Health Care Homes and the role of the practice nurse: an exploration using case study methodology.

by

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Statement of original authorship

I certify that this thesis:

Does not incorporate without acknowledgment any material previously submitted for a degree or diploma in any university.

The research within will not be submitted for any other future degree or diploma without the permission of Flinders University.

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.

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Date: January 19th 2023

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Abbreviations

AGPAL	Australian General Practice Accreditation Limited
AHP	Allied Health Professionals
AHCA	Australian Health Care Agreements
AHPRA	Australian Health Practitioner Regulatory Agency
AMA	Australian Medical Association
ANF	Australian Nursing Federation
BGL	Blood glucose level
CSR	Case study research
CC	Chronic conditions
cdmNet	Collaborative decision-making Network
CPHC	Comprehensive Primary Health Care
DGP	Division of General Practice
DVA	Department of Veterans Affairs
EPC	Enhanced Primary Care
GNP	Gross National Product
GP	General Practitioner
GPMP	General Practice Management Plan
HECS	Higher Education Contribution Scheme
HCMA	Health Care Management Advisor
INCA	Integrated Care Platform
INR	International Normalised Ratio
LHN	Local Health Network
MBS	Medicare Benefits Scheme
ML	Medicare Local
NiGP	Nursing in General Practice
PAM	Patient Activation Measure
PCMH	Patient Centred Medical Home

PEN CAT	PEN Clinical Audit Tool
PBS	Pharmaceutical Benefits Scheme
PIP	Practice Incentive Payment
PN	Practice Nurse
PNIP	Practice Nurse Incentive Payment
PRM	Predictive Risk Model
PHC	Primary Health Care
PHCO	Primary Health Care Organisations
PCNP	Primary Care Nurse Practitioner
PHN	Primary Health Network
QUEST	Quality Enhanced general practice Services Trial
RST	Risk Stratification Tool
RACGP	Royal Australian College of General Practitioners
SIP	Service Incentive Payment
TCA	Team Care Arrangement
VIP	Very important patient
VPR	Voluntary Patient Registration

Abstract

Using a case study approach, this thesis examines the impact of the Australian Federal government's trial of Health Care Homes (2018-2021) on the role of practice nurses using Alford's (1975) structural interest theory and Carol Bacchi's policy analysis as the analytical lenses. Health Care Homes is one of the most recent in a raft of reforms instigated by the Federal government over the last two decades to create a more organised and coordinated primary health care system and to reorient general practice towards population-focused, patient-centred, multidisciplinary care for those with chronic conditions.

Underlying this thesis are three assumptions. Firstly, over the last two decades, the Federal government has attempted to reorient general practice through a series of initiatives, none of which have fully achieved the stated policy objectives. These have taken the direction of monetary and other incentives for general practice as well as the formation and funding of primary care organisations to assist general practitioners to take a population health approach that enhances the coordination of care. Examples of these organisations are Divisions of General Practice, Medicare Locals, and Primary Health Networks. While each of these initiatives has some differences, a common aim has been to support the primary health care sector by enhancing care coordination and improving access to care for those with chronic conditions. It was hoped that these initiatives would assist in preventing unnecessary hospitalisations and relieve the pressure on an already burdened acute system.

The second assumption argues that these policy directions have had an impact on the professional status, role, and position of practice nurses, mostly contributing to an expanded and enhanced role. The third assumption aligns with Alford's theory on the role of competing structural interests in health policy reform, suggesting that those with 'dominant' interests will ensure that any policy reform that does not align with their views will be resisted or manipulated to meet their interests.

Further analysis of the Health Care Homes initiative is made using Carol Bacchi's framework of policy interrogation, using 'problematisation' to explore how people create and identify problems and make sense of them within policy. Data supports the underlying premise of Alford's theory, demonstrating that individuals and groups act

according to their own interests. Any attempt at reform in general practice is challenged by the prevailing nature of private business and an intrinsic fee-for-service business model.

The case studies used for this thesis showed that the role of the practice nurse when assisting people to manage their chronic conditions was essentially unchanged during the trial. The greatest influence on the nurse’s role was their relationship with the general practitioner and the ability of the nurse to demonstrate initiatives that resulted in creative and new ways of working.

Forty-seven years on from the development of Alford’s theory, I have demonstrated that his basic argument remains. Over these years, the landscape of general practice has changed to include more nurses, increased use of information technology. and a variety of health care professionals. This altered structure and context has done little to change the power dynamics within the general practice context. The application of Alford’s theory to general practice today has demonstrated through the Health Care Homes initiative that the role of the general practice nurse, despite many attempts at health reform, remains relatively unchanged.

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Chapter 1: Introduction and Background

1.1 Introduction

This chapter provides the reader with an overview of the contextual background to the research thesis. It identifies the three main assumptions used to investigate and understand the influences upon, and changes to, the role of the practice nurse (PN) during the Federal government trial of Health Care Homes (2018-2021). **In summary, this thesis explores the role of the practice nurse in response to the Health Care Homes (HCH) trial. Specifically, the thesis:**

1. **Examines the impact of the shift to bundle payments on the role of the PN, and:**
2. **Explores the impact of the trial on the PNs role in the multi-disciplinary team.**

When examining the role of the PN during the HCH trial, I draw on two theoretical perspectives. Robert Alford's structural interest theory and Carol Bacchi's policy problematisation framework are used to interrogate influences upon, and changes to, the role**.**

The chapter explores Federal government policies and initiatives at both the micro and the macro level designed to address a complex and fragmented primary health care system. Factors impacting the role of the PN are highlighted with particular emphasis on payment systems and associated models of care. The chapter provides specific focus on the assumption that government policy has an impact on the role of the PN and offers an overview of the PN role in Australia between 1999, when Medicare care planning items were introduced for PNs, and the current day. The importance of the chosen methodology of case studies is substantiated, and the use of Alford's Theory of Structural Interests is explained and justified as the theoretical underpinning of the study. Carol Bacchi's problematisation framework is introduced as a key tool to interrogate the HCH trial. The chapter concludes with a synopsis of the thesis argument.

1.2 Background

This thesis uses case study methodology to explore variations to the role of the PN in response to the Australian Federal government's HCH trial (2018 to June 2021) (Department of Health 2020c, p. 6). The significance of selecting the HCH model to explore changes to the PN role arises from the way general practice funds are used to care for those with chronic conditions. Health Care Homes provides a model of care based on a bundle payment system, where a fixed amount of funds for each patient is allocated on the premise that these are used to enhance care and encourage the integration of this care by an interdisciplinary team. The move away from the traditional fee-for-service funding model is significant and provides scope for the exploration of a potentially enhanced and expanded PN role. Of equal significance is the general practice environment within which this takes place. Case study methodology allows for a deeper analysis of the work of the PN, capturing the complex interactions between members of the general practice HCH team. When exploring any changes to the PN role, the thesis uses the theoretical underpinning of Robert Alford's 1975 'Theory of Structural Interests' with modifications that adapt to the Australian context. Alford claims that dominant individuals/groups will ultimately resist reform if it challenges their needs, even at the risk of forsaking the healthcare needs of others (Alford, 2008).

Alford places these interests into three main categories:

1. Dominant interests belonging to those he refers to as 'professional monopolists'. This group consists mainly of professionals in clinical practice, such as doctors, who are focused on individual patients and seek to maintain their clinical autonomy (Alford, 1975).
2. Challenging interests refers to those he calls 'corporate rationalisers', such as people in government departments who work towards achieving the wishes of politicians, deans of medical schools, academics, and managers of some health services. These people value control through cost-effectiveness and regulatory measures (Alford, 2008).
3. Repressed interests. Alford uses the term 'the community' for this group which may include advocates for equity, and high quality, free health care. Examples include patients, patient advocates, and activists. These groups are thought of as 'repressed' because they are generally smaller in number and their interests

are rarely accounted for (Alford, 2008).

This thesis will explore the position of the PN in relation to Alford's theory. To substantiate this and align it to the HCH trial, I use Carol Bacchi's framework of policy interrogation, designed to probe policies that focus on change. I demonstrate the impact of the corporate rationalisers' imperatives for change to the role of the PN.

The thesis explores the role of the PN within four different general practice sites across metropolitan South Australia. Each of these sites is represented as a 'case', and importantly, is used as a way of evaluating existing theoretical insights and examining new theoretical knowledge (Cope, 2015) as they relate to the role of the PN in response to the HCH trial. Case study methodology is an intense study of one, or a small number of cases, and focuses on one phenomenon, which in this instance, is the PN role within the HCH trial. Using case study methodology allows the PN to be placed at the centre of this context/space, and for the phenomenon to be explored within each given context (Yin, 2018). This is particularly relevant when exploring and explaining contemporary and 'real' social phenomena within each general practice and the effects the HCH policy may have on the PN role. Each case study draws on qualitative data from interviews with PNs, GPs, and patients, with supporting data gleaned from interviews with PNs from non-HCH practices, the HCH coordinator from the Adelaide Primary Health Network, as well as those affiliated with similar initiatives.

Alford's (1975) Theory of Structural Interests is used to illustrate the complexities and implications of change within a dynamic team environment where a variety of individuals and groups can be seen to prioritise and promote their own interests and needs in order to achieve them. His theory is also used to explain the challenges experienced by individuals and groups within each general practice case study as they strive to have their views heard. The thesis highlights these challenges as they occurred during the HCH trial with a focus on the PN role and the forces that come into play to influence it.

This study is underpinned by three assumptions; firstly, over the last two decades, the Australian Federal government has attempted to reform general practice through a raft of policy initiatives, with varying degrees of success in terms of meeting policy objectives. Secondly, these policy directions have occurred over a number of years and influenced the professional status, position, and role of PNs, mostly contributing

to an expanded and enhanced role. Thirdly, it is assumed that competing structural interests act as impediments to reform. These three assumptions are outlined below. Assumption 1 and 2 form part of the background material, while assumption 3 will be expanded upon in chapter three.

1.3 Assumption 1: Federal government policy initiatives to re-orient general practice

The principal means of delivering primary care in Australia is through general practice. General practices in Australia are private businesses, funded by a subsidised fee-for-service in conjunction with some additional government funding to support chronic disease management. The subsidised fee and the chronic disease management funds are provided by the Federal government health insurance scheme known as Medicare. Medicare was introduced in 1984 with the intention that all Australians should and would have access to affordable high-quality health care at no or minimal cost (Department of Health, 2018a). The use of Medicare was initially developed with a strong focus on free, ‘bulk billed’ primary care services, with no patient contribution as Medicare was the universal health insurance system, which has now evolved to become a mix of free services and those requiring a patient contribution. Patients now contribute to their health care at a proportion relevant to their ability to pay (i.e., an income-related Medicare levy), but also in many instances, through gap payments for the service/s provided. General practice revenue therefore relies on a patient service fee as well as government financial support, with the fee calculation based on the time and number of consultations. Hence, the greater the number of patient consultations, the greater the revenue, leaving little incentive for doctors to spend extended time with patients (Fuller et al., 2014).

The fee-for-service model adopted by many private business general practices is not ideal when patients have a chronic illness. The Australian Institute of Health and Welfare (AIHW) has defined chronic health conditions as “long lasting conditions with persistent effects”, and highlighted eight conditions of interest: “arthritis, asthma, back pain, cancer, cardiovascular disease, chronic obstructive pulmonary disease, diabetes and mental health conditions” (Australian Institute of Health and Welfare, 2019). Data from the National Hospitals morbidity database shows that chronic conditions were responsible for 5,800,000 hospitalisations (52 per cent of all hospitalisations) in 2019-2020 (Australian Institute of Health and Welfare, 2022b).

Chronic conditions have become a major burden on the Australian health care system and in the 2021 Australian census, it was reported that over 8 million Australians reported having at least one chronic condition, with 16 per cent (4 million people having a chronic disease management plan (Australian Institute of Health and Welfare, 2022b).

While total Medicare claims for chronic disease management items, such as care plans, fell dramatically at the start of the COVID-19 pandemic, cardiovascular disease remains the leading cause of death in Australia for men, with dementia the leading cause for women (Australian Institute of Health and Welfare, 2020b; Royal Australian College of General Practitioners, 2020a).

Health policy in Australia supports general practice to incorporate the prevention of disease through Medicare-based incentives such as health checks and health assessments (Harris et al., 2017); however, care for those with chronic conditions in the primary health sector is seen as complex and fragmented (Henderson et al., 2017), with most people seeing approximately seven or eight health professionals and attending approximately 80 different appointments annually (Gilbert et al., 2013). The current fee-for-service model with its associated time restrictions works against providing coordinated care for patients given the limited amount of time required to attend to patient needs and the range of services required. The challenges of providing chronic disease management within a fee-for-service model contribute to a lack of coordination across the primary health care sector, which has been seen to lead to high rates of unnecessary patient admissions to acute public hospitals (funded by state governments with varying support from the Federal government), creating a significant financial burden on the hospital system and the health care system as a whole (C. Robinson et al., 2015). According to Dixit and Sambasivan (2018), the Australian health care sector needs policymakers to address the current poor coordination of care and lack of patient engagement through the redesign of funding mechanisms.

Attempts to re-orient general practice to meet the needs of patients with chronic health conditions and alleviate the burden on the acute sector fall into two main categories: **policies directly focused on general practice itself that attempt to re-organise**

general practice services to take a whole-of-population or macro approach, and micro policies or incentive-based funding programs that attempt to change the way general practitioners work.

Examples of macro policies include the introduction of Divisions of General Practice (DGP), Medicare Locals (MLs), and Primary Health Networks (PHNs). Divisions of General Practice were developed in Australia in 1992 (Harris & Zwar, 2014), MLs in 2011 (Robinson, S et al., 2015), and PHNs in 2015 (Henderson et al., 2017). Further initiatives included the funding of GP Super Clinics and the formation of GP Plus centres. While each of these initiatives had some differences, a common aim was to support the primary health care sector by improving coordination, access, and care for those with chronic conditions. More micro-based reforms directed at GP-patient interactions (while still fee-for-service), included funding for the development and preparation of chronic disease management care plans, age-related health assessments, and other monetary incentives linked to Medicare reimbursement, many of which involved the work of PNs. The work of DGP, MLs, and PHNs is outlined briefly below.

Macro reforms – organisations

Divisions of General Practice were first established in 1992 in response to concerns by the then Federal Labor government about perceived inefficiencies in service delivery and individualistic approaches to care by general practice (Pegram et al., 1995). Divisions were proposed by the Australian Medical Association (AMA) and the Royal Australian College of General Practitioners (RACGP) as a means of responding to the government's reform agenda by promoting the coordination of local Primary Health Care (PHCRIS) services while maintaining medical autonomy (Pegram et al., 1995). With the RACGP keen to address a fragmented system, divisions provided a way GPs could work more closely together at a local level to plan health care for their communities (Bollen, 1996).

Divisions were developed as independent corporate bodies governed by boards of directors whose core funding came from the Australian Government Department of Health and Ageing. In 2005, 94 per cent of GPs in Australia were members of a DGP (Smith & Sibthorpe, 2007), and in 2008, there were 110 divisions across Australia. Division members consisted of GPs (80 per cent), PNs (7 per cent), and other practice staff (7 per cent), with the remainder made up of specific health-related specialists (Davies, 2010). The role of these DGP was to provide a range of services to meet the health needs of communities through health promotion, prevention, service development, and chronic disease management to improve local health outcomes (Smith & Sibthorpe, 2007). Federal funding was provided through infrastructure grant to cover core functions and through project funding to provide specific services (Pegram et al., 1995). One of the main goals of DGP was to shift some of the health care services away from the acute sector and into the primary health sector. It was envisaged that this would contribute to alleviating the burden on the acute sector while also controlling costs (Smith & Sibthorpe, 2007). Divisions are now incorporated within PHC and still exist in some Australian states. While they have been successful in improving access to services through enhancing integration, they have not achieved any real improvement in hospital avoidance, nor have they demonstrated any improvement in cost saving (Smith & Sibthorpe, 2007). According to Kalucy (2004), evidence to support the success of divisions is difficult to find. Reporting processes have focused on activities rather than outcomes, while a lack of nationally agreed goals and data links between acute and primary care has hindered any measurement of success (Kalucy, 2004).

GP super clinics were developed in 2010 as another attempt to enhance access to multi-disciplinary primary health care. The aim was to bring together a team of health professionals to tackle health issues within a local community with a focus on the management of chronic diseases through health prevention and promotion and extended hours of service (Department of Health, 2013a). However, according to Lane et al. (2017), these super clinics made little progress towards integrated interdisciplinary care for those with chronic conditions, mainly due to a lack of institutional support, meaning that any improvements came about because of the interests of individuals and local groups rather than the general practices themselves.

In 2011, a further attempt was made to reorient the primary health system and improve the patient experience. This saw DGP replaced by Medicare Locals (MLs), which were formed with the intent to further improve collaboration between health professionals and encourage more locally responsive services. The governing bodies of these independent Primary Health Care Organisations (PHCOs) decided where funds were to be allocated and who was to deliver the services. Once again, the main impetus for this initiative was to improve the coordination of care, promote hospital avoidance, and provide a system less cumbersome for patients to navigate (Lovelock & Stitzel, 2011). Although MLs were only in operation for 4 years, one of their notable features was that they were represented by a board of members, with no single dominant profession (S Robinson, et al., 2015). Another notable feature was the focus on collaboration between MLs and Local Health Networks (LHNs) to deliver coordinated services. This created some confusion due to the sharing of data, training, and evaluation which led to constant policy and structural changes, ultimately proving to be confusing and a barrier to collaborative efforts (Javanparast et al., 2015). Inconsistencies in budget expenditure and funding across programs with differing accounting practices also contributed to a lack of direction and clarity. These macro reforms operated outside of the small business models of general practice, and the move to activity-based funding within the public hospital sector was seen as a move away from a focus on disease prevention and the health of populations (Javanparast et al., 2015). The change from DGP to MLs came at a significant cost. In a study by Elnour et al. (2015), GPs, PMs, and PNs reported feelings of loss of support and engagement, attributed to a lack of consultation with GPs and existing providers which was said to have resulted in a duplication of services.

