the busy lives the majority of respondents lead. Each participant was only interviewed once, and while I was able to check some ideas raised by one participant with those interviewed later, the method of seeking further respondents to check out emerging theory was not pursued. I also did not give the respondents the opportunity to verify the accuracy of the transcription, and relied on my own coding decisions without seeking a second person to review the way I had coded the data. The veracity of my findings may have been improved if these steps had been taken but also may have introduced issues regarding the consistency of interpretation and assignment of codes.

While I agree with Charmaz that what we know is a construct of reality rather than a true reflection of it, I do believe that multiple perspectives can elucidate an issue in a different light. I had worked in state-funded healthcare systems for two decades before I commenced this study, from community health settings, hospitals in rural and remote areas and metropolitan centres, and finally, within the bureaucratic heart of both the South Australian and New South Wales health systems. I had a deep immersion in the subject matter of models of care, and how they did or did not meet the needs of older people with chronic conditions. I had ‘constructed’ ideas about how new models of care were either successfully or unsuccessfully implemented. However, the opportunity to acquaint myself with the views of the 30 health leaders who participated in my study allowed me to generate some shared understandings about health change, and these emerged in the four themes I identified in my study. I was then able to further illuminate my sense of ‘reality’ in my research findings through the application of Alford’s theory. For example, his theory allowed me to see that models of care could be achieved if they did not challenge the ‘status quo’ and came with ‘new’ money. Models of care were blocked if the roles of ‘Professional Monopolists’ were threatened, and would only become a state-wide program (in other words, a large-scale reform) if the ‘Corporate Rationalists’ then provided new funds and dictated its introduction.

Clearly, the time taken between the initial collection of the data and the final comparison with theory is a further limitation of this study. I limited the impact of the time delay between data collection, analysis, and the final write-up of this thesis by re-reading each of the 30 transcriptions, reading my interview notes, and examining my in-vivo coding.

An advantage of the time delay was that I had access to the research literature of the various models of care that had emerged from the initial data collection, and this gave my study a unique perspective in that I could review what the respondents thought were innovative models of care that improved the services for older people and what impact they had. This also provided evidence of the outcomes for each model of care. I also did not provide as much in-depth reflection on the roles of ‘Equal Health Advocates’ in my discussion, as they were not as evident in the respondents’ views as frequently as were the other themes. I also acknowledge that they were not included specifically as a group in my study sample; however, I could also argue that we are all at one time in our lives in the position of ‘Equal Health Advocates’ through our need to access healthcare.

I acknowledge that there are a multitude of theorists which I could have contrasted my findings with; and as previously explained, I did explore other theorists and their theoretical models of change within the healthcare system; however, I found that Alford’s theory had the greatest resonance with the themes emerging from the interview responses. In order to be true to grounded theory methodology, it was critical that I did not ‘force’ the data into a framework that was not congruent with the emergent themes – the synergy between the themes that emerged from the respondents and Alford’s own observations of the New York health system was strongly evident, and therefore, was the most logical choice to follow.

And finally, the focus on New South Wales may not be reflective of experiences in other jurisdictions; however, the inclusion of a number of highly influential thought leaders, particularly from the National Hospital and Health Reform Commission, did provide some balance in terms of a nationwide perspective.

Recommendations for future study

The role of political processes in changing the health system requires further research. I also believe that the phenomena observed by Alford (1975), and in the data I have presented, provides evidence of the cycles of ‘crisis’ leading to ‘inquiries’ with hundreds of recommendations. Governments would find it useful to review how many of these recommendations have been put into practice and what impact they have had in improving either patient care or healthcare costs. My concern is that these inquiries may or may not assist in resolving the ‘crisis’. As the increasing costs related to healthcare in Australia continue to spiral upwards, it is vital that governments invest in activities that lead to system improvements. I do not believe that Australia has the financial resources to continue this trend of ‘crisis’ and ‘Inquiry’, unless these inquiries deliver improvements that are real and sustained. However, in a country with three-year political cycles, bipartisan support for any improvements will need to be achieved, otherwise there are risks that these improvements will be lost by a new government. The replication of this study in another jurisdiction or country would provide a further substantive case in support of Alford’s (1975) theory; that is, the way in which structural interests block or stymie reform, and the possibilities for new structural interests to emerge that champion healthcare reform.