In 2013, the new Minister for Health, Peter Dutton, requested a review of MLs to be undertaken by the previous Chief Medical Officer, John Horvath. This review was assisted by two consulting firms: Ernst and Young to explore operations and structure, and Deloitte to explore financial issues (Thompson, 2015). One of the recommendations following the Deloitte audit was that the government should not fund a national alliance for primary health organisations and that a greater proportion of funding be directed to frontline services (Horvath, 2014). It was also recommended that patient care should be integrated across all health sectors through new organisations with strong linkages to national health priorities with a focus on chronic disease (Horvath, 2014). In July 2015, the Australian government established 31 Primary Health Networks (PHNs) across the country with the intent to support general practice to improve coordination of care and health outcomes. These were larger than the previous MLs with an aim to work with Local Health Networks (LHN) to enhance public health activities such as smoking cessation, health checks, and screening, but also the management of chronic diseases (Booth & Boxall, 2016).

While PHNs do not directly provide services, they do commission them. This means they also have responsibility for clinical governance in safety requirements by identifying areas for improvement and monitoring the quality of processes and outcomes (Australian Healthcare and Hospitals Association, 2021), making them a corporate rationalist. PHNs receive funding from the Federal government to commission services in their local government region; however, because it is a Federal system, the PHNs work with the state and territory governments as well as healthcare providers, and therefore, priorities and interests can be at odds with those of the Federal government (Henderson et al., 2017). Although the RACGP agreed in principle with the development of PHNs, in 2014, one year before PHNs were established, they produced a five-page position statement outlining the principles that they suggested PHNs adhere to (Royal Australian College of General Practitioners, 2014).

These networks sought to present a solution to the previous difficulties in managing costs, activity, and performance while having a population health focus and moving away from an incentive-based policy (Foster et al., 2016). Building on past imperatives to streamline and coordinate care in the primary health sector, PHNs would assist in population health planning through the collection and analysis of data in collaboration with Local Health Networks (LHNs), which were to deliver state government initiatives to both public hospitals and the community sector, set priorities, and allocate resources. Working to commission and integrate local health services, PHNs work in partnership with many government and non-government organisations. One example is the partnership between the Adelaide PHN, Asthma Australia, and the Lung Foundation Australia to enhance outcomes for people living with asthma and chronic obstructive pulmonary disease (COPD). This partnership includes training and upskilling of health professionals and facilitates collaboration between them (Department of Health, 2019a). According to Reed (2017), the provision of community-based care through collaborative efforts that focus on those with chronic and complex conditions has the potential to lower hospital admissions (Australian Health Care and Hospitals Association, 2017a).

In the same year as the establishment of PHNs, the Australian government released the Primary Health Care Advisory Group Final Report (Department of Health, 2016). This report was initiated to streamline primary health care to better manage people with chronic health conditions and decrease the financial burden of a health system not set up to manage them. The report was the culmination of an extensive public consultative process over several years. The advisory group consisted of a mix of consumers, carers, doctors, allied health professionals, and health system organisations, and revealed that patients frequently experienced a fragmented and uncoordinated health care system where services were often working in isolation, leading to a duplication, or even an absence of services (Department of Health, 2016).

Organisational reforms such as those mentioned above highlight the Federal government's attempts to streamline and coordinate primary health care services. In addition, Federal, state and territory governments have an interest in moving towards an efficient PHC system as costs and demand for care rises across all sectors (Reddy, 2017). Organisational reforms such as DGP, MLs, and PHNs have demonstrated some improvement in integrated care (Smith & Sibthorpe, 2007). The Australian Health Care and Hospitals Association (2017b) claimed that the most important factor in preventing hospital admissions in primary care is access to integrated care, with socio-economic status being a significant driver (Australian Health Care and Hospitals Association, 2017a). According to McDonald et al. (2007), two features of the Australian health care system inhibit the use of primary care organisations to coordinate PHC delivery. Firstly, there are two levels of government responsible for funding: the Federal government predominantly funds general practice while the state government predominantly funds acute public hospitals and some public community services. Secondly, reliance on a private fee-for-service payment model for general practice limits the capacity to affect comprehensive outcomes. This promotes a focus on general practice policy, incentives, and processes rather than monitoring the performance of the PHC sector as a whole (J. McDonald et al., 2007).

For most of the 1990s and into the 2000s, macro government policies such as the HCH initiative focused on improving quality while maintaining budgetary targets, with public servants often charged with implementing these policies (Dwan, 2005).

Micro reforms – incentives

Federal funding for PHC in Australia is predominantly through the national public health insurance scheme known as Medicare. This covers visits to GPs and access to many medications through the Pharmaceutical Benefits Scheme (PBS). Under Medicare, various attempts by the Federal government have been made to encourage GPs to improve and enhance collaboration with other health care providers, especially in relation to the management and prevention of chronic disease through incentive-based funding to general practice. These attempts include specific Medicare incentive payments for the preparation of care plans, service incentive programs (SIPs), and practice incentive programs (PIPs), focusing on continuity of care, specific diseases, and services. In addition, incentive payments were made for the annual cycle of care initiatives for specific conditions such as diabetes (Swerrisen & Taylor, 2008). Other incentives (outlined below) such as the South Australian General Practice Plus practice nurse initiative, and the Medicare practice nurse incentive payment were designed to increase the number of PNs within general practice and expand and enhance their role in managing chronic disease, thereby reducing the strain on the acute sector (Fuller et al., 2014).

In an attempt by the Federal government to encourage general practice to enhance and deepen the care of those with chronic conditions, and as a response to the growing number of people experiencing chronic diseases, the Australian Federal government through the 1999 budget, introduced the Enhanced Primary Care Package (EPC) (Short, 2009). Through this package, $171,000,000 was directed at enhancing primary health care with a focus on preventative health care for older Australians and people with complex and chronic conditions (Department of Health, 2014d). Through this scheme, patients were eligible to have formalised care plans developed by their local GP. The aim of these care plans was to provide a structured way to identify and address patient conditions to improve health and encourage care coordination through referral to members of the multidisciplinary team. These plans were to be patient-specific and patient-centred. The Australian government pledged financial incentives to the general practice for the preparation and review of these care plans (Department of Health, 2018a).

General Practice Management Plans (GPMPs) were available for patients who had a known chronic or terminal disease. Care plans were also available for patients who were “75 years of age or older” and could be prepared in the patient’s home or with the patient when they visited the general practice. Both the GPMP and the “75 years of age or older” health assessments attracted a slightly higher financial incentive (Medicare rebate) when prepared for Aboriginal or Torres Strait Islander patients. Given that Aboriginal and Torres Strait Islander people had a known lower life expectancy, the “75 years of age or older” health assessment was adapted to the “55 years of age or older” plan for this population group (Department of Health, 2014a).

Patients with complex needs that required multidisciplinary care were eligible for a Team Care Arrangement (TCA) plan. When this TCA plan was coupled with a GPMP, they were known as an Enhanced Primary Care Multidisciplinary Plan. These care plan services attracted a 100 per cent Medicare rebate, except when the patient was a hospital in-patient, and the services were provided in hospital (Department of Health, 2014a). In 2006, the multidisciplinary Medicare rebate care plans known as Enhanced Primary Care were replaced by the more generic term Chronic Disease Management (CDM). With the change of name also came the introduction of the Mental Health Care Plan, and the health check for people “45-49 years”, along with the Aboriginal and Torres Strait child health check and the health check for Refugees and other Humanitarian Entrants (Department of Health, 2014a). While the GP was required to see the patient for all these interactions, the PN could assess the patient and prepare the health assessment or care plan documents, identifying care needs and liaise with the required members of the multidisciplinary team. In conjunction with the preparation and review of care plans, another important aspect of the PN’s role was to provide education and encourage patient self-management (Newland & Zwar, 2006).

The Australian Primary Care Collaborative (APCC) of 2004 was another initiative designed to enhance the quality of clinical care provided by general practice through a peer learning model based on education, training, and support, especially for those with chronic diseases such as diabetes. This initiative was funded by the Australian Government Department of Health and Ageing and supported by Divisions of General Practice. The belief was that a whole-of-practice approach was needed to improve care. The idea was that motivated and educated teams would work together to improve patient outcomes (Knight et al., 2012). The success of the APCC was to some degree measured by the improvement of clinical parameters such as glycaemic control for people with diabetes and blood pressure reduction for people with hypertension (Knight et al., 2012).

Between 2007 and 2010, the South Australian state government, with a budget of $7,800,000 implemented the GP Plus Practice Nurse Initiative with the aim of increasing the number of PNs across South Australian general practices (Government of South Australia, 2006/7). Through this initiative, nurses were employed to work in general practice with the aim of improving care and care coordination for people with chronic conditions (Fuller et al., 2014). Following an extensive eight days of training funded by the state government, 157 nurses were placed in 147 practices across metropolitan South Australia for a period of 20 weeks (Fuller et al., 2014). As Fuller et al. (2014) explained, 52 per cent of the nurses placed in general practices were eventually employed by them, thus meeting the overall aim of increasing PN numbers.

In 2012, the Australian Federal government introduced the Practice Nurse Incentive Payment (PNIP) which replaced a number of Medicare Benefits Scheme (MBS) item numbers with one payment to acknowledge some of the work done by PNs that was not covered by Medicare (Anderson, 2012). The PNIP included incentive funding of between $25,000 and $125,000 to practices to employ PNs depending on the number of general practice patients and the total weekly hours worked by the PN (Department of Health, 2017b). However, these payments were not indexed, and the formula was capped at 5 full-time equivalent (FTE) GPs, so practices with more than 5 FTE GPs could not access any extra funds to support the employment of more nurses (C Bollen, personal communication, 7th June, 2019).

Despite these government attempts at reform, there have been ongoing tensions between the three levels of government Federal, state, and local) and their responsibilities, evidenced by a lack of dedicated resources and uniform legislation which has made processes difficult (Javanparast et al., 2018). In addition, it has been acknowledged that the fee-for-service model used by most general practices is inadequate when caring for people with chronic and complex conditions as it focuses more on volume rather than comprehensive patient care (Harris & Zwar, 2014; Reddy, 2017). As the delivery of PHC and the introduction of ongoing reforms to tackle chronic disease continue, there is growing consensus that successful collaboration between several health disciplines is key, but the organisation of general practice as a small business makes this problematic. Despite this, the development of various software programs has been seen to be one seamless way of sharing information between providers and contributing to the success of integrated care for people with chronic complex conditions (Goodwin, 2014).

1.4 Assumption 2: The impact of policy on the role of the practice nurse

The second assumption of this study argues that policies directed at reform have had an impact on the professional role, status, scope of practice, and position of PNs, mostly contributing to an expanded and enhanced role. While the role of the PN has become more diverse, articulating a definition of the role is challenging due to the many variables associated with it. This section explores how government policies in general practice have shaped the PN scope of practice in Australia and influenced how the role is defined. An outline of the role of the PN within Australia is provided along with an identification of the more prominent factors influencing it. The section concludes with a chronology of government policies and associated models of care, highlighting their impact upon the role and scope of the PN. The third assumption of this study aligns with the work of Robert Alford and assumes that structural interests impede health reform. This will be discussed in depth in chapter three.

The Practice Nurse role in Australia

In Australia, a PN is defined as “a registered nurse or an enrolled nurse who is employed by, or whose services are otherwise retained by a general practice” (Department of Health, 2009b). In 2005, there were approximately 5,000 PNs in Australia, with 57 per cent of practices employing one or more nurses (Australian Divisions of General Practice, 2006; (Porritt, 2007). In 2007, there were 7,728 PNs working in Australia, in 2009, 8,914, and in 2011-2012, there were approximately 10,693 nurses working in general practice across the country (Australian Medicare Local Alliance, 2012). In 2018, it was reported that this number had risen to approximately 14,000 nurses with around 63 per cent of practices employing one or more nurse (Australian Primary Health Care Nurses Association, 2018). This growth in PN numbers is largely linked to Federal government initiatives to improve the management of chronic disease and associated incentives for practices to employ nurses (Halcomb et al., 2014; McInnes et al., 2017b). Despite this, the Australian Medicare system provides limited reimbursement for work performed by the PN independently of the doctor (Halcomb et al., 2005).

According to Henderson et al. (2014), PHC in Australia is seen as an avenue for reducing the burden of chronic disease, and general practice is the optimum context in which PHC occurs. Practice nurses are significant contributors to the delivery of PHC services within Australia and their role has significantly changed over the last few decades (Heywood & Laurence, 2018).

Watts et al. (2004) described the role of Australian PNs as diverse, explaining that each nurse was forging their own role particular to the practice in which they worked. They went on to describe a PN as a “specialist generalist” where the nurse may have special interests but articulated that the role for all Australian PNs had four elements in common: clinical care, clinical organisation, practice administration, and integration (Watts et al., 2004). This description would later be further enhanced by Christine Phillips in 2009 to include the following six descriptors: carer, organiser, quality controller, problem-solver, educator, and agent of connectivity (Phillips et al., 2009).

The role of the PN in Australia has evolved from once being viewed as a handmaiden, assistant to the GP, or in some instances, referred to as an office nurse (Joyce & Piterman, 2009; Willis et al., 2000), to become a specialist area of nursing that complements the role of the GP (Clendon & Munns, 2019, p. 92). Practice nurses in Australia now play a central role in the promotion of wellness and prevention of disease through the management of chronic conditions (Halcomb & Ashley, 2019)..The work of the PN is in many instances central to the primary health care team through the preparation of patient-centred care plans, the coordination and facilitation of services, and the promotion of access to these services, especially for people with chronic conditions. (Halcomb et al., 2014). The growing prevalence of chronic disease has meant that the PN role now includes more information technology and interdisciplinary care (Guzys et al., 2021).

According to McInnes et al. (2017b), clarifying the role of the PN is important as it assists with collaborative practice. However, according to Walker et al. (2010), because the role is so diverse, when asked to describe their role, PNs will often provide a description of their daily activities. There remains a wide variety of PN roles from task-oriented skills such as the testing of urine, the taking of vital signs, immunisation, and pap smears to the more advanced roles of care coordination and chronic disease management. This variety is a result of many local and global influences, some of which are addressed in the literature review.

In Australia, general practices vary considerably in relation to size, staff complement, the provision of care, and patient population needs (Watts et al., 2004). General practices are predominantly small businesses, and the PN is in the unique position of being employed by another health professional, usually the GP or a corporation. This poses specific challenges relating to the employer/employee relationship and the role of the PN (Walker et al., 2010). As a business, the practice is required to generate funds, and the generation of funds related to Medicare incentives may be a major focus for some, which in turn may restrict the PN role of task-oriented care. The GP/PN relationship is also an important one. Traditionally, the work of the PN was delegated by the GP. The Australian government states that, “The general practitioner must be satisfied that the practice nurse is appropriately qualified and trained to provide chronic disease support and monitoring” (Jolly, 2007). Therein lies the assumption that GPs understand the PN’s qualification/s and training, and that both have the necessary skills to adequately care for those with chronic conditions. With much of the medical and nurse training historically revolving around acute care rather than disease prevention and management, there is recognition of the need for a paradigm shift to enhance care provision for those with chronic and complex conditions. It may well be that both the GP and the PN need additional training in the care of patients with chronic illnesses (C Bollen, personal communication, 7th June, 2019).

Influences on the role of the practice nurse – local influences

The PN operates within the realm of general practice, which is an environment that is subject to many internal and external influences. Walker et al. (2010), along with Clendon and Munns (2019), describe these influences as both local and global. They identify that local influences relate to the demographics of the practice population, consumer needs, the nurse’s education and experience, the working space and geography of the practice, the practice owner’s philosophies, the business nature of general practice, and the professional relationship between the PN, the GP, and other health professionals. Despite the strong focus by the Australian government on an interdisciplinary approach as a means to improving health care for those with chronic and complex conditions (Dixit & Sambasivan, 2018), there are potential risks for the enhancement of the PN role. While there is some evidence that the role of the PN has been enhanced because of the broad range of other health professionals involved in collaborative care, when tasks are delegated to the PN by the leader of an interdisciplinary team (usually the GP), there is potential for the PN to become a passive force in the patient's care rather than a collaborative team member. As a result, this may prove prohibitive to any enhancement of the collaborative process (McInnes et al., 2015).

Influences on the role of the practice nurse – national influences

Macro influences on the role of the PN, as described by Walker et al. (2010), include government policy and legislation, funding arrangements, the health system, public demand, workforce supply, and financial, social, and professional issues. Halcomb in Joyce & Piterman, (2009) claims that the role of the PN has been influenced largely by national health policy more than the nursing profession itself. For example, in the last decade, the significant growth in PN workforce numbers in Australia can largely be attributed to government incentives for practices to employ PNs as part of an attempt to re-orient general practice (McInnes et al., 2017b). The government recognised the need for more coordinated care across both the acute and PHC systems, and the Better Practice Program of 1992, initiated by the Federal government as part of the 1991-1997 General Practice Strategy, dedicated a limited funding stream for general practices to employ PNs and support their role in care coordination and collaborative care, although there were reports of some resistance from both GPs and some PNs at the time (Hall, 2007).

General Practice payment systems

Payment systems have a direct impact on the PN role. In 2004, the Australian government's 'Strengthening Medicare' initiative introduced Medicare item numbers linked to payment for nurses to perform immunisation and wound care (Jolly, 2007). This was quickly followed in 2005 by additional items for the PN to assist the GP in the preparation and review of chronic disease care plans, and this assisted with the generation of revenue through the Medicare Benefits Scheme (MBS) when some services provided by the PN could be billed through the MBS. The MBS fee-for-service model is an example of the traditional fee-for-service payment system used by GPs where payment is received for each individual service and linked to the MBS item number, with the most common example being the patient consultation. Interestingly, the position statement of the Australian College of General Practitioners claims that GPs have no obligation to set their fees according to the MBS, nor are they obliged to bulk bill any service (Royal Australian College of General Practitioners, 2018a). They go on to argue that while the GP should abide by the legislation, they should also consider the impact that billing has on their patients when determining the cost of services (Royal Australian College of General Practitioners, 2018a). This has significant implications for how general practice billing and finance models are created, and it is interesting to note that even when fee-for-service care delivery and payment systems are used, there is scope to develop individual practice payment models.

General practice payment models in other countries include the use of ‘capitation’, which refers to a system in which providers are issued funds (usually monthly or yearly) per patient rather than a fee-for-service. Providers receive a fixed amount for each patient based on expected care needs. In doing so, they may experience a financial loss if that patient requires additional acute and/or complex care. If the patient requires or experiences less care than predicted and some health services are not utilised, the service provider (general practice) may retain any surplus funds (Donato & Segal, 2010, p. 616). Bundled payments, such as those associated with Health Care Homes (HCH), occur when patient care and services are grouped together into a single payment. A ‘bundle’ is defined as a group of services provided to a patient over a given timeframe. The aim of the bundle payment system is to enhance the coordination of care between various health care providers. If the cost of treating the patient is less than the bundle amount, the general practice revenue will increase (Australian Healthcare and Hospitals Association 2015).

Given the private business nature of most general practices, all work by a nurse within that practice is paid from general practice revenue by the owners/principal operators of the practice. Therefore, PN wages vary between different general practices and rates are largely determined by the employer, as most general practices are small businesses and rely on the generation of funds to meet operating costs (Mills & Hallinan, 2009). Since the advent of care planning items, Medicare reimbursement through chronic disease management and other care initiatives performed by the PN have assisted in the provision of sufficient monetary gains for practices to employ nurses (Iles, 2014). In addition, government initiatives, such as the Commonwealth's Practice Incentive Payment (McDonald, Harris, et al. 2008), the Practice Nurse Incentive Payment (PNIP) in 2012, and the South Australian State government's GP Plus Practice Nurse Incentive in 2007, used to support the work of nurses in general practice, have included financial incentives for general practices to employ nurses.

The success of the role of PNs can be determined by many variables and influences such as the generation of funds for nursing services through the government Medicare Benefits Scheme (MBS) and improvements in patient care and care coordination. While MBS item numbers and their associated funding have been in some cases the driving force for PNs to be employed, they have also been an impediment to role expansion, with some PNs restricted to only performing care related to MBS item funding such as care planning and health assessments (Anderson, 2012). While there are known benefits to a successful PN-GP collaboration (Iles, 2014), its success is dependent on the willingness of the GP to relinquish some of the duties traditionally performed by them (Verrall, 2007) and, according to Afzali et al. (2014), this has contributed to some limitation of the role of the PN in relation to clinical care.

Government initiatives and the role of the practice nurse – a chronology from 1999 to the current day

The period from the late 1990s to the commencement of the HCH trial in 2019 has been selected for discussion because during this time, there was increasing awareness that the fee-for-service model of care was inadequate when addressing the needs of patients with chronic and complex conditions (Harris & Zwar, 2014). In addition, until 1999 in Australia, general practice was funded only by a fee-for-service model where no substitution of services from other health providers was permitted, even if this was on behalf of the GP. This meant that the GP alone needed to see the patient in order to trigger a government remuneration payment for a given Medicare item number (Chang & Johnson, 2018). During the late 1990s, there were also changes to the way the Divisions of General Practice were funded, with an increased emphasis on program and policy outcomes. This had an impact on the tasks of some PNs working within divisions in specific roles such as asthma education when simple project implementation became less of a focus (Hall, 2007).

Since 1999, there has been a shift towards the delivery of multidisciplinary care within general practice, especially in relation to the management of chronic disease, and in turn, changes to policy, funding, and models of care have ensued. For example, in 1999, the Australian government introduced the Enhanced Primary Care (EPC) package. This included new Medicare item numbers associated with the development of health assessments and care planning for patients with chronic conditions (Newland & Zwar, 2006). The impetus of this initiative was to support and streamline a coordinated approach to chronic disease management. Medicare item numbers were expanded to include services provided by PNs to support this work of the GP (Donato & Segal, 2010). This consisted of Medicare reimbursement through the introduction of specific MBS items for the development and review of care plans for those with chronic conditions. Introduced in 1999, a PN could prepare a care plan for a patient that included the facilitation of access to allied health professionals. The general practice would receive funds associated with the formulation of this care plan through the MBS scheme. The involvement of the PN in the collaborative team varied greatly between general practices and there is evidence to suggest that a fee-for-service funding model has a negative impact on the collaborative arrangement between the GP and the PN (McInnes et al., 2017b). Care plans involving multidisciplinary professionals also provided reimbursement of up to five allied health provider visits per year. The majority of the work required to prepare these care plans was undertaken by the PN on behalf of the GP (Donato & Segal, 2010). According to Keleher et al. (2007), the introduction of these MBS items for chronic disease management was a strong indicator in acknowledging that the PN can work autonomously as well as be an effective member of the multidisciplinary team. However, in an article by Anderson (2012), the then Senior Federal Professional Officer of the Australian Nursing Federation, Julianne Bryce, suggested that MBS items were an impediment to the expansion of the PN role because they only allowed for certain tasks to be undertaken, and restricted their ability to provide health promotion and prevention at a more holistic level (Anderson, 2012).

As an attempt to improve access to GPs and services for rural populations in Australia, the Federal government in 2001/2002, introduced the Nursing in General Practice Initiative (NiGP initiative). This initiative was to be rolled out over four years, providing financial incentives for general practices to employ nurses (Jolly, 2007). In 2005, an evaluation of this initiative was commissioned by Health Care Management Advisors (HMA) who concluded that it was successful in increasing the number of PNs working in rural locations, and consequently assisted in relieving GP workloads and improving waiting times, affordability, and access to care (Jolly, 2007).

The NiGP initiative was followed in 2004 by the introduction of specific Medicare item numbers for PNs for the provision of vaccinations and the management of wounds. Also commencing in 2004, the Australian Primary Care Collaborative was an initiative designed to improve care provision by general practice via a model of peer learning, and education, training, and system supports (Donato & Segal, 2010). In 2005, CDM items involving care provided by PNs were introduced (Jolly, 2007). These items involved financial incentives for PNs to prepare and review care plans and the facilitation of a multidisciplinary team, known as a ‘Team Care Arrangement’ (TCA). A TCA was designed for patients with chronic or terminal conditions and required the involvement of care from a minimum of two health professionals in addition to the regular GP (WA Primary Health Alliance and Rural Health West, 2018).

Keleher, and colleagues (2007) expressed concern that Medicare item numbers provided for PNs were implemented devoid of sound cost analysis with no evidence substantiating links to improvements in population health outcomes. Practice Incentive Payments (PIPs) for the management of clinical conditions such as asthma and diabetes, which were often undertaken by PNs, were not attributed to any particular care provider despite 67 per cent of accredited practices receiving PIP payments in 2010 (Harris & Zwar, 2014). This meant that in this instance, the work of the PN in association with practice-generated funding was not tracked (Keleher et al., 2007).

Commencing in 2007, with further implementation in 2010/11, the government committed to the establishment of 28 GP Super Clinics designed to bring together GPs, PNs, allied health professionals, and visiting specialists to meet the health needs of local communities. This positioned the PN amongst a team of health professionals as a further initiative to enhance care coordination in the primary health care sector and improve access to multidisciplinary care (Department of Health, 2014b). These clinics were intended to be located in areas where people had difficulty accessing GPs; however, some were positioned near pre-existing, well-established general practices where access was already easily available to many. Funding agreements for these clinics only allowed the funds to be used for the building of the clinic and infrastructure, with staff salaries still being covered by the existing fee-for-service payments (C Bollen, personal communication, 7th June, 2019). In addition, there were poor evaluation processes and, according to the then president of the Australian Medical Association Dr Hambleton, there was no real indication of whether they actually contributed to improved access (Australian Medical Association, 2014).

With the development of Medicare Locals in 2011, emphasis was directed to further improving multidisciplinary care and population health planning (Javanparast et al., 2015). The Australian Medicare Local Alliance developed a number of strategies to support PNs, including orientation manuals, education sessions, and information to develop the expanding and advanced role (Department of Health, 2013b). Service and health directories were also available via Medicare Locals to support the work of the PN (Department of Health, 2014e). Medicare Locals aimed to enhance the care of people with chronic conditions, and through their alliance with the Australian National Preventative Health Agency, a number of local government councils became involved in the development of programs such as those associated with immunisation, nutrition, health and fitness (Department of Health, 2014e). This contributed to greater collaboration between MLs, community nurses, and PNs.

In January 2012, the Practice Nurse Incentive Program (PNiP) commenced. Through this initiative, general practices were provided with incentive payments to offset the costs of employing a nurse and to encourage their expanded role (Department of Health, 2012a; Harris & Zwar, 2014). This program built upon previous incentives with the amalgamation of six previously used MBS PN items (Department of Health, 2012a). This initiative can be considered an example of ‘block funding’ to enhance the role of the PN given that there was a fixed amount provided (McKenna et al., 2015).

The move towards Primary Health Networks (Wentworth Healthcare-PHN Nepean Blue Mountains) in 2015 was identified by The Department of Health as improving the health of populations by “ensuring patients receive the right care at the right place at the right time" (Department of Health, 2015a). These organisations depended on the commissioning of services through a process of tendering to establish the most favourable services to deliver care (Henderson et al., 2017). While this did not directly affect the role of the PN, an important element and indirect influence on their role was the coordination of care between state hospitals and primary healthcare providers who worked closely together (Henderson et al., 2017).

The above provides a brief history of some of the more prominent policy influences on the role of PNs in Australia, particularly around funding mechanisms. Donato and Segal (2010) note that most of these initiatives have failed in their goal to improve care coordination in the primary health care sector; instead, they have contributed to a confusing and complex arrangement where there is a limited level of coordination and integration between the primary health care sector and general practice. Furthermore, the impact of these policies on the work of the PN varies considerably between each general practice, contributing to the challenges in articulating one clear definition of the PN role.

The table below illustrates a selection of health reform initiatives between the emergence of Primary Health Care in Australia in 1975 and the commencement of the Health Care Homes trial in 2018.

Table 1.1: Health reform initiatives 1975-2018

Year	Initiative	Aim/s OR Outcome/s
1975	The emergence of Primary Health Care in Australia	
1978	Ratification of the Alma Ata Declaration (World Health Organization, 2022)	The principles of PHC were outlined
1984	The introduction of Medicare The original Medicare safety net was introduced (Department of Health, 2021c)	Australia's universal health system A Medicare rebate increase from 85 per cent of the (MBS) fee to 100 per cent for out-of-hospital services once the annual threshold amount had been met
1991	Introduction of co-payments (Davies, 2013)	A $2.50 co-payment for all direct billed consultations, except concession card holders

1991 cont:	Introduction of a Safety Net (indexed annually) (Parliament of Australia, 2004)	To offset impact on low-income earners
1992	Establishment of Divisions of General Practice (Smith & Sibthorpe, 2007) Accreditation of general practices commenced (mpconsulting, 2021)	To support GPs to provide quality care and outcomes for communities A formal peer-driven process designed to focus on continuous quality improvement
1995	Coordinated care trials commenced (Parliament of Australia, n.d.)	To test whether multi-disciplinary care planning and service coordination led to improved health and well-being for people with chronic health conditions
1999	The Enhanced Primary Care program was introduced (Short, 2009) Additional coordinated care trials (Parliament of Australia, n.d.)	To improve the quality of chronic disease management
1998-2001	Practice accreditation linked to incentives was introduced (Harris & Zwar, 2014)	This became a threshold for practice incentive payments in 2001
1999/2000	EPC package (Enhanced Primary Care) (Department of Health, 2014d)	New MBS items for the development and review of multi-disciplinary care plans and reimbursement of up to five allied health visits per year. Items were extended to include PN services provided on behalf of GPs.
2000	The development of Australian Practice Nurses Association, later known as the Australian Primary Health Nurses Association (Australian Primary Health Care Nurses Association, 2022b)	The peak body and membership association for nurses working outside of the hospital setting
2001/2002	Nursing in General Practice (NiGP) initiative (Jolly, 2007)	To build capacity and support PNs
2002	Introduction of Practice Incentive Payments (Cashin & Chi, 2011)	Funding for rural general practices to employ PNs to improve access to services. Other incentives based on quality and capacity
2004	Specific MBS items for PNs performing immunisation and wound care (Jolly, 2007)	
2004	Primary Care Collaboratives (Knight et al., 2012)	Quality improvement program to find better ways to provide PHC services to patients through shared learning, peer support, training, education and

2005	Enhanced Primary Care replaced by Chronic Disease Management (Jolly, 2007) The introduction of General Practitioner Management Plans and Team Care Arrangements and their reviews (Jones & Schattner, 2014) MBS items for rural PNs to perform pap smears (Jolly, 2007)	To enhance interdisciplinary care for people with chronic conditions
2005	Australian Primary Care Collaboratives (Ford & Knight, 2010) MBS items for metropolitan PNs to perform pap smears (Jolly, 2007)	To improve outcomes for people with diabetes and coronary heart disease, and to improve access
2006	Extension of PN PIP in urban areas (Jolly, 2007)	
2007	Proposed introduction of new MBS for PNs to support CDM (Department of Health, 2007)	MBS for PNs to monitor and support patients between reviews of a care plan
2008	National Health and Hospitals Reform Commission (Bennett, 2009)	To address access and equity issues, to respond to emerging challenges through 123 recommendations
2009	Australia’s first National Health Preventative Strategy (Biggs & Jolly, 2010)	To expand MBS to support more preventative initiatives, target high-risk groups
2007-2010	The GP Plus Practice Nurse initiative (Fuller et al., 2014)	To employ and educate nurses to work as PNs and increase PN numbers
2010	GP Super clinics (Lane et al., 2017)	Enhance care through systematic chronic disease management, multidisciplinary care for those with chronic conditions
2011	Medicare Locals (Horvath, 2014)	Regional primary care organisations with a wide range of community-based health professionals to improve access to care, plan services to meet local needs, promote prevention and chronic disease management
2011	Development of the Australian National Preventative Health Agency (Parliament of Australia, 2014)	To strengthen preventative health and streamline efficiency
2012	Practice Nurse Incentive Program (PNIP) (Practice Assist, 2017)	Incentives for practices to employ PNs and support enhanced roles

2012/2013	PEP Practice intervention (Harris et al., 2017)	Intervention to target the clinical management of patients by both GPs and PNs and promote evidence-based preventative care of patients who smoke, drink excessive alcohol, have a poor diet, are physically inactive, are obese, or have a risk of cardiovascular disease or diabetes.
2014	Disestablishment of Medicare Locals	
2015	Establishment of Primary Health Networks (Henderson et al., 2017)	Commissioning organisations to improve health outcomes and people's experiences with PHC
2017	National General Practice Accreditation Scheme (NGPAS) (Australian Commission on Safety and Quality in Health Care, n.d.-b)	Supports assessment of general practices against the RACGP standards
2018-2021	Health Care Homes trial (Australian Government, 2020e)	Multidisciplinary care for those with chronic and complex conditions. Trial of a blended payment system

The above table highlights some of the more noticeable Australian health reform initiatives within general practice between 1975 and 2018. Common imperatives focused on improving access, clinical outcomes, and the need for an interdisciplinary approach to care for those with chronic conditions. Over the years, initiatives have also included strategies for practices to employ nurses, as well as the inclusion of MBS items associated with their work. Assumption 2 assumes that attempts at reform have influenced the role of the PN, which underpins the thesis question.

1.5 Assumption 3: Structural interests as impediments to reform

The third assumption aligns with Robert Alford's 1975 Theory of Structural Interests. Alford's theory explores the concept of political interest and power among people and groups. Alford proposed three main groups; the first he calls the professional monopolists or those with dominant interests, who are mainly doctors who seek clinical autonomy and are primarily concerned with individual patients (Williamson, 2008). The second group proposed by Alford are those known as corporate rationalists. He suggests that this group consists of people in government health departments, politicians, and service managers, and he suggests they illustrate a challenge to dominant interests due to their focus on cost-effectiveness and regulation (Williamson, 2008). Williamson (2008) goes on to illustrate Alford's third group, the community and community advocates, who he calls ‘the repressed’, because this group consists of fewer people sitting on policy-making boards and committees, although this has changed significantly since 1975. This thesis explores the idea that structural interests hinder attempts at health reform, and more specifically, those associated with the HCH trial. It places the PN at the centre of the inquiry to examine the influences of HCH on the PN role. Alford’s Structural Interest Theory is discussed in greater detail in chapter three.

1.6 : Thesis outline

The first chapter has provided a background to the thesis. The research question has been identified and three assumptions proposed to guide the exploration of the research question. Chapter two introduces the Health Care Homes initiative as the focal reform strategy used for the study. I discuss the impact of the COVID-19 pandemic upon the HCH trial and introduce the reader to two trial variants undertaken in Australia at the time of the HCH trial. These two trials provided an exploration of alternate funding for the care of people with chronic and complex conditions, and had similar aims to the HCH trial, thus providing an avenue for comparison. I also introduce the reader to the significance of the Medicare freeze upon the HCH trial as an explanation of how organised medicine responded to HCH. Chapter three outlines the theoretical underpinning of the thesis, providing a reflection on its significance to the research question. A systematic literature review is the focus of chapter four. This review examines the role of the PN in Canada, the United Kingdom, and New Zealand when assisting people to manage their chronic condition/s. This investigation provides some contextual comparisons between attempts at reform and the role of the PN in Australia and other countries. Chapter five identifies the research methodology and the methods used to investigate the research question. Chapters six, seven, and eight provide the findings from interviews from four general practices used as case studies in the thesis. Following this, Carol Bacchi’s system of policy interrogation with specific application to the Health Care Homes initiative and the thesis research question is examined. The final chapter presents the implications of the research findings from which conclusions are drawn to address the research question.

The following chapter introduces the Health Care Homes trial in Australia, providing context for the exploration of the role of the PN. A brief outline of the history of the initiative is presented, along with a comparison of similar initiatives undertaken in Australia when exploring a shift in funding to assist the care of people with chronic and complex conditions. I introduce the significance of the Medicare freeze to the thesis and outline the COVID-19 pandemic and its impact on the HCH trial. The chapter concludes with an introduction to the ensuing chapter which details Alford’s Structural Interest Theory as the theoretical underpinning of the thesis.

Chapter 2: Health Care Homes

2.1 Introduction

The purpose of this chapter is to provide context to the thesis by introducing the Health Care Homes trial. A brief history of the trial is provided, followed by detailed explanation of the aims of the trial and the main elements within it designed to facilitate change to how care is provided for people with chronic and complex conditions. The role of the Primary Health Network (Wentworth Healthcare-PHN Nepean Blue Mountains) in establishing and supporting practices throughout the trial is also explained. The notion of the PHN as a 'corporate rationaliser' is introduced as it relates to Alford's Structural Interest Theory and impediments to reform. The chapter includes an introduction to the COVID-19 pandemic and its significance to the thesis as well as the role of the Medicare Freeze in the success of the trial. I introduce the reader to two Australian trials funded by the Royal Australian College of General Practitioners (RACGP) and the Federal government, aimed at trialing alternate funding models and improved patient outcomes. The chapter concludes with a discussion aligning the research question with the role of the practice nurse (PN).