Beyond the scope of this current study was to examine contemporary models of care that evolved from those identified in the research period. For example Wallis et al. (2018) evaluated a Geriatric Emergency Department Intervention in a tertiary hospital emergency department in Queensland. The model contains elements similar to those of the ASET and AARCS models of care described in chapter six; but their study demonstrated that this model achieved higher rates of discharge in patients aged 70 years and older with no increased risk of mortality or risk of same cause re-presentation in 28 days with a cost savings of $35 per Emergency Department presentation and $1469 per hospital admission (Wallis et al., 2018). However, note this model of care only exists in one hospital in Queensland and has not been adopted on a state-wide basis.

Further areas for future study should also consider and focus on the role of nurses, midwives and the allied health professions play in the development and implementation of new models of care.

Summary

This final chapter has demonstrated that Alford’s structural interest groups were clearly identified by the respondents in this thesis. The respondents provided examples in which the ‘Professional Monopolists’ maintained the status quo and resisted any improvements that encroached upon their autonomy and incomes. The ‘Corporate

Rationalists’ took up the challenging structural interest in an effort to abate the ever-increasing costs of healthcare. Temporary coalitions formed in order to introduce new models of care, and these succeeded, but only if they did not challenge the professional monopoly. Models of care that did challenge the role of the ‘Professional Monopolists’, such as Hospital in the Home, were met with resistance, took a long time to establish, and ultimately required the ‘Corporate Rationalists’ to intervene to establish them on a state-wide basis. ‘Equal Health Advocates’ were leveraged by the ‘Corporate Rationalists’ to challenge the ‘Professional Monopolists’ in the Clinical Service Redesign Program to improve systems, but as Alford (1975) argued, they played only a small role in health reform. I have also presented an argument about the emergence of a fourth structural interest group, the ‘Professional Advocate’, who I believe, as did Garling (2008), had the power to lead improvement in the health system. Garling (2008) referred to them as Clinical Champions, while other authors have also demonstrated their effectiveness in leading system change. I have also established a third way that reform can be achieved, that is through the mechanisms of clinical and economic evidence. I believe that ‘Professional Advocates’ are the system’s best hope to meet the needs of the ageing population with increasing rates of chronic disease, and by doing this, to halt the endless upward spiral of healthcare costs.

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APPENDIX ONE

The University of Sydney

<insert current date>

Dear <insert name>

re: **Invitation to participate in a short interview to discuss ageing and chronic disease Models of Care in your jurisdiction.**

I would like to invite you to participate in the project titled “NSW Models of Care that reflect innovation in ageing and chronic disease management and their links to policy”. The purpose of the project is to explore the influence that policy is having on innovation in the health system, and to identify innovative Models of Care in ageing and chronic disease management. To determine this influence, I am inviting health leaders at Commonwealth, State and Area Health Service level to participate in a short interview to discuss their expert opinions and professional views.

This project is being supervised by Dr. James Gillespie and Professor Stephen Leeder, from the Menzies Health Policy Centre and School of Public Health, Faculty of Medicine at the University of Sydney.

Attached to this letter is a Participant Information Sheet outlining the project in more detail. If you agree to participate in the study you will be interviewed for 30-60 minutes. Interviews will take place at a time and a location of your choosing, and will be audio-recorded. Participation in the study is entirely voluntary; you are free to refuse or to withdraw from the project at any time. Your decision to do so will not prejudice your future relations with the University of Sydney in any way.

I will contact your office in the next week to determine if you are willing to participate. Alternatively, you can advise of your willingness or refusal by emailing me at alit1367.usyd.edu.au or phoning 0488 229 161.

Thank you for taking the time to read this letter and consider the invitation.

Yours Sincerely,

Angela Littleford

PhD Candidate

University of Sydney

APPENDIX TWO

The University of Sydney

School of Public Health
Faculty of Medicine

ABN 15 211 513 464

Dr. James Gillespie
Sesquicentenary Senior Lecturer in Health Policy
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RESEARCH STUDY INTO NSW INNOVATION IN AGEING AND CHRONIC DISEASE MANAGEMENT.