2.2 Health Care Homes in Australia

In December 2015, the Primary Health Care Advisory Group presented the 'Better Outcomes for People with Chronic and Complex Health Conditions' report. Building on the numerous past reforms to primary health care, this report highlighted the fragmented and poorly coordinated primary health care system and outlined a new model of care for people with chronic and complex health conditions in Australia (Department of Health, 2016). In March 2016, the Australian government presented the 'Healthier Medicare' package with one of the key features being the development of the new model of care known as 'Health Care Homes' (HCH) (Biggs, 2018). Health Care Homes is the term used for the initiative undertaken within a general practice or Aboriginal community-controlled health service. The HCH model encouraged a team-care approach, better coordination of services, and offered a new bundle payment model (Department of Health, 2016). Within this model, patients were invited to 'sign up' to the initiative after nominating a clinician within a general practice who was responsible for coordinating and managing the care of their chronic disease(s). The designated coordinator could be a general practitioner (GP), PN, or any one of the multidisciplinary team members associated with the person's care.

Adapted from the Patient-Centred Medical Homes (PCMH) model in the United States, the Australian government sought expressions of interest from general practices to participate in the HCH trial. Interest in adopting the PCMH model came from an ongoing desire to improve patient outcomes, the quality of care, and to reduce hospitalisations, outcomes that evidence suggests can be achieved through the PCMH (John et al., 2018). The PCMH model was initially introduced in the United States of America (USA) by the American Academy of Pediatrics in 1967, with the American Academy of Physicians launching the initial national trial in 2006 (John et al., 2018; Metusela et al., 2020). The PCMH model was based on a partnership between a coordinated multi-disciplinary team addressing the wishes of the patient, and according to Dwyer and Duckett (2016), voluntary enrolment by the patient to a medical home provided them with a sense of belonging to one facility where all of their concerns could be managed. This personalised focus was to address inefficiencies in care integration and minimise hospitalisation (Dwyer & Duckett, 2016).

The HCH trial commenced in Australia in 2017 when $21 million was dedicated to fund the first phase of the trial over the following 3 years (Jackson & Hambleton, 2017; Jan, 2017). As an adaption of the PCMH with the aim of improving the effectiveness of primary care, the features of the Australian implementation included:

- *voluntary enrolment of patients to a practice, which became their HCH*
- *the patient nominating a GP as their preferred clinician*
- *the identification of patients at risk of hospitalisation using a risk stratification tool*
- *a bundled payment for every enrolled patient based on their tier (for services relating to the patient's chronic conditions), which replaced the Medicare fee-for-service payment*
- *training resources to support transformation of practices towards the HCH model*
- *support for practices to undertake transformation provided by PHN practice facilitators*

- *a system of shared care planning that gave authorised health professionals access to an up-to-date electronic medical record for each enrolled patient* (Health Policy Analysis, 2019a, p. 5).

The HCH model provided flexibility within the system to allow for either face-to-face, virtual, or a mix of these avenues for the patient to liaise with their chosen clinician and/or allied health professional (Jackson & Hambleton, 2017). The HCH acted as a base for the management of eligible patients with one or more chronic diseases. The premise was that patients with chronic conditions would be better managed with improved coordination of resources to meet their needs (Department of Health, 2017a).

Working towards health reform in primary health care requires a strong foundation. *The 10 building blocks of high performing care* is a conceptual framework used by both the PCMH and HCH in Australia to guide practice improvement (Bodenheimer et al., 2014). Consisting of four foundational elements, engaged leadership, data- driven improvement, empanelment, and team-based care, these building blocks were used as a framework to facilitate innovative thinking for primary health care reform (Bodenheimer et al., 2014). Ongoing training and upskilling using this framework was provided by the PHN facilitators and, according to Australian General Practice Accreditation Limited, “offered the best opportunity for successful and sustainable transformation in practices” (Australian General Practice Accreditation Limited, 2022). Figure 2.1 below illustrates the 10 building blocks for high performing primary care.

Figure 2.1 The 10 building blocks for high performing care (Australian General Practice Accreditation Limited, 2022) (Image removed above due to copyright).

Recognising that HCH required whole-of-practice engagement, each participating practice was offered 11 online training modules designed around a ‘plan, do, study, act’ (PDSA) framework to assist in change management in small cycles which included information about each of the 10 building blocks shown above (Department of Health, 2020d).

To determine patient eligibility for the HCH trial, a Risk Stratification Tool (Wright & Versteeg, 2021) was used. This tool included a Predictive Risk Model (PRM), which is an electronic tool used to scan patient records to assist in determining the patient’s eligibility for the Health Care Homes initiative (Department of Health, 2018c; Dera, 2019). As mentioned by Dera (2019), managing patients with a wide variety of complexity requires different amounts of resources depending on that complexity, and the RST categorises patients based on their complexity to assist in the allocation of resource and care needs. The PRM examined more than 50 variables and interactions, including patient demographics, diagnoses, medical observations, medications, and lifestyle (Department of Health, 2018c).

Under the HCH initiative, care associated with the patient's chronic and complex conditions that was previously reimbursed through the Medicare Benefits Scheme (MBS) fee-for-service was now funded from a bundle payment provided to the general practice for each enrolled patient. Retrospective monthly payments were made to the practice which also facilitated review and adjustment of the patient's associated level of funding if required (Department of Health, 2018c). One of the aims of HCH was to eliminate the fragmentation and duplication of care often associated with the fee-for-service model (Jan, 2017).

2.3: Bundle Payments within Health Care Homes

One of the most significant changes brought about by the HCH trial was the move away from the traditional fee-for-service payment model to a system of bundle payments for care associated with chronic conditions. Health Care Homes patients could still access fee-for-service billing for care not associated with their chronic condition/s (Department of Health, 2021b). Within the HCH bundle funding model, there were three different payment amounts, each relating to one of three tiers of patient complexity. As shown in the following table, general practices received a single payment of between $591 and $1,795 per patient per annum based on patient complexity (fixed for the duration of the trial) as determined by the RST (Department of Health, 2017a).

Table 2.1: HCH patient complexity per tier level and associated bundle payments

	Payment Value
Tier 3 — the highest level of patient complexity	$1,795 per annum
Tier 2 — increasing level of patient complexity	$1,267 per annum
Tier 1 — the lowest level of patient complexity	$591 per annum

(Department of Health, 2018c).

A one-off payment to the practice of $10,000 was also provided for training and the initial set up of the initiative (Jackson & Hambleton, 2017). It was proposed that the bundle payment system would provide practices with the flexibility to provide the care needed for people with chronic and complex conditions; for example, phone call follow-up and nurse-run consultations (Department of Health, 2021b).

2.4: Shared Care Plans

One of the requirements of the HCH trial was that an electronic online care plan was prepared for all HCH patients. This online care plan could be accessed by all members of the patient's health care team as well as the patient. This included any health care professionals associated with the patient's care outside of the HCH trial, such as medical specialists and pharmacists (Department of Health, 2017a, 2021b). This was an attempt to promote interdisciplinary shared care and 'real time communication' (Precedence Health Care, 2021). The software was supported and installed into practices by the PHN and initially provided through a system known as cdmNET (collaborative decision-making Network) which also included software for patient risk stratification (Precedence Health Care, 2017). A lack of interface options and consistency across HCH practices meant that the platform was eventually moved from cdmNET to a state-wide platform known as INCA.

These shared care plans were designed to enhance communication between health professionals and facilitate team-based, coordinated care so that the needs of people with complex and chronic conditions could be facilitated (Department of Health, 2017a). Figure 2.2 below illustrates the original intent of the shared care plan as presented in a patient information sheet.

Figure 2.2 Your shared care plan (patient information) (Department of Health, 2021b).
(Image removed below due to copyright)

2.5: My Health Record

Another component of the HCH trial was the use of My Health Record. Supported by the PHN, all patients signed to HCH were required to have an electronic health record. The premise was that medical and other pertinent patient information could be quickly and easily accessed by the HCH team, thus facilitating patient care. The aim was to sign up all Australians to this centralised electronic patient data website. According to the Australian government's *My Health Record* website, 5.9 million Australians had signed up by July 2018 (Pha, 2018). For patients enrolled in HCH, the use of My Health Record was compulsory.

2.6 The Health Care Homes trial – medical resistance

With an initial goal to enrol 65,000 patients across 200 medical practices and Aboriginal Community Controlled Health Services in Australia, the trial commenced in October 2017, with 20 practice owners signing up to the initiative and a further 120 commencing in December 2017 (Biggs, 2018).

Despite this reasonably positive number, there was some negativity expressed by members of the Royal Australian College of General Practitioners (RACGP). Concerns were raised at the perceived lack of funds within the HCH model to adequately care for people with complex and chronic conditions. According to Dr. Bastian Seidel in an article written by Amanda Lyons, HCH was based on a capitation funded model which was "nonsensical" and set up the HCH trial for failure (Lyons, 2017). In support of this, Dr. Ackermann stated that a return to the principles underlying the RACGP model of funding was necessary (Lyons, 2017). Doctor Richard Kidd (former president of the Australian Medical Association) (AMA) also expressed concern about confusion around funding models and the distinction between MBS billing and HCH billing, questioning which category the management of wounds actually fell into (Kidd, 2018). In 2016, vice-president of the AMA Dr. Tony Bartone expressed concern that HCH was at risk of failing due to inadequate funding (Rollins, 2016).

Concerns about inadequate funding and delays in signing up practices due to issues with information technology and concerns over the tax component of the funding also caused a delay in the implementation of the trial by three months (Biggs, 2018). These issues influenced the initial target of signing 65,000 patients to the HCH initiative by June 30, 2019, and by this time, only 12,000 patients had signed to the trial (Department of Health, 2019b). As of September 2020, a total of 13 practices across metropolitan Adelaide had signed to the trial, with a total of 145 participating practices across Australia (Department of Health, 2020e).

As a response to concerns about the poor funding of the HCH trial from the RACGP and the AMA (Australian Medical Association, 2016a; Lyons, 2017), the RACGP lobbied the Commonwealth government for funding to test whether Australian general practices that were assisted logistically and financially could deliver better health outcomes in a cost-effective way (Flinders University, 2021).

The Quality Enhanced general practice Services Trial (QUEST) and the EQuIP-GP trials ran in South Australia between 2018-2019 (Flinders University, 2021; Peterson et al., 2019). Both trials tested alternate funding systems and included cohorts of patients with chronic and complex conditions. The EQuIP-GP trial tested "incentives for specific quality improvement factors in high-risk chronic disease populations" (Peterson et al., 2019, p. 529), while the QUEST trial provided a $1,000 payment for each participating patient to "determine whether a multicomponent general practice intervention cost-effectively improved health outcomes" (Reed et al., 2022, p. 469). Both these trials are discussed in more depth in chapter nine when I align Carol Bacchi's policy interrogation framework to the HCH trial.

2.7 Factors affecting the Health Care Homes trial

Transformation to an HCH required changes to many processes. For example, enrolment alone involved installing software, cleaning up data, identifying patients suitable for HCH, explaining what enrolment meant, and registering patients. But even greater challenges existed in changing culture, mindsets, roles, and how practice staff worked together. These additional resources and support required time, and the initial trial was to take place over 2017-2018; however, due to what was deemed an inadequate timeframe to set up and establish the trial, it was extended, and participating practices were encouraged to continue the trial until 30 June 2021 (Department of Health, 2020e). Support to practices was provided through designated personnel within related Primary Health Networks with additional funding support to cover the extended trial period (Department of Health, 2019b).

Patients enrolled into an HCH could have several chronic conditions or only one, depending on complexity. The bundle payment meant that care for people with chronic conditions that would have previously attracted funding through the MBS service model, such as a General Practice Management Plan (GPMP) or a Team Care

Arrangement (TCA) was funded through a bundle payment system. Although all enrolled HCH patients required the formulation of a ‘shared care plan’, they no longer needed to have a GPMP, TCA, or other care plan developed to address chronic illness. In addition, any services not related to the patient’s chronic disease management as well as any diagnostic or specialist services could still be billed through the MBS (Department of Health, 2017a).

2.8 The challenge of Health Care Homes and reform

Given the many attempts to reform general practice over the years, it is not surprising that the early experience of implementing HCH aligns with previous experiences of other countries such as the USA and New Zealand (NZ). These countries have reported a lack of true interdisciplinary care, and the need to improve communication strategies around funding models and the initiative itself (Flieger, 2017; Hefford, 2017; Jackson, Powers, Chatterjee, Bettger, et al., 2013). Challenges to the reform included the need for doctors to re-work their view of team-based care, financial uncertainty, and a lack of time for implementation (Flieger, 2017).

Additional challenges illustrated within the Australian general practice context include role confusion between GPs and PNs, and time constraints emanating from increasing workloads and a lack of opportunities for interdisciplinary care and communication (Lucas et al., 2016). The Health Care Homes initiative claimed to rectify some of these challenges through the development of a multidisciplinary shared care plan to facilitate communication, and the move to bundle payments to manage and provide care to people with chronic conditions (Department of Health, 2009a).

Despite these claims, early signs of resistance to the initiative came from organisations such as the Australian Medical Association and the Royal Australian College of General Practitioners who voiced concern about the costs of changing to the new model, and the size of the bundle payment (Jackson & Hambleton, 2017). In a newspaper article in the Weekend Australian in September 2018, the Health Care Homes initiative was branded as “unpopular and … politically sensitive” (Parnell, 2018). Interestingly, the literature surrounding the initiative shows little reference to PNs and the role they played within the new model. There appeared to be little resistance from PNs in relation to the initiative, albeit personal communication with a few PNs has demonstrated otherwise. Given previous reforms left PNs performing task-based skills linked to Medicare item remuneration, the new Health Care Home model would presumably have enhanced their role. In the absence of fee-for-service MBS items related to chronic conditions, and in a system where the practice was responsible for distributing funds from a bundle payment, there was an opportunity for the role of the PN to develop and expand to incorporate a greater degree of care coordination within the multidisciplinary team (Department of Health, 2017a).

2.9 The COVID-19 pandemic and its influence on the Health Care Homes trial

In March 2020, the World Health Organization's declaration that COVID-19 was a global pandemic triggered an immediate response to the way PHC was delivered in Australia and across the world (Boissy, 2020; Kidd, 2020). To assist in reducing the transmission of the COVID-19 virus, physical separation between health care providers and patients was encouraged, and telehealth was used as one means to achieving this (Taylor et al., 2021).

According to the Australian Government Department of Health (2015b, p. n.p.), telehealth is the:

> *… use of telecommunication techniques for the purpose of providing telemedicine, medical education, and health education over a distance, while drawing a distinction between this and telemedicine, which is defined as the use of advanced telecommunication technologies to exchange health information and provide health care services across geographic, time, social and cultural barriers.*

In March 2020, as a response to the COVID-19 pandemic, the Australian government introduced temporary MBS telehealth items to primary care providers; this was subsequently extended to March 2021 (Australian Government, 2021a). Given that telehealth was an inherent part of the HCH initiative (funded by the bundle payments), this proved to be a significant impediment to the trial. Telehealth funding during the HCH trial is explained below:

> *Telehealth consultations for acute conditions unrelated to the patient's chronic disease or shared care plan should be undertaken using the temporary*

> *telehealth MBS items, with bulk billing as appropriate … Telehealth consultations relating to a patient's existing chronic disease or shared care plan should be covered by the HCH bundled payment and the temporary telehealth MBS items should not be used* (Australian Government, 2020c).

The impact of COVID-19 on the health of Australians has been reported by the Australian Institute of Health and Welfare (AIHW) (2020a) and includes a decrease in the number of people attending breast screening, a reduction in emergency department presentations and the number of diagnostic procedures, and an increase in mental health services and telehealth consultations through the MBS. The COVID-19 pandemic resulted in a general decline in preventative screening as well as reduced patient engagement, especially when caring for people with chronic diseases (Halcomb et al., 2021; Wright et al., 2020).

The impact this has had on the PN role has been explored by Halcomb et al. (2021) who surveyed 359 PHC nurses who reported that during the pandemic, there was a reduction in detection, support, and management of people with chronic diseases, leaving some nurses to express feelings of low job satisfaction. While not immediately evident, this lack of detection and management of chronic disease is thought to lead to an increase in the number of people who will require preventative care after the pandemic (Wright et al., 2020).

Findings from Labrague et al. (2021) and Chudasama et al. (2020) concluded that the COVID-19 pandemic influenced a myriad of factors that can potentially affect the provision of nursing care, resulting in missed or compromised care. Halcomb et al. (2021) suggest that one reason for the reduction in chronic disease patient engagement and diagnostic procedures during the pandemic was because the management of chronic diseases was seen as less urgent than other health-related issues. The challenges brought about by COVID-19, including changes in workplace systems, have been expressed by some nurses as prohibitive to patient-centred care and nurses' ability to complete required tasks in the same manner as pre-COVID (Labrague et al., 2021).

A significant impact of COVID-19 during the HCH trial came about as a result of the initiation of telehealth services (Taylor et al., 2021). The use of telehealth was deemed one of the major elements of the HCH trial:

> *As Health Care Homes is not restricted by a fee-for-service, … a range of innovative care delivery options may be considered, including telephone, email, and videoconferencing* (Australian Government, 2018a, p. 11).

Bulk billed teleconference appointments were originally offered as part of the HCH initiative; however, because of the COVID-19 pandemic, they were offered to all patients. This was a significant disruption to the HCH trial.

According to De Guzman et al. (2022), GPs had mixed views on the use of telehealth, with some supporting face-to-face consultations, given the need for physical examinations, suggesting that telehealth should complement rather than replace the traditional face-to-face model of care. They went on to say that some GPs in their study felt that telephone consultations were appropriate for busy patients wanting scripts, results, or follow-up consultations; however, this did not meet the financial needs of the practice (De Guzman et al., 2022).

Although acknowledging the need for telehealth in response to the COVID-19 pandemic, Dr Djakic, the deputy chair of the RACGP, noted that the pandemic had placed additional financial pressure on an already stretched primary health sector (Tsirtsakis, 2021). Consequently, the RACGP welcomed the move to add telehealth as a billed MBS item, noting that:

> *The RACGP has always and unequivocally maintained the right of every GP and/or practice to bill for services as they see fit. We strongly advocated for the removal of the restrictions on private billing of telehealth MBS items and welcome the Australian Government's announcement that the bulk billing requirements are removed from 1 October 2020* (Royal Australian College of General Practitioners, 2022, p. 3).

According to Pereria et al. (2020), although telehealth may be convenient for some patients, it provides a less personal experience for the patient and less job satisfaction for the nurse.

It is difficult to quantify the effect that any changes to the role of the PN in response to the COVID-19 pandemic has had on the health outcomes of those with chronic conditions. There is, however, evidence to suggest that the way care was provided for those with chronic conditions was modified during the pandemic. This is in part because of the fear of catching and transmitting the COVID-19 virus and the associated increase in the use of telehealth. There is consensus that as a result of COVID, these modified working systems and conditions enabled missed opportunities for early detection and intervention of disease and might culminate in an increase in the number of people requiring chronic disease management post-pandemic (Halcomb et al., 2021; Halcomb et al., 2020; Labrague et al., 2021). Enhancing communication systems in PHC is vital, especially during COVID, given the focus on integrated care for those with chronic conditions. Other challenges illuminated by the COVID-19 pandemic were reflected in a change to the already complex funding system in general practice, when 281 new temporary MBS item numbers were added to the schedule (Snoswell et al., 2020).

The Commonwealth government's 10-year plan claims to address many of the issues that the HCH trial promised to address such as a person-centred system of care integration supported by a connected interdisciplinary team and new and innovative funding models (Department of Health, 2021a). One of the ways this proposed reform has been marketed in the 10-year plan is by promoting the use of MBS-funded telehealth. While the HCH trial also claimed to provide a more integrated team-based approach to care, the COVID-19 pandemic and the telehealth response prompted its inclusion in the 10-year plan (Wright & Versteeg, 2021). The 10-year PHC plan, 2022-2032 states:

> *The COVID-19 pandemic has proven the value of telehealth funded through the MBS as a vital part of the future service mix. The safety and quality of telehealth can best be assured in the context of an ongoing relationship between practice, provider, and patient* (Department of Health, 2021a, p. 7).

The ability to undertake telehealth was a significant component of the HCH trial and when introduced as a consequence of the COVID-19 pandemic, this element was no longer unique to the trial. The impact of this is presented in the case study chapters and further explored in the discussion chapter.

2.10 The Medicare freeze and its influence on the Health Care Homes trial

In 2013, as part of a $664 million dollar budget savings plan, the Australian Labor government introduced the Medicare rebate freeze (Dickinson, 2019). Without any specific timeframe given, the freeze was initially deemed a ‘temporary measure’ by the government, and despite some resistance and criticism from the Australian Medical Association (AMA) and the opposition at the time, the Medicare freeze was introduced for a four-year period by the newly-elected Coalition government in 2014 (Dickinson, 2019). This ultimately meant that the fee amount for a consultation covered by Medicare was frozen at the Federal level for six years (Green, 2022). According to Dr Bartone from the AMA (2018), “Medicare has failed to keep up with the rising costs of providing medical services”. With various governments freezing the value of the Medicare rebate, and not increasing the rate to match the Consumer Price Index (CPI), the Medicare rebate had not kept up with the real costs of delivering services such as those associated with paying staff, medical products, rent, and generally running a business (Dickinson, 2019). According to Tsirtsakis (2021), the RACGP estimated that general practice lost approximately $1 million dollars because of the freeze and had no choice but to pass on the out-of-pocket fee to the patient.

The freeze was to be extended until 2020; however, since 2017, there has been a phased lifting of the freeze which, according to Duckett (2017), would assist in reinforcing bulk billing as the pillar of Australia’s health system. In 2022, the impact of the Medicare freeze is still being felt with many practices removing bulk billing, and despite Medicare rebates rising in July 2022, they only rose 1.6 per cent which was far less than the inflation rate of 6.1 per cent (Davey & Convery, 2022).

In the next chapter, I provide an overview of Robert Alford’s Theory of Structural Interests (1975) as the theoretical framework used to interrogate the researcher’s assumptions on the Health Care Homes trial and the research question.

Chapter 3: Alford's Structural Interest Theory

3.1 Introduction

The third assumption informing this study aligns with Alford's 1975 theory of political interests where he argues that various structural interests obstruct health reform. This chapter introduces the work of Robert Alford and provides an account of its relevance to the thesis. In exploring Alford's theory, I provide an overview of his seminal work and then move to explore commentary of his ideas by other political theorists. I discuss the many challenges to successful health reform, and align these with Alford's assertions that inefficient practices, power imbalances, and the specific agendas of people and groups impede successful health reform. This chapter includes an overview of the Australian health care system and a discussion of the general practice environment, its organisation, people, and relevant governing bodies. I demonstrate how these groups align with Alford's theory and identify the challenges encountered for successful health reform within the general practice environment, with specific consideration to the Health Care Homes (HCH) initiative and the role of the practice nurse (PN). Emphasis is placed on the relationship between Alford's theory and the Australian Medical Association's (AMA) response to HCHs. In addition, given that the HCH trial was premised on interdisciplinary care, consideration will be given to the absence of the interdisciplinary team within Alford's theory. In the final section of this chapter, I consider how Alford's theory relates to the PN and health reform particular to the HCH initiative.

3.2 Alford's Structural Interest Theory

Health reform in Australia is influenced by the response of certain groups to government strategies and policy (Duckett, 1984). With this in mind, this PhD draws on Robert Alford's 1975 *Theory of Structural Interests*. Robert Alford was a professor of sociology at the City University of New York who died of pancreatic cancer in 2003 just before his 75th birthday (Berkeley University of California, 2019). Alford was known as a political sociologist and had a particular interest in the exploration of health care politics. In 1972, he published his work in response to the 'crisis' within the United

States of America (USA) health system. He proposed that despite growing numbers of health professionals, an increase in health care costs and associated services, in conjunction with a variety of proposed reforms, it was apparent that the health system in New York had remained stagnant and in crisis over many decades (Alford, 1972). He went on to argue that the many proposed reforms such as an increase in personnel, clinics, and additional insurance subsidies were all absorbed into a system that was essentially resistant to change. Alford (1972) argued that this resistance to change was in part because the suggested reforms were “sponsored by different elements in the health system and advantaged one or more elements but did not damage any interests” (p. 128). He suggested that it was this balancing of costs and benefits that prevented the proposed policies from contributing to any real structural change. According to Mullane (1976), Alford illustrated that in the hands of interest groups, crises can act as political weapons.

In his 1972 paper, Alford established that despite the expansion of the health care system in New York in terms of both human and material resources, significant change did not occur, and he postulated that this was attributed to tensions between certain interest groups operating within the context of a market society. In essence, Alford was arguing that the methods used to drive reform were initiated by three different types of reformers: market reformers, bureaucratic reformers, and equal health advocates.

Market reformers

Alford asserted that people within the community were consumers of health care and should be able to evaluate the care they receive, and consequently, select their most favoured care from a variety of options. This in turn would contribute to a competitive market resulting in an expansion of available services and facilities, and an increase in the number of available doctors and private health insurance companies. Market pressure would then result in survival of the most accessible, cheapest, and seemingly best care (Alford, 1972). The market reformers in this case would have an interest in providing more choice to consumers by providing care that was responsive to their needs (Chapin, 2010). This would assist in maximising the use of their health dollar but would also increase the number of spaces for medical training, and therefore, maintain control for the doctor over his/her own practice (Alford, 1972). The market reformers comprise powerful interest groups who carry power because of their links to many public and private organisations. This group consists of government health departments, doctors in public health, medical schools, and the specialty boards which govern them and their affiliated associations (Alford, 1972). In Australia, this includes the Royal Australian College of General Practitioners and the Australian Medical Association.

Bureaucratic reformers

According to Alford (1975), bureaucratic reformers are concerned with the coordination of services to avoid the fragmentation of care. They believe the hospital to be where health service coordination occurs and strive to place doctors under the control of hospital boards and managers. They assume that health care requires a complex and coordinated division of labour between all health care sectors, doctors, specialists, and ancillary care (Alford, 1972). Despite this, these reformers are challenged by the behaviours of doctors, who Roberts and Bogue identify as the key decision-makers (Roberts & Bogue, 1975). In Alford's later work, when categorising interest groups, he refers to these market and bureaucratic reformers collectively as corporate rationalisers.

The proposed groups of reformers outlined above have some similarities such as a focus on the reduction of costs, and a desire to review the health insurance system; however, Flash et al. (1976) argue that while people are different and have different needs, it is not the community that dictates power, but the doctors. They concur with Alford that while people should be free to choose who and what is best for them, it is actually the doctor's 'power' that decides this (Flash et al., 1976). In his 1972 paper, Alford cites a 1971 article by Dr Milton Roemer of the University of California, Los Angeles, where he proposes a socially oriented system in which primary health centres would be placed close to people's homes and staffed by general practitioners (GPs) and medical assistants (MAs) to provide basic diagnostic and preventative services. He proposed that:

> *Each person served by this health centre would be attached to a particular doctor and his team of colleagues … ideally health care should be a public service like schools or roads, paid for from general tax revenues. All*

> *professional personnel would be salaried, with salaries varying according to qualifications, skills and responsibilities* (Roemer, in Alford, 1972, p. 131).

Roemer (Alford, 1972) goes on to propose that a hierarchy of officials would oversee the system to ensure all parts were appropriately coordinated. Interestingly, Roemer alludes to the importance of a team of colleagues; however, it is not clear whether this relates to doctors or allied health professionals. Alford, on the other hand, appears to have omitted any consideration of the importance of the multidisciplinary team, something that will be explored further in this chapter in relation to the promotion of an integrated model of care and the HCH initiative.

Alford asserts that health reform based on the ideals of the market and bureaucratic reformers is unlikely to be successful because each promotes certain aspects above others, and he suggests that both groups fail to recognise that the groups driving the functions of change have their own interests and agendas, some of which are directed at maintaining certain aspects of the current system, and thus, impeding change (Alford, 1972). The market reformers constitute powerful interest groups because they carry significant power having links with many public and private organisations. The bureaucratic reformers such as private health insurers, hospitals, and government public health agencies assist in the organisation and funding of health care (Alford, 1972). Alford (1972) goes on to say that these organisations become powerful interest groups and as mentioned, he later refers to them as corporate rationalisers who become the major challengers to the power of the doctors in clinical practice, such as GPs. This is, in part, because of their role in the investigation and inquiry into health care. Examples of corporate rationalisers include those working in government health departments who may strive to deliver the agendas of politicians, managers of health services, medical school Deans, and public health doctors (Williamson, 2008). Often referred to as bureaucrats, these corporate rationalisers and managers also have and desire some control over the provision of health care infrastructure such as health insurance and the hospital system as a whole (Alford, 1972; Williamson, 2008).

Equal health advocates

The third type of reformers identified by Alford in his early work are those he termed the equal health advocates who advocate for free, high-quality accessible health care for all people. They advocate for the community as health care consumers who have a vested interest in the quality of health care services and delivery (Alford, 1972). Alford would later call this group ‘the community’ (Alford, 1975; Williamson, 2008).

Despite Alford himself claiming in his 1972 paper that his writings could be seen as a set of “outrageous hypotheses”, this was to be the origins of his 1975 Theory of Structural Interests, developed to illustrate his observations of interactions between doctors, managers/bureaucrats, and consumers in the 1970s within the New York health system. This theory has been used by researchers to analyse health system reform around the world (Checkland et al., 2009a). The basis of his argument was that inherent to the structure of health systems, certain interest groups are automatically privileged. For example, he argued that the success or failure of health reform is premised on the political relationships between various groups who hold an interest in the reform. Alford postulated that these differing interests underpin the tension among groups and can either create a barrier to reform or facilitate it. He surmised that ‘resistance to change’ brought about by the interests of certain individuals and groups was influenced by a ‘dominance of the private sector and of the middle class’ (Checkland et al., 2009a). In other words, his early work led to the development of a structural interest theory based on “interests served or not served by the way they fit into the basic logic and principles by which the institutions of a society operate” (Duckett, 1984, p. 959).

In 1975, Alford published his *Theory of Structural Interests* which was an extension of his earlier work exploring the structure of health services in New York. He postulated that this structure privileged certain groups and facilitated a structural conflict between “managers wishing to rationalise and bureaucratise health services and doctors seeking to maintain and extend their professional monopoly” (Checkland et al., 2009a, p. 607). In his 1975 publication, Alford further defined the three interest groups he had previously proposed: clinicians or professional monopolisers (those who control health resources), funding agencies or corporate rationalisers (those who challenge the power of the clinicians), and patients/the health care consumer (seeking improved health care) (Williamson, 2008). The premise of his structural interest theory was that people usually hold an interest based on the positive or negative effects the reform will have on them or the social group/s to which they belong (Williamson, 2008). He suggested that some clinician groups (professional monopolisers) hold what he terms a “dominant interest”. These groups are determined to secure compliance with their own policies even if it means vetoing others. Alford suggested that this group consists predominantly of clinicians; especially doctors whose interests are usually embedded within current structures which have a propensity to maximise activity and increase efficiency while ensuring a favourable fiscal return (Checkland et al., 2009a).

As identified by Alford, corporate rationalists are people working in government health positions, such as bureaucrats, who follow the wishes of politicians and academics, such as Deans of medical schools or in some instances those associated with private health organisations such as health insurers. This group share some fundamental areas of interest such as control over the work of clinicians, power through auditing, and the cost-effective use of resources (Williamson, 2008). Checkland et al. (2009a) suggest that there is a sub-group within the corporate rationalisers they term “professional rationalisers” (usually doctors), whose interests are primarily driven by their desire for appropriate resource allocation which again, can be a barrier to successful reform.

The third category proposed by Alford is the group of people he refers to as having ‘repressed interests’; the community and more specifically, patients. This group also consists of patient advocates and representatives such as family members, and those who represent the community in terms of policy and decision-making. Alford argues that patient interests are often repressed because the patient may not be aware of certain policies and practices or their influences (Williamson, 2008). In addition, Alford postulated that this group is often poorly represented with major policy decisions being made with little or no input from them. Although the situation of consumer involvement has improved in the 21st century with the inclusion of more community/patient representatives participating in advisory committees and exerting some influence over policy decisions (Baggott et al., 2004), it is not clear if they are aware of how their interests are met given the often limited amount of information provided to them. Alford proposed that this lack or restriction of information denies them equality and therefore they become repressed. This can be further complicated when a number of interest groups choose to withhold information so that their own interests can be met.

According to Williamson, not telling patients about policies that might affect them is one form of control (Williamson, 2005, 2008).

3.3 Alford’s Structural Interest Theory and Neoliberalism

When analysing Alford’s theory, one cannot escape the notion of the somewhat crude parallels with neoliberalism. According to Baum et al. (2016), it is widely known that the theory of neoliberal economics is centred around the premise that economies are too complex for governments to manage, and therefore, less government interference will result in better outcomes. Neoliberalism in health care has been known to manifest as an increase in private sector operations, the privatisation of elements of the public sector, and cuts to public spending (Baum et al., 2016). As described by Dewey (2017), neoliberalism is an ideology that is so common in our everyday society that it is almost the normal condition of mankind (sic) yet is the cause of many of our social and economic problems. She states:

> *… neoliberal thinkers have used their wealth to create institutions that tilt the ideological perspective of the world towards free market enterprise, a system which rewards the wealthy and penalizes the poor* (Dewey, 2017, para 2.).

Longley (2021, para 1.) stresses that neoliberal economic policies are premised upon two fundamental elements of capitalism: deregulation as the removal of government control, and privatisation as the transfer of the government’s ownership of property or business to the private sector. According to (Kenton et al., 2022), this results in the freedom of individuals from the unwarranted power of the government, which results in greater economic, and therefore, greater perceived social progress for people (Kenton et al., 2022).

General practice is a business and businesses strive to make profit. When asked about their business purpose, general practice staff will acknowledge their quest to promote health and prevent illness and disease. To add to this, general practice, although predominantly private business, is plagued by tensions between providing optimum patient care while ensuring the running of a profitable enterprise. According to Baum et al. (2016), with neoliberal health reform comes uncertainty, increased managerial control, and an increased focus on outputs rather than patient outcomes. One example of this perceived managerial control in Australia was the development of Primary Health Care Organisations such as Medicare Locals, when it was supposed by many that the Federal government was taking control and creating a system less driven by community needs and input, and more structured towards tracking productivity in terms of short-term throughputs (Baum et al., 2016). In their 2019 article, Dawson et al. (2019) make the point that these market-based neoliberal elements impede health reform and the adoption of new models of care by increasing the challenges to reform and contributing to poor staff morale in the process.

The parallels between Alford's Structural Interest Theory and neoliberalism lie in the tensions between government and market value. Neoliberalism can be characterised by the dominance of market-led approaches as seen through the examination of relationships between financially and non-financially focused people and organisations. Alford proposed that GPs fall into the group he calls professional monopolists, who he claimed held dominant interests and power. Many GPs are owners or part-owners in the business of general practice, and businesses work towards profit, yet there can be tensions between profit-making, efficiency, and productivity. Corporate rationalists (as coined by Alford), focus on productivity and efficiency and can be represented by the Federal government. The Federal government's HCH trial within general practice perfectly places neoliberalism at the heart of health reform where we see tensions between various people and organisations competing to assert their interests within an economically focused, yet state-run system.

3.4 A critique of Alford's theory

At its very core, Alford's Structural Interest Theory is based on the premise that the structure of health services inherently favours certain interest groups and that, as a consequence, the challenges to successful health reform are impeded by the power of individuals and groups within this structure (Checkland et al., 2009a).

According to a review of Alford's work (Taylor, 1977), one flaw is that he makes the assumption that the issues faced by one city (New York) would have an influence on the US health system as a whole (or for that matter, other health care systems in other countries). Taylor claims that New York is not typical of all cities and therefore the link is weak (Taylor, 1977). In his 1972 work, Alford introduced the notion of "major interest groups", and then later introduced a conceptual change by referring to "structural interests" which "are served by the way they fit into the basic logic and principles by which the institutions of a society operate" (Alford, 1972, p. 13). He also clarified his definition of an interest group as "the organised action of a group to represent its interests" (Alford, 1972, pp. 13-14). Taylor argues that by making this distinction, Alford emphasises the different tensions between politics and the pluralistic approach (consensus can exist between different political interests) and the Marxist view (based on social conflict, class, and history). According to Taylor (1977) and Flash et al. (1976), Alford attempts to meld the two differences between politically driven people and institutions/groups, giving little relevance to the influence of the reality of the political landscape both at the time and from a historical perspective. Giddens quoted in Taylor, (1977) agrees that the term 'structural interests' is confusing, and although Alford does acknowledge that interests are influenced by social change, his theory is predominantly grounded on the goals and motivations of people and groups rather than on these societal changes. Corporate rationalism is then a consequence of the wants and needs of corporate rationalisers who attempt to assert power over health services; however, Alford falls short of clarifying exactly what these structural interests consist of. According to Taylor (1977), this confusion is exacerbated when the professional monopolist (usually the doctor) can also support the cause of the corporate rationaliser. This is further illustrated by Alford himself when he states that the same individual could potentially fit within the categories of professional monopoliser and corporate rationaliser at different times depending on changes within the political and social environment, adding to the lack of clarity around the various interest groups that Alford proposes (Williamson, 2008).