PARTICIPANT INFORMAION STATEMENT

You are invited to take part in a research study into *NSW innovation in ageing and chronic disease management.* The object is to investigate innovation in the areas of ageing and chronic disease management in NSW. We are interested in your views on the kinds of changes that are needed in the health system to meet the needs of the ageing population, the current policies that are delivering innovation in this area, and any examples you have from your jurisdiction where these innovations have been implemented. The study is being conducted by Angela Littleford and will form the basis for the degree of PhD at the University of Sydney under the supervision of Dr. James Gillespie and Professor Stephen Leeder.

If you agree to participate in this study, you will be asked to participate in a 30-60 minute semi-structured interview which will be audio-recorded for later transcription. The interview will take place at a time and location of your choosing or can be conducted over the telephone if you prefer.

All aspects of the study, including results, will be strictly confidential and only the investigators named above will have access to information on participants. A report of the study may be submitted for publication, but individual participants will not be identifiable in such a report.

Participation in this study is entirely voluntary: you are not obliged to participate and - if you do participate - you can withdraw at any time. Whatever your decision, it will not affect your relationship with the University of Sydney in any way.

You may stop the interview at any time if you do not wish to continue, the audio recording will be erased and the information provided will not be included in the study.

When you have read this information, Angela Littleford will discuss it with you further and answer any questions you may have. If you would like to know more at any stage, please feel free to contact Dr. James Gillespie on 9351 5048.

Any person with concerns or complaints about the conduct of a research study can contact the Manager, Ethics Administration, University of Sydney on (02) 9351 4811 (Telephone); (02) 9351 6706 (Facsimile) or gbriody@usyd.edu.au (Email).

This information sheet is for you to keep.

APPENDIX THREE

The University of Sydney

School of Public Health
Faculty of Medicine

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Dr. James Gillespie
Sesquicentenary Senior Lecturer in Health Policy
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PARTICIPANT CONSENT FORM

I, ...[PRINT NAME], give consent to my participation in the research project

TITLE: **NSW INNOVATION IN AGEING AND CHRONIC DISEASE MANAGEMENT**

In giving my consent I acknowledge that:

1. The procedures required for the project and the time involved (including any inconvenience, risk, discomfort or side effect, and of their implications) have been explained to me, and any questions I have about the project have been answered to my satisfaction.
2. I have read the Participant Information Statement and have been given the opportunity to discuss the information and my involvement in the project with the researchers.
3. I understand that I can withdraw from the study at any time, without affecting my relationship with the researchers or the University of Sydney now or in the future.
4. I understand that my involvement is strictly confidential and no information about me will be used in any way that reveals my identity.

5. I understand that being in this study is completely voluntary – I am not under any obligation to consent.

6. I understand that I can stop the interview at any time if I do not wish to continue, the audio recording will be erased and the information provided will not be included in the study.

7. I consent to: –

   i) Audio-taping YES ☐ NO ☐

   ii) Receiving Feedback YES ☐ NO ☐

   If you answered YES to the “Receiving Feedback Question (ii)”, please provide your details i.e. mailing address, email address.

<u>Feedback Option</u>

Address:

Email:

Signed: ....

Name: ....

Date: ....

APPENDIX FOUR

NSW innovation in ageing and chronic disease management project.

Questions for the interview:

Discuss Participant Information Sheet and provide opportunity for any clarifying questions to be asked. Please state your name and position for the purpose of cataloguing the interview data.

1. Please describe the changes you believe will be necessary to meet the needs of the ageing population with increasing rates of chronic disease over the next decade?

(Clarifying questions related to information provided may be required for all interview questons).

2. What policies do you believe are shaping the way older patients with chronic diseases receive care?

3. In relation to each named policy in 2. what are the core elements of the policy that are driving changes in the mangement of older people with chronic disease?

4. Why are these changes significant?

5. Can you describe any models of care that are operating in your jurisdiction that you believe are delivering innovative care for older people with chronic disease?

6. What elements make each model/s named in 5. 'innovative'

7. Who are the leaders of each model/s?

8. In relation to each model named in 5. what policies do they reflect?

(if they do not represent any policy at all – what is the model based on? How is it funded?)

9. Can you describe any models of care that are operating anywhere around the world that you believe are delivering innvoative care for older people with chronic disease?

In your opinion, what has led the implementation of these models of care?

What do you think is needed to improve the way we manage older people with chronic disease?

If there were three things you could instantly change in your jurisdiction to improve the health care delivery for older people with chronic disease what would they be?

Would you like to make any other comments. Thank you for your time.