Williamson agrees with Taylor (1977) and notes that while Alford does acknowledge that some interest holders support the interests of other groups, people are individuals and cannot always be defined as a particular 'type' and can hold and support varying views for a number of reasons (Williamson, 2008). In support of this criticism that Alford's classification of interest groups can cause some confusion, Giddens in Taylor, (1977) claims that Alford's theory illustrates a rather pluralistic approach where people can display seemingly contradictory beliefs and roles; for example, a GP may experience tensions between their role as a doctor and their role in supporting the directions of the general practice, a situation that can either hinder or enhance reform and profits. In addition, Harrison (1999) has shown some skepticism towards Alford's assertion that managers are 'corporate rationalisers', mainly because managers primarily work to maintain their business rather than strive for major change, supporting others' claims that membership within Alford's structural interest groups may not be as straightforward as he proposes.

A critique of Alford's structural interest theory by Kelman in Flash et al. (1976), initially provides a more favourable analysis. Kelman praises the work of Alford in bringing to the attention of academics, issues within the American health system. As mentioned, Alford's theory has been criticised as being too pluralistic, focusing more on organisations and their arrangement, but devoid of recognition of the significance of historical influence (Imershien, 1976). In addition to this, Kelman in Flash et al., (1976) criticises Alford for his perception that organisational structures favour the wealthy and powerful, as well as his assertions that this impedes change and produces a sense of futility. In his 1976 critique of Alford's theory, Kelman describes it as dated, and because Alford's work was confined to the 20 years between 1950-1970, significant historical events that occurred before and after those years placed the USA in a favourable economic position at the time (Flash et al., 1976). Kelman adds that this resulted in Alford's theory being less transferable to other times and contexts (Flash et al., 1976).

There is a plethora of literature critiquing Alford's structural interest theory and its application to health care within a variety of contexts and at varying times. While there is consensus that Alford's theory has merit in broad terms, the specificity of his focus on New York City and its government and policies, as well as the economic climate of the time, means that there has been criticism of its applicability to other contexts (Checkland et al., 2009b; Flash et al., 1976).

3.5 Australia's health care system – a complex division of responsibility

Before discussing the relevance of Alford's theory to this thesis, it is prudent to provide some contextual background on the Australian health care system. This is followed by an overview of general practice in Australia, its organisation, people, and associated governing bodies. According to Bennett (2013), for decades, Australia has grappled with a fragmented health care system, flawed with issues around funding and governance. She acknowledges the challenges of developing a coordinated health system and agrees with MacIntyre (2011) that recent health reform in Australia has been driven by the government's recognition that health care spending has favoured the acute rather than the primary health care sector. Despite this, the acute sector has been overwhelmed for many years; a study by Robinson et al. (2015) found that 32.5 per cent of patients visiting the emergency department (ED) (n=332) over a 48-hour mid-week period were referred by a GP. In addition, almost 50 per cent of ED presentations occurred between the business hours of 9am and 5pm, a statistic supported by Nagree et al. (2013) who illustrate that it is not a lack of GPs that contributes to ED presentations during working hours. Robinson et al. go on to state that the reasons include limited after-hours general practice services, an increase in the number of GPs bulk billing their patients, an ageing population, and associated increases in chronic disease (Fry, 2009; Nagree et al., 2013; C. Robinson et al., 2015). In response to the changing health care needs, Australian health reform has been directed at reducing hospital admissions through a myriad of hospital avoidance strategies (Finlayson et al., 2012). Some of the broader strategies such as the establishment of GP Super Clinics in 2010 and Medicare Locals in 2011, were derived from the National Primary Health Care Strategy of 2010; however, these reforms have not been successful in their remit to reduce the burden on the acute sector by placing increased focus on the primary health sector and interdisciplinary care models. These objectives have been replicated in subsequent versions of this strategy released over a number of years.

According to Allsop and White in Annesley, (2019, p. 496), a policy is:

> *A position or course of action reflecting decisions, intentions and choices made by governments, society or other group that sets out how resources and actions will be prioritised to address areas of concern.*

Health policies in Australia directed at health reform are developed by three tiers of government: Federal, state, and local. The complex division of responsibility spread across all tiers contributes to a system vulnerable to tensions when each has varying levels of interest and input as to how the system functions. The Federal (or national) government funds general practice via the fee-for-service model through the MBS, and also provides some funding to the state government for public hospitals and health promotion services (Fisher et al., 2017). It is also responsible for aged care funding and providing funds for major programs such as the Pharmaceutical Benefit Scheme (PBS) and regulation of health care practitioners via the Australian Health Practitioner Regulation Agency (AHPRA and National Boards) through representation on various committees. The Federal government also provides national direction on health reform (Willis et al., 2016).

State and territory governments assist with the funding and management of public hospitals, some community health and promotion and preventative services such as breast screening and immunisation, as well as regulating, inspecting, and providing licensure to some health premises (Department of Health, 2020b). Local or municipal governments have some role in the delivery of community health services, food safety, and creating and maintaining healthy environmental spaces in the community (Willis et al., 2016).

On 29 May 2020, the Prime Minister of Australia, Scott Morrison, announced that the previous Council of Australian Governments (COAG) was to cease. The COAG was composed of state and territory premiers, the Prime Minister, and the president of the Australian Local Government Association through the Standing Council on Health and numerous committees and was responsible for driving a national health reform agenda (Willis et al., 2016). The Prime Minister announced that the COAG would be replaced by the National Federation Reform Council (NFRC) which comprises the National Cabinet, the Council on Federal Financial Relations, and the Australian Local Government Association. According to a statement from the Department of the Prime Minister and Cabinet, this new arrangement was designed to streamline processes, facilitate communication and collaboration, and improve effectiveness (Australian Government, 2020a). According to Saunders (2020), one failing of COAG was that it was ‘heavily bureaucratised’ having many discussions prepared by layers of intergovernmental ministerial officials. She goes on to say that COAG was a top-down model where the Commonwealth drove the agenda for decisions based on its perception of the issues at hand, lending to compliance by the states and territories based on the fiscal dominance of the Commonwealth, therefore affording them little ownership of outcomes, despite the premise that under COAG, there was a shared responsibility between Federal and state governments for some services under a national agreement (Department of Health, 2020b). The new structure of the NFRC will initially focus on improving Australia’s response to bushfires and the COVID-19 pandemic and will have a focus on jobs and health. Although similar in structure to the COAG, the NFRC will involve two-way reporting between the National Cabinet and the

Council on Federal Financial Relations so that existing agreements between the Commonwealth, states, and territories are reviewed and funding distributed appropriately (Nexus Apac Group, 2020).

Despite what appears to be a reasonably successful and cost-controlled health system by international standards, the recognition of a fragmented health care system based on a complex mix of funding and responsibilities between the state and Federal governments has been acknowledged for decades (Hall, 2015; Kearney, 2010). Coupled with this has been criticism of the system that encompasses many barriers to care coordination, especially for those with complex and chronic conditions. These barriers include a fee-for-service payment system that does not afford the necessary time to facilitate integrated care, a lack of patient-centred care, poor communication between health care providers, and a convoluted and complex system for patients to navigate (Berenson & Horvath, 2003; Kearney, 2010).

3.6 The general practice environment, organisation, people, and governing bodies

According to Wood et al. (2016b), successful research in general practice requires knowledge and understanding of the complexity of how it is organised, the roles of the people within it, and the characteristics of its uniqueness. Until the 1990s, general practice in Australia consisted almost entirely of small independent practices made up of sole practitioners or those working with associates and partners, many of which still operate today (Reddy, 2017).

The evolution of the general practice environment over many years has been dependent upon the health needs of the population, but also on the professional standards set by the RACGP. Prior to the 1970s, general practices in Australia rarely had a nurse or a practice manager. It was not until the 1990s that practices moved from paper-based records and adopted electronic record-keeping, mainly due to Commonwealth incentive grants to do so (Harris & Zwar, 2014). As a private business, over 90 per cent of income in general practice is generated from fee-for-service arrangements, while other funds are generated by government incentive initiatives and patient co-payments. Bulk billing is common in Australian general practice. This means that there is no out-of-pocket cost for the patient as Medicare covers the entire cost of the general practice consultation. The MBS contains over 6,000 different items related to services which determine how much Medicare will pay for a particular service; this is known as the scheduled fee (Willis et al., 2016). Private service providers such as GPs can choose how much they charge a patient and whether or not they charge over the scheduled fee. If they do charge over the scheduled fee, the patient is required to pay a gap fee (the difference between what the GP charges and the Medicare benefit/scheduled fee).

Some GPs have a policy in place where they automatically bulk bill certain groups such as children under 16, people over 65, and those holding either a government health care card or a seniors' card. According to the Department of Health, 86.1 per cent of services provided by GPs in Australia were bulk billed in 2017-2018 (Department of Health, 2020a). In contrast, the RACGP has this figure at 23 per cent, citing the average out-of-pocket cost for a '20-minute level B' consultation as $37 in 2018, and claiming that this was likely to increase (Hendrie, 2019a). This issue is likely to contribute to an increase in hospital emergency department presentations (C. Robinson et al., 2015).

With an increase in chronic conditions and a focus on hospital avoidance, the fee-for-service funding model, while an effective reimbursement scheme, has been criticised as an inappropriate model to address those with complex and chronic conditions. Effective primary health care can reduce ED burden through the efficient management of older people suffering from chronic and complex conditions, yet only a third of general practice patients eligible for Medicare rebated chronic disease care plans receive one (Turner et al., 2018). There has been increasing emphasis on the need for a collaborative multidisciplinary approach to chronic disease and the fee-for-service model has been prohibitive to this (Harris & Zwar, 2014; McInnes et al., 2017a). As highlighted in chapter 1, a raft of policy initiatives with various funding models have attempted to address the ongoing health needs of this cohort, of which the Health Care Homes initiative is one of the most recent. In addition to these initiatives, the past two decades has seen the emergence of corporate groupings of general practices as a distinctive business model of primary health care delivery. This involves the purchase of general practices by investment corporations. These are usually larger practices, sometimes called clinics, with a propensity for a strict business model to keep costs at a minimum and to maximise revenue, as noted:

> *Corporatisation of general practice has the potential to deliver reduced cost of care through economies of scale; increased patient convenience via medical service access within a central location and financial security and improved working hours for doctors* (Department of Health, 2012b).

Economies of scale refers in part to cost savings from the sharing of both human and material resources. The administrative functions of running a general practice are significant, and by having a number of GPs working in one location concentrating only on medical care (devoid of any business duties), the revenue can be maximised as overall running costs are reduced (Erney-Albrecht & Bywood, 2016). For some patients, visiting a corporate practice has meant a less convoluted care journey by having a number of services offered in the one space such as pathology and radiology (White, 2000b).

Understanding the driving forces behind the business of corporate general practices requires them to be viewed through a number of different lenses. Economists will favour market efficiency and comparative advantage, and this is why it is generally assumed that economists are proponents of privatisation and fiscal austerity, and thus, neoliberalism. While there are many arguments for the pros and cons of neoliberalism in certain contexts, Rodrik (2017) points out that contemporary discussion of policy is often grounded on the theory of ‘homo economicus’, which supports the notion that it is a perfectly normal human trait to always pursue one’s own interests. According to Sakellariou and Rotarou (2017), neoliberal health policies have been detrimental to the health of individuals and created a situation where economic gain has effectively disempowered people, making them subordinate to the market and exposed to fluctuating out-of-pocket costs.

For some GPs, working in a corporate practice has led to feelings of being an agent of a corporation whose main concern is profit (Reddy, 2017). As White (2000b) notes, the motivation of GPs is not profit in and of itself, in contrast to the motivation of a health business being profit. He goes on to say that services provided to those with chronic conditions, the poor, Indigenous peoples, and those of non-English speaking backgrounds are often time-consuming and complex, and in monetary terms, this does not serve their business well. Issues of equity and access are often overlooked as corporate practices are situated in city and inner-city areas, luring GPs to greater remuneration, leaving a smaller labour force to work in areas where remuneration is lower, such as some rural practices and those in poorer areas (White, 2000c).

Many corporate practices use the fee-for-service funding model, although it can be said that both private and corporate practices are businesses, and both are intent on maximising financial gain (Erney-Albrecht & Bywood, 2016). There have been reports of over-servicing in terms of the generation of computerised care plans and their associated MBS generated funds, (whether intentional or in error), especially for those with chronic and complex conditions, and there has been some suggestion that the generic computerised care plan templates facilitate this (Erney-Albrecht & Bywood, 2016).

This corporate investment in the health care market presents a number of issues that align with Alford's Structural Interest Theory. For example, in terms of the patient, the health care market does not enable a person to 'shop around', a sort of trial-and-error situation when dealing with their health. This is especially pertinent in rural locations where choice of services is limited. Secondly, health is important and people will often pay what is needed or what they have been asked to pay, and it is the doctor who tells the patient what services they need to purchase, a view promoted by Roberts and Bogue (1975). The reality is that unless a patient has an understanding and awareness of what constitutes good medical specialist care or where to find that care, it is usually the GP who chooses which specialist to refer them to.

The basic model upon which markets operate is supply and demand. For example, buyers know what they want and pay the sellers what they believe the item to be worth. The market price is what the buyer pays directly to the seller. Yet, this is not straightforward in the health care market. For example, a patient without medical knowledge may not know what health care they need or indeed what the cost should be, which culminates in an inability to adequately evaluate its effectiveness both from a clinical and fiscal standpoint. Another notable difference with the health care market is that health care providers are usually paid by other parties, such as the government or health insurers. These points illustrate some of the fundamental deviations from a true market economy, yet health care is perhaps the most important service that an individual requires. With the health care ‘market’ prone to the influences of many external parties, the propensity for failure is high. Government policy may attempt to correct any failures, and this is seen through the many attempts at health care reform and associated policy initiatives, of which Health Care Homes is one.

In addition to private and corporate general practices, there are a small number of government not-for-profit general practices where services are provided to the community and any profits made, directed at improving these services. A not-for-profit organisation operates so that its members do not benefit from any profit raised by the business; instead, this profit is re-invested into the business for improvement. With changing funding models associated with many private and corporate general practices, not-for-profit practices have needed to find new ways to be competitive from both a care and fiscal perspective. It is usual for a not-for-profit practice to consist of a Chief Executive Officer (CEO) and a number of directors who make up ‘the board’. This board will meet to plan how best to carry out the organisation’s mission. It is not uncommon for the CEO or board members to also be GPs within the organisation. Some practices may have contractual arrangements linked to funding, and it is part of the responsibility of the board to ensure that financial reports are presented to these funding bodies whether they be governmental or otherwise. The board will monitor the organisation’s performance and ensure that governing principles are adhered to (Australian Institute of Company Directors, 2017).

3.7 The general practice team

The general practitioner

A doctor working within the general practice environment is known as a GP. According to the RACGP (Royal Australian College of General Practitioners, 2020d), GPs relieve illness in all its forms and, as coordinator of their clinical team, promote accessible and flexible integrated care. They go on to say that in Australia, a GP:

> *… is most likely the first point of contact in matters of personal health, they:*

- *coordinate the care of patients and refers them to other specialists*
- *cares for patients in a whole of person approach and in the context of their work, family and community*
- *cares for patients of all ages, both sexes, children and adults across all disease categories*
- *cares for patients over a period of their lifetime and provides advice and education on health care*
- *performs legal processes such as certification of documents or provision of reports in relation to motor transport or work accidents*

(Royal Australian College of General Practitioners, 2020d).

The dominant structural interest group identified by Alford is known to consist of people and groups he termed ‘professional monopolists’. This group consists of doctors. It is acknowledged that while the premise of the work of GPs aligns with the dot points identified above, their work is influenced by the context in which they work. Some of these influences include the health needs of visiting patients, the number of associated allied health professionals, the business model of the practice, and a variety of government policies and initiatives. The role of some of these other players is outlined below.

The practice manager

The trend towards the development of larger general practices with more multidisciplinary care providers has contributed to an increase in demand for the practice manager (Wood et al., 2016b). Practice managers (PMs) are responsible for the day-to-day management of staff and operation of the general practice. Their roles will vary depending on the make-up of the practice and associated care provision. Practice managers are often involved with improving the overall operations of the practice, including financial profits. Having experience or qualifications in management and business are desirable attributes of a PM, especially in large corporate practices (Wood et al., 2016b). Smaller practices with only one or two GPs might have a PM who acts as the receptionist, or in some solo GP practices, the PM may be the PN as well. Despite their overall management role, it is the GPs (usually the practice principle) who hold the overall management of the practice. According to Wood (2016b), there still appears to be some confusion as to whether it is the PM or the GP who ‘manages’ the PN. Nevertheless, there has been an increased reliance on the PM to manage fiscal duties, and thus, the flexibility of bundle payments through HCH, while also managing other fee-for-service systems related to non-HCH patients.

Other general practice staff

As promoted by the Australian Government, HCH patients will have the benefit of a team of health care professionals through an integrated team-based approach to their care, facilitated by a shared electronic care plan (Department of Health, 2018b).

> *A team-based model of care strives to meet patient needs and preferences by actively engaging patients as full participants in their care, while encouraging all health care professionals to function to the full extent of their education, certification, and experience* (Heath, 2019).

The HCH health care team may include the GP, PN, pharmacist, medical assistant, podiatrist, physiotherapist, and specialist as well as non-clinical team members such as the PM and reception staff. Benefits to a successful team include co-location of the team, strong leadership, open communication, and mutual respect (Smith et al., 2018). It is also imperative to success that all members of this team, including the patient, have access to the electronic shared care plan. Of significance is the transformation of the general practice landscape since the development of Alford’s theory. Today, the care of people attending general practice is facilitated by a number of allied health professionals, something that was not considered by Alford.

The consumer

When evaluating the availability of required services, there is a need for greater engagement of consumers, and also the reporting of clinical outcomes so they can make informed choices about their care (Dixit & Sambasivan, 2018). According to Reynolds et al. (2018), education to empower the patient in their own disease management is crucial to successful primary care.

In Alford’s 1975 theory, he identified patients as belonging to the repressed group who held little power compared to the dominant interests held by the medical profession, and challenging structural interests held by medical administrators (Peckham & Willmott, 2011). Peckham and Willmott (2011) go on to say that Alford felt that this group was repressed because of a lack of opportunity to engage brought about by the absence of any mechanisms to do so. At the time that Alford wrote his theory, this may have been the case; however, since then, there have been attempts to address this. In Australia today, the Australian Commission on Safety and Quality in Health Care has developed tools to assist consumers to engage with health care providers, share their experiences, and be involved in decision-making about their care (Australian Commission on Safety and Quality in Health Care, n.d.-a).

3.8 Governing bodies

Aligning with Alford's Structural Interest Theory, the following section provides an overview of the governing bodies associated with the various health professionals discussed in this thesis.

The Royal Australian College of General Practitioners (RACGP)

The Royal Australian College of General Practitioners was established in 1958 with the intention of reinforcing the role of the GP within the health system and ensuring its continuing presence (White, 2000a). Today the RACGP represents over 40,000 members and according to their website, their principal mission is to support GPs, general practice registrars, and medical students with education, training, and research. They do this by providing ongoing professional development with accompanying resources and also through assessing the skills and knowledge of doctors. In 1989, the RACGP developed a vocational register (Dierick-vanDaele et al.) for GPs who agreed to undertake additional training by the RACGP and to take part in quality assurance activities, such as surveillance of general practice activities. GPs who enrolled on the register would be entitled to use a new set of content-based descriptors that would entitle them to higher Medicare fees and benefits (Willis, 2006). The VR and the conditions adhered to it were strongly opposed by the AMA and the arrangement was withdrawn in 1988 (Willis, 2006). Today, the quality of care provided by general practice is measured and based upon standards developed by the RACGP (Royal Australian College of General Practitioners, 2020c). These standards are the benchmark used to accredit general practices. Australian General Practice Accreditation Limited (AGPAL) is one of the not-for-profit organisations providing accreditation to general practices. Approximately 80 per cent of Australian general practices are accredited today, in part because of the financial incentives associated with accreditation (Australian Government, 2020d; Debono et al., 2017). The Practice Incentives Program (McDonald, Harris, et al., 2008) run by the Australian Federal government provides funding to general practices to support improved patient outcomes for activities such as teaching, e-Health, after hours care, Indigenous health, and others (Australian Government, 2020c; Debono et al., 2017). In order to receive the PIP incentives, practices must:

- *be a general practice as defined by the Royal Australian College of General Practitioners (RACGP)*
- *be an open practice as defined by the PIP*
- *be accredited, or registered for accreditation against the RACGP Standards for general practices*
- *maintain at least $10 million in public liability insurance cover*
- *have professional indemnity insurance cover for all GPs and nurse practitioners*

Today, the RACGP consists of a board of directors responsible for its governance. This board consists almost entirely of GPs from various regions across Australia. The RACGP has an office in each of the states and territories of Australia, employs over 350 staff, and engages approximately 1,800 GPs in at least one of their activities (Royal Australian College of General Practitioners, 2020c). In 2020, the annual membership cost to the RACGP ranged from $1,445 for GPs working 20 hours or more a week to $80 for medical students (Royal Australian College of General Practitioners, 2020b).

The Australian Medical Association (AMA)

The Australian Medical Association (AMA) is a member-run organisation that supports the interests of medical doctors and medical students. According to their website, the AMA works with governments to develop and influence health policy for the benefit of themselves, patients, and the community (Australian Medical Association, 2021).

Formed in 1962, the AMA was an amalgamation of the Australian branches of the British Medical Association, and in 2016, around 30 per cent of the medical profession were members (Duckett, 2016a).

As an organisation, the AMA has a tradition of opposing a number of government reforms. One example was the introduction of Medibank and later Medicare which was strongly opposed by the AMA, along with some other medical professions and private health funds. The AMA argued that Medicare was a ‘socialist takeover’ which would restrict their incomes (Russell, 2015). Despite this particular opposition occurring decades ago, there are lingering suspicions between the AMA and the government that remain present today. In 2016, the AMA vice-president, Dr Bartone, expressed the following position in relation to the HCH trial: “The modelling is concerning and potentially leaves the whole program at risk of falling over because of being underfunded from the beginning” (Australian Medical Association, 2016b). The AMA has also been seen to lobby the government to take more action on a number of issues such as equity and access of health care for all consumers, domestic violence, and climate change. Despite this, the AMA has generally opposed Medicare reforms and its support for bulk billing has been mediocre despite speaking out against out-of-pocket expenses for patients (Russell, 2015). When other interest groups have proposed changes to existing practices, the AMA has largely been defensive when challenging these reforms, something identified by Alford when he wrote that when interests serve those of dominant groups, challenge must come from somewhere (Alford, 1972).

The Australian Nursing and Midwifery Federation (ANMF)

The Australian Nursing and Midwifery Federation is Australia’s largest union and professional organisation offering support and education for nurses, midwives, and carers (Australian Nursing and Midwifery Federation, 2020). According to their website, the Federation represents the political, industrial, and professional interests of over 290,000 members across Australia (Australian Nursing and Midwifery Federation, 2020). In 2018, the newly appointed ANMF secretary, Annie Butler, was quoted as saying:

> *The political landscape changes frequently but the collective capacity of the ANMF is equipped to confront and deal with current and emerging challenges facing our professions* (Australian Nursing and Midwifery Federation, 2018, np).

The ANMF has also released national standards for nurses working in a variety of contexts. Standards for nurses working within general practice were released in 2014 and serve in part to communicate the scope of practice of nurses working within general practice. They also act as a benchmark for educational purposes and are often used as a benchmark for assessing the nurse within their field of work.

3.9 The Australian Health Practitioner Regulation Agency (AHPRA) and National Boards)

The Australian Health Practitioner Regulation Agency (AHPRA) provides advice on policies to the national boards on standards of care, codes, and standards of practice. In addition, AHPRA ensures that practitioners have the necessary skills to practice in their chosen field. The Agency processes annual registration for most health professions, including those from overseas as well as students, monitors and deals with complaints and concerns regarding health professionals, and works with accreditation providers to ensure students enter the workforce as registered professionals with appropriate knowledge and training (AHPRA and National Boards, 2021). The Nursing and Midwifery Board of Australia (NMBA) works closely with AHPRA to develop standards, codes, and guidelines for practice, ensure nurses are registered to practice, approve accreditation standards, and ensure overseas nurses and students are adequately prepared to register in Australia.

Similarly, AHPRA works closely with the Medical Board of Australia to carry out duties and tasks mentioned above that relate to the medical profession. In essence, AHPRA works with relevant health profession boards to protect the public from adverse care resulting from incompetent, unprofessional, and inappropriately trained health professionals.

3.10 The Australian Primary Health Nurses Association (APNA)

The Australian Primary Health Care Nurses Association is the peak national body and professional membership association for nurses working in primary health care (Australian Primary Health Care Nurses Association, 2022b). This association supports nurses through education programs, conferences, and newsletters to work with nurses and promote their role (Australian Primary Health Care Nurses Association, 2022b; Biggs, 2018).

The following chapter provides an illustration of the process and findings of a systematic literature review aimed at ascertaining the barriers and facilitators to the role of the PN in Canada, New Zealand, and the United Kingdom when assisting people to manage their chronic conditions. This international perspective provides meaning to the role of the PN within the HCH initiative by way of comparison with countries sharing a similar economic climate and similar demographics.

Chapter 4: Systematic Literature Review – facilitators and barriers to the role of the practice nurse in Canada, New Zealand, and the United Kingdom

4.1 Introduction

This chapter provides the reader with the process applied to, and findings from, a systematic literature review undertaken to determine the role of Practice Nurses (PNs) working in general practice settings in Canada, New Zealand, and the United Kingdom when caring for people with chronic disease/s. These high-income, English-speaking countries share similar population demographics to Australia, and therefore, people with similar needs in relation to chronic disease management (CDM). In addition, nurses working within primary health care practices within these countries hold similar qualifications to those working within Australian general practice. This literature review has been published in the September 2022 edition of the Australian College of Nursing Journal 'Collegian' and identifies similarities between these countries while exploring comparisons and considering the role of the nurse, policy sharing, and health reform. It should be noted that an exploration of the role of PNs working in family care in the United States of America (USA) is not included in this review as their expanded role equates more closely to the nurse practitioner role rather than the PN role.

The second part of this chapter provides an overview of Health Care Homes variants in New Zealand, (NZ), the United Kingdom, (UK), and Canada, to illuminate where chronic disease management policy-sharing specific to this initiative has occurred. Because the Health Care Home initiative was developed from a number of 'Medical Home' models in the USA designed to facilitate the integration of care for people with chronic diseases (Robert Graham Centre, 2007), the USA is included in this section. The conclusion summarises the impact of funding and policy on the role of the PN in the selected countries and provides a discussion of the associated implications for practice.

4.2 Background

Over the past few decades, an increase in life expectancy has led to greater demand for primary health care services in high income countries (Afzali et al., 2014). The impetus for this has been the increase in chronic disease, which according to the World Health Organization (WHO), accounts for the greatest number of deaths across every region and socioeconomic group (World Health Organization, 2018). In 2017, the incidence of chronic conditions worldwide increased dramatically, with conditions such as cancer, diabetes, and respiratory and cardiovascular diseases accounting for almost 70 per cent of global deaths (Prados-Torres et al., 2018).

Policymakers in many countries have attempted to respond to the increased prevalence of chronic disease by strengthening primary care and providing high quality equitable and accessible care (Maier et al., 2018). A desire for a more integrated collaborative approach to primary care in general practice has prompted initiatives which explore a variety of funding models and a move away from traditional fee-for-service systems (Norful et al., 2017). For example, according to Kuluski et al. (2017), primary care reforms in developed countries such as New Zealand and Canada have moved towards a team-based approach and to mixed funding models that include capitation as well as more sophisticated electronic health records to ensure integration of care (Kuluski et al., 2017).

Chronic condition self-management is a core activity of PNs (van Hooft et al., 2016). Nurse-led interventions for chronic condition management such as health teaching and counselling have reduced the impact of behavioural and lifestyle risk factors and lessened disease progression (Nolte et al., 2014; Stephen et al., 2017). However, to date, there has been very limited research on the role of the nurse in response to various policy reforms aimed at assisting general practice to manage chronic disease. Much of the research has been directed at the patient and physician response. According to Maier et al. (2018), barriers to the role of the general PN are mirrored in several high-income countries. This review highlights some of these barriers as well as facilitators to the PN role when managing chronic disease in NZ, Canada, and the UK.

The rationale for selecting these three countries arises from the similarities in the role of the nurse and in policy sharing between the three jurisdictions. Papers from Australia were not included as the purpose of this review was to gain insight into the impact that policy changes in these countries might have on CDM for the Australian PN.

While it is acknowledged that there are some differences, nurses working with general practitioners (GPs) in a general practice/family practice in the UK and NZ have the title of PN. In Canada, these Registered Nurses (RNs) hold a college diploma or university degree and are referred to as primary care nurses or family PNs (Baxter et al., 2013). Each province in Canada has its own regulatory body and assessment process (National Nursing Assessment Service, 2022). As Lukewich et al. (2018) explain, RNs in Canada can care for people with complex health issues in a variety of contexts and have a wider scope than Registered Practical Nurses (RPN), who generally care for the more stable patient with predictable conditions. In New Zealand, nurses must complete an approved undergraduate program and be registered with the Nursing Council of New Zealand which allows them to work independently or with a group of health professionals to develop and implement a plan of care within a variety of settings (Ministry of Health, 2019). Following an undergraduate university course of three to four years, the RN in the United Kingdom has a similar scope of practice and must register with the Nursing and Midwifery Council of the UK (Nursing and Midwifery Council, 2022). When referring to the RN working within general practice in each of the three mentioned countries, the term PN will be used. While nurse practitioners also work in general practice within each of these three countries, this review does not include their role given their extended training and associated expanded role and scope of practice.

There has been significant sharing of strategies to address chronic disease between these three countries (Finlayson et al., 2012; Nolte et al., 2014). The replication of policies across countries occurs when one country adopts or modifies ideas from another. This has occurred between Canada, the UK, and NZ (Gauld, 2014; Tenbensel et al., 2017). Whenever a new policy initiative is implemented, an opportunity exists to explore the impact this has on the role and scope of health professionals, including PNs working within primary care alongside GPs.

Despite the commonality of universal health care, health systems in these countries vary, with the UK having a national health service Willis et al. (2016), Canada, a regionally administered universal insurance program Hutchison et al. (2011), and NZ, a public health care system with government funds devolved to regional health boards (Goodyear-Smith & Ashton, 2019). However, all three countries promote universal access to primary care, and have identified the need to address increasing levels of chronic disease and health inequalities, and to strengthen the primary health care sector through cost-effective, team-based care (Doolan-Noble et al., 2015; Kennedy et al., 2014; Poitras et al., 2018). These countries also share populations with similar demographic characteristics and similar burdens of illness (Papanicolas et al., 2018).

The work of the PN is influenced by a myriad of factors including the patient population, their education and training, funding arrangements, the management structure within the practice, the general practice team, and policy initiatives. To date, there has been very limited research on the role of the PN in response to policy reform when managing chronic disease. Much of the research has been directed at the patient and physician response. According to Maier et al. (2018), the consequences for the role of the PN should be explored in relation to the impact that policies and financial incentives have made. The objective of this systematic literature review is to explore the research literature to determine the various roles of nurses working in general practice settings in Canada, NZ, and the UK when caring for people with chronic disease/s. The review uses meta-synthesis to formulate key themes, and the barriers and enablers related to the role of the PN within the identified countries and settings. This illuminates any impact on the PN role as a consequence of policy reform and shared models of care.

4.2 Literature review

Methods

An initial search was undertaken to identify the facilitators and barriers to the role of the PN in NZ, Canada, and the UK when addressing chronic disease. Consultation with a research librarian assisted in identification of the following search terms and databases: nurs*: chronic disease: management: policy: government: general practice: intervention: The role of the Practice Nurse in NZ, Canada, and the UK when managing chronic disease 4 community: primary health care: UK OR NZ OR Canada.

Electronic databases: Scopus, Web of Science, Cumulative Index to Nursing and Allied Health Literature (CINAHL), and MEDLINE were searched.

The following example from the Scopus database illustrates the search terms used and how they were combined:

> (TITLE-ABS-KEY(policy OR policies OR "policy reform" OR fiscal) OR TITLE-ABS-KEY(policy OR policies OR "policy reform" OR "fiscal polic*" OR government* OR governance OR "government reform") AND TITLE-ABS-KEY(health W/3 (reform* OR alter* OR change* OR adjust* OR adapt* OR change)) AND TITLE-ABS-KEY(nurs* W/3(practice* OR role* OR practition* OR general*)) AND TITLE-ABSKEY(care* W/3(primary OR "enhanced primary" OR community OR nurs* OR health OR patient OR management OR plan*)) OR TITLE-ABS-KEY("chronic disease" W/3 (manage* OR intervention* OR care OR caring)) AND TITLE-ABS-KEY(canada OR "United Kingdom" OR uk OR "New Zealand" OR nz))

Articles were screened via titles, abstracts, and full text against the inclusion criteria and appraised for methodological quality. A table representing the inclusion and exclusion criteria can be found below:

Table 4.1: Inclusion and exclusion criteria

Inclusion Criteria	**Exclusion Criteria**
Articles written in English	Articles not written in English
Articles published from 2007 to 2020 inclusive	Articles published before 2007
New Zealand OR Canada OR The United Kingdom	Other countries
Case control studies, analytical cross-sectional studies, qualitative studies including semi-structured interviews and questionnaires were all considered	Government reports
Practice nurses	Nurse practitioner, community nurse, medical assistant, GP (without the PN)
General Practice, family practice	Community health organisations
Chronic disease, long-term illness management/care	Acute care
Peer reviewed articles	Articles that were not peer reviewed

To assist in capturing all relevant studies, two reviewers independently screened the databases using the identified search terms. Following this, the reference lists of all studies selected for critical appraisal were screened for additional papers. Nine articles met the criteria for inclusion. All papers were in English and published between 2007 and 2021. The year 2007 was selected as this was when the major primary care physician associations in the USA developed and endorsed the principles of the Patient Centered Medical Home model (American Academy of Family Physicians, 2020). This model uses integrated and coordinated care that is deemed to be person- centred and driven by a practice-wide, team approach (Epperly, 2011). Variants of this policy were incorporated into primary care in NZ, Canada, the UK, and Australia. The assumption behind this policy initiative is that the role of the PN would be enhanced across the three designated jurisdictions, and evaluation research would identify possible barriers and facilitators to the role of the PN.

Critical appraisal

The Critical Appraisal Skills Programme (CASP) qualitative checklist was used to facilitate a structured approach to determine the quality and validity of the retrieved articles (Critical Appraisal Skills Programme, 2021). The CASP tool and associated key criteria was consistently applied to all retrieved articles. The checklist used can be found in Appendix A. As many of the articles were qualitative, the quality of the research was also assessed using criteria developed by (Popay et al., 1998). They argue that quality in qualitative research is associated with the incorporation of lay perspectives; purposeful sampling; contextualisation of data; reflection of the meanings given to actions; thick description and interpretation of data; and triangulation of data. The quality of the retrieved articles varied, but all used purposeful sampling and contextualised findings, factors which address the research question.

The methodological process identified above is represented in the Preferred Reporting Items for Systematic Reviews and Meta-analyses (PRISMA) diagram shown below:

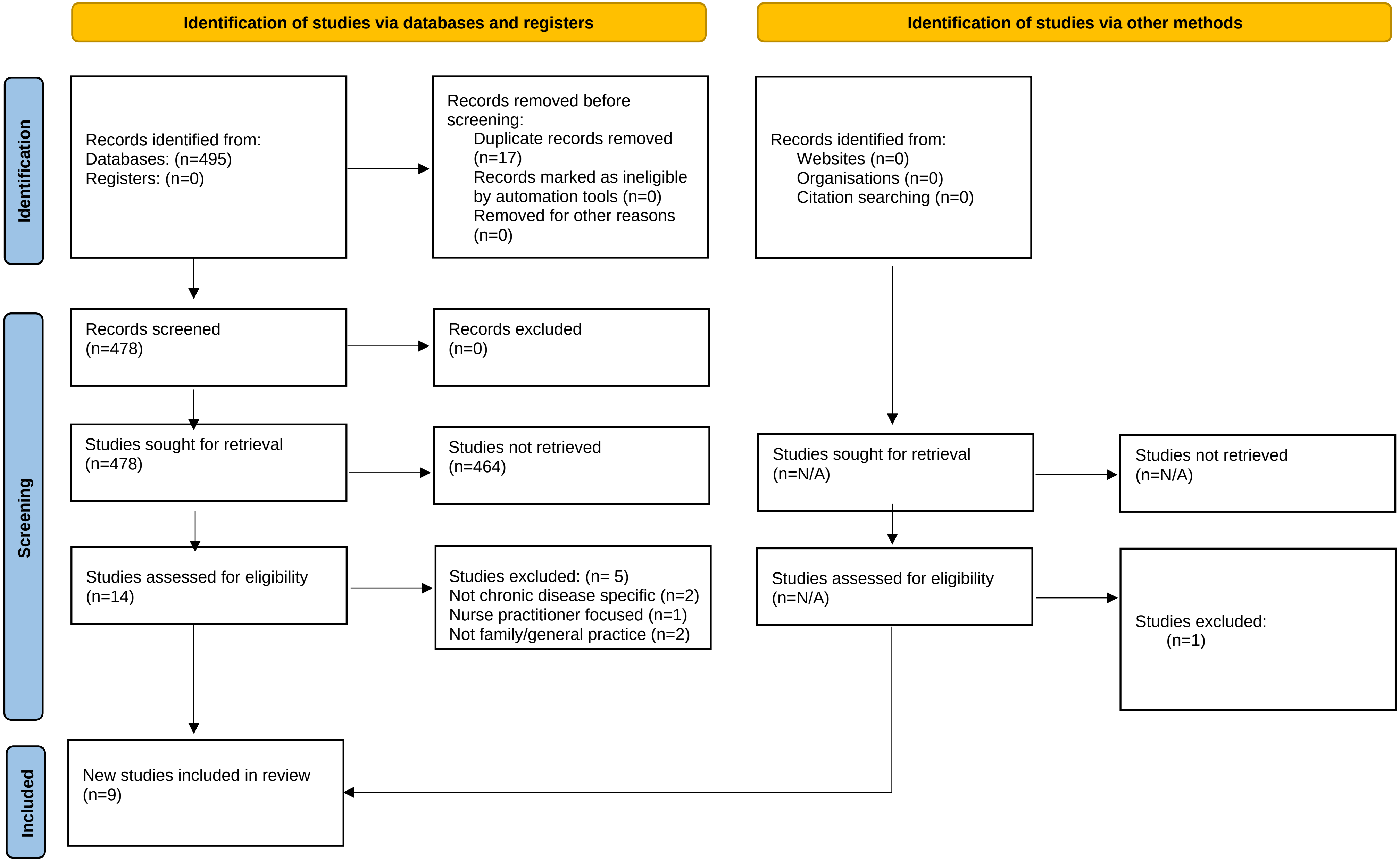
Identification of studies via databases and registers
Identification of studies via other methods
Identification
Screening
Included
Records identified from:
Databases: (n=495)
Registers: (n=0)
Records removed before screening:
Duplicate records removed (n=17)
Records marked as ineligible by automation tools (n=0)
Removed for other reasons (n=0)
Records identified from:
Websites (n=0)
Organisations (n=0)
Citation searching (n=0)
Records screened
(n=478)
Records excluded
(n=0)
Studies sought for retrieval
(n=478)
Studies not retrieved
(n=464)
Studies sought for retrieval
(n=N/A)
Studies not retrieved
(n=N/A)
Studies assessed for eligibility
(n=14)
Studies excluded: (n= 5)
Not chronic disease specific (n=2)
Nurse practitioner focused (n=1)
Not family/general practice (n=2)
Studies assessed for eligibility
(n=N/A)
Studies excluded:
(n=1)
New studies included in review
(n=9)

Figure 4.1 : PRISMA diagram source: (Haddaway et al., 2021).

Using the step-by-step guide to thematic analysis by Braun and Clarke (2006) assisted in identifying, analysing, and interpreting important aspects of the data related to the research question.

Results

A total of nine articles were included in the final review, with three from each of the selected countries, NZ, Canada, and the UK. Four articles reported using PN surveys, four used interviews, and one detailed the PN's role from the research and development of a long-term condition program at a large practice in NZ. All the retrieved articles discussed strategies to assist adults with managing chronic disease and were devoid of any reference to children. The data extraction table below highlights the study characteristics and findings from the selected articles.

Table 4.2: Data extraction table

Reference	**Country**	**Aim**	**Setting and population**	**Methods and Methodology**	**Interventions and key findings**
Lukewich, J., Edge, D., VanDenKerkhof, E., Williamson, T., Tranmer, J. (2014)	Canada	To determine the roles of nurses working in primary care settings in Ontario and the extent to which chronic disease management strategies have been implemented	May-July 2011 1,911 surveys sent, 359 returned. (18.8% response rate)	Cross-sectional survey and questionnaire, followed by a reminder letter two weeks after initial invitation	• Nurses reported whether they had a clear role description that identified their scope of practice. Nurses outlined their CDM activities and strategies • Screening not uniformly done. Scope of practice and role descriptions need clarification
Reference	**Country**	**Aim**	**Setting and population**	**Methods and Methodology**	**Interventions and key findings**
Poitras, M., Chouinard, M., Fortin, M., Girard, A., Crossman, S., Gallagher, F. (2018)	Canada	To describe the chronic disease management activities performed by nurses within	Ten nurses working within five FMGs in Quebec	Multiple case-study methodology considered interpretive	• Nurse/patient encounters were observed, and a data collection grid was used to mark nursing activities and contextual influences • Unstructured field notes were also taken • Nurses and patients were interviewed separately

		Family Medicine Groups. To describe the influences of context on the nurses' ability to provide this care		Semi structured interviews with ten nurses and ten patients Twenty nursing notes (charts) along with documents describing nursing practice in the FMGs were reviewed	• Nursing activities were classified into four groups: global assessment of the patient, care management, health promotion, and nurse-physician collaboration • Organisational elements were considered the most important influence by nurses in this study • Leadership was considered the most important attribute for nurses, in terms of them explaining to doctors and patients what they can do • Lack of time, education, and experience Within family medicine groups, the nurse's role differed
Reference	**Country**	**Aim**	**Setting and population**	**Methods and Methodology**	**Interventions and key findings**
Lukewich, J., Edge, D., VanDenKerkhof, E., Williamson, T., Tranmer, J. (2018)	Canada	To understand organisational attributes of PHC teams, specifically nursing roles and strategies to support CDM	13 PHC practice location sites in eastern Ontario, including FHT (9), CHC (3), and 1 NP led clinic. 34	Cross-sectional survey Looked at distribution of healthcare provider NPs, RPNs, and RNs (June/November 2014)	• Most nurses delivered care within clinical practice guidelines • Without support of multi-disciplinary professionals, nurses absorbed other specialised care

			participants invited; 26 participated		- Nurses need to identify their roles in CDM, relationships within CDM teams need to be examined
Reference	**Country**	**Aim**	**Setting and population**	**Methods and Methodology**	**Interventions and key findings**
Daly, B., Kenealy, T., Arroll, B., Sheridan, N., Scragg, R. (2013).	New Zealand	(n=571): 287 phone interview and 284 postal survey	Funding ended, but was retained for new Diabetes Care Improvement Package	Cross-sectional survey Sept 2006-Feb 2008	- Nurses reported an equal division of care between them and GPs in relation to the Get Checked diabetes annual review - Diabetes-specific programme successful in growing capacity of PNs and for collegial PN/GP relationships - This parallels the changes being made in the USA, Canada, the UK, and Australia
Reference	**Country**	**Aim**	**Setting and population**	**Methods and Methodology**	**Interventions and key findings**
Doolan-Noble, F., Gauld, R., Waters, D. (2015)	New Zealand	To compare perception of GPs and PNs, re: CDM	335 GPs and 302 PNs (86 general practices)	Surveys via post.	- Nurses completed a Likert scale to respond to the questions - Nurses completed paper-based questions and returned them via mail - 56% of nurses reported assisting patients to develop care plans

					• Results demonstrated the importance of funded care planning by PNs
Reference	**Country**	**Aim**	**Setting and population**	**Methods and Methodology**	**Interventions and key findings**
Askerud, A., Conder, J. (2016).	New Zealand	A review of the successful long-term condition program in NZ	One large South Island Medical Centre Comm 2009-2013 (lack of funding)	More than 500 patients enrolled, each having a care package. Quarterly 30 min appt with nurse then 15 min with GP	• Multi-D nurse led case management care • A nurse-led financially viable well-funded long-term national program for CDM is needed • Nurse-led care keeps people out of hospital. Nursing roles continually being developed
Reference	**Country**	**Aim**	**Setting and population**	**Methods and Methodology**	**Interventions and key findings**
Macdonald, W., Rogers, A., Blakeman, T., Bower, P. (K. McDonald et al.).	The United Kingdom	Reports a study to explore PN involvement in facilitation of self-management for people with long-term conditions	25 PNs	Semi-structured interviews between 2004-2005	• Nurses reported the need for education to equip them with the necessary techniques to work with complex patients with long-term conditions • CDM clinics, also found in PsychInfo, PNs lacked resources to encourage self-care. Most CDM in GP is done by PNs

					• PNs made assumptions about patients' abilities and tailored care to this PNs need specific education, re: CDM patient self-care
Reference	**Country**	**Aim**	**Setting and population**	**Methods and Methodology**	**Interventions and key findings**
McDonald, R., Rogers, A., Macdonald, W. (2008)	The United Kingdom	Explore the concept of identity threat for nurses working in self-management and patient empowerment	Semi-structured interviews with 25 PNs in Northern England	In-depth semi-structured face-to-face interviews November 2005-June 2006	• Nurses expressed encouraging patients to comply with self-management strategies • PNs expressed having dependence on patients to self-manage to achieve incentive targets • PNs tend to categorise patients which may impede CDM self-management
Reference	**Country**	**Aim**	**Setting and population**	**Methods and Methodology**	**Interventions and key findings**
Kennedy, A., Rogers, A., Bowen, R., Lee, V., Blakeman, T., Gardner, C., Morris, R., Protheroe, J., Chew-Graham, C. (2014)	The United Kingdom	To explore the work of self-management support and explain why the implementation of a systemised	GPs, PNs (11), other practice staff, and 5,599 patients from 12 General Practices in	Face-to-face semi-structured interviews	• Practice staff undertook 3–6-month training in self-management support before interviews took place. A whole-of-practice approach was included; however, the nurses commented on the way they work, citing their work from a task perspective and their associated unwillingness to change

		evidence-based approach failed to engage the nurses tasked with supporting patients to self-manage	Northwest England		• "A randomised controlled trial of an approach to improve the health outcomes of patients with long-term conditions through improving the self-management support they received from primary care showed no effect" (p. 1104).

Data analysis identified six main themes outlining the barriers and facilitators to the PN role when managing chronic disease: PNs working to financial incentives, funding for the self-management role, power differences between the nurse and patient and the nurse and doctor, time constraints, education, and role ambiguity. These themes highlight both barriers and facilitators and will be discussed concurrently.

Financial incentives

Many initiatives brought about to improve the management of care for people with chronic conditions have been linked to financial incentives. These incentives often shape the way that care is provided and how the doctor and/or PN operate. For example, a UK study by Kennedy et al. found that payment systems drive tasks performed and outcomes achieved. Practices were required to demonstrate through clinical information systems and computer templates, the undertaking of specific processes and tasks, such as setting up registers for patients with hypertension and regular recording of blood pressure, which are common activities performed by the PN (Kennedy et al., 2014). In New Zealand, another initiative was Care Plus, a government-funded initiative designed to extend the time for GP and PN consults for people with chronic disease (Doolan-Noble et al., 2015).

Meeting targets often involves setting up and undertaking review appointments with patients. During these appointments, PNs may undertake and record vital signs, blood glucose levels, and lung capacity which often marginalised other non-incentivised work such as self-management support (Macdonald et al., 2008). This means that self-management activities needed to be performed in between other tasks (Kennedy et al., 2014). In turn, PNs may do the work of self-management support, but it is hidden and seen as additional to the more valued work directly associated with clinical outcomes (Kennedy et al., 2014). In Macdonald's UK study, PNs cited a lack of resources such as care plan templates/guidelines to provide self-management, which resulted in them working from intuition and personal experience (Macdonald et al., 2008).

Closely aligned to incentive funding is the issue of how self-management is defined and measured. This gives rise to certain procedures that may or may not enhance the PN role. For example, some UK PNs reported that care plans were a barrier to providing self-management because the directive tick box nature of the process hindered them from using their creativity in finding solutions for the patient. Practice Nurses often found that handing out information while educating patients was the quickest and easiest thing to do, which hindered the two-way therapeutic relationship needed for successful chronic disease management (Kennedy et al., 2014). Another barrier to self-management in Canada was a lack of allied health professionals such as pharmacists, dietitians, psychologists, and physiotherapists to participate in team-based care, leaving PNs to absorb some of the care otherwise provided by these health professionals (Lukewich et al., 2018). Doolan-Noble et al. (2015) also found that the development of a patient care plan did not necessarily demonstrate successful patient outcomes. Some of the barriers to the success of care plans has been a lack of system support in conjunction with a lack of patient and PN engagement driven by the belief that while they attracted a monetary incentive, they were devoid of value and applicability (Doolan-Noble et al., 2015).

Funding for the self-management role

Despite funding being attached to many primary care programs, PNs report that in many instances, there are insufficient funds to provide adequate patient self-management care. In NZ, insufficient funding for care planning for people with chronic conditions was seen as a barrier (Doolan-Noble et al., 2015). Lack of funding was also prohibitive to the continuation of various chronic disease and self-management initiatives when Primary Health Organisation funding was not sustained (Askerund & Conder, 2016). In some cases, this lack of funding was linked to too few resources. Askerund and Conder (2016) note that a lack of information technology, the absence of a national electronic health record, and lack of funding means that initiatives are disbanded because the costs are often too high for a general practice to take on in the long-term. Practice Nurses felt that guidelines within care plans helped them to focus on patient priorities rather than practice priorities (Askerund & Conder, 2016).

In NZ in 2004, as an incentive to enhance long-term care, ‘Care Plus’ funding was established providing additional funds to GPs above capitation funds paid to them by the government (Doolan-Noble et al., 2015). This money was intended to subsidise extended consultations with either a GP or PN, and was seen as a facilitator for collaborative care and self-management strategies to enable shared decision-making

(Doolan-Noble et al., 2015). This was seen as an opportunity for PNs to expand their role and use their skills base more effectively.

Power differentials exist between the practice nurse and patient and the practice nurse and doctor

According to McDonald, Rogers, et al. (2008), relationships between the PN and the patient can be affected when the role of the PN is influenced by tensions between respecting the person’s autonomy and the inherent element of control required to care for them. There emerges a mutual vulnerability where the PN is reliant on the patient to achieve targets and the patient is reliant on the PN for them to do so. According to McDonald, Rogers, et al. (2008), caring relationships involve power differentials, and when a PN knows the whole person, such as their clinical and non-clinical aspects of life, the person is defined as more than just their body. This manifests in a vulnerability for the patient which in turn adds to the power differential when the patient is more ‘exposed’. This may culminate in a barrier to a therapeutic patient/PN relationship.

To achieve targets associated with chronic disease management such as those related to blood pressure or diabetes, PNs are dependent on patients to comply with treatment and lifestyle regimens. Practice Nurses in McDonald, Rogers, et al. (2008) study tended to classify patients as either good or bad depending on their ability to comply with instructions and self-manage; those who did not comply were considered to be ‘bad’ patients.

Some PNs expressed feelings of powerlessness because they needed to rely on the patient’s active participation in the self-management process to achieve these targets (McDonald, Rogers, et al., 2008). They also expressed a dependence on patients returning for follow-up or review and practices being dependent on the PNs to reach targets. A potential barrier to this, however, is an increase in the patient’s confidence and capacity because their dependence on the practice may diminish, thus hampering the ability to reach required targets (McDonald, Rogers, et al., 2008). Any coercion of patients against their will is likely to create discomfort on the part of the PNs since it clashes with respect for patient autonomy which, according to McDonald et al. (2008), explains why PNs “claim to respect the patients right to choose noncompliance” (p. 302). Thus, PNs have a professional dependence on patients to comply, and when they are faced with non-compliant patients, their response is not to understand them, but to increase their attempts to control them (McDonald, Rogers, et al., 2008). As highlighted by McDonald, Rogers, et al. (2008), dominance can lead to damaging consequences for both the PN and the patient. Practice Nurses in the McDonald study did not see any tension between attempts to control patients because they considered their role in chronic disease management as one of caring, noting that some patients were happy to be ‘controlled’ (McDonald, Rogers, et al., 2008). Practice Nurses viewed many patients with chronic conditions as lacking in knowledge and understanding, and themselves as having the status of expert, given that this knowledge is defined within a medical framework which in some ways diminishes lay discourses and ways of knowing (McDonald, Rogers, et al., 2008). Therefore, a tension exists when there is ambiguity created by a system that requires PNs to both control patients and respect their autonomy at the same time (McDonald, Rogers, et al., 2008). In addition, shared decision-making between the PN and the patient illustrates asymmetries in power and knowledge when new technologies were used by the PNs that patients were unfamiliar with (Kennedy et al., 2014).

A second power differential arose between the doctor and the PN. A major barrier to chronic disease management for Canadian nurses in Poitras’ study was the organisational context in which they worked (within a Family Medicine Group) because, according to the PNs, their activities depended on medical governance. For example, PNs conveyed information to doctors about the patient, yet when they sought information about a patient, they were required to read the patient notes (Poitras et al., 2018). Lukewich et al. (2018), reported that PNs felt that government reimbursements that encouraged GPs to focus on specific aspects of care contributed to a greater emphasis on the roles played by GPs over that of the PN. A lack of shared understanding meant that the PNs felt they needed to be autonomous practitioners as well as team players (Poitras et al., 2018). Poitras et al. (2018) go on to say that unless the doctor had a good understanding and respect for the PN’s role, communication, care, and PN participation in chronic disease management were hindered.

Time

According to Kennedy et al. (2014), PNs within their UK study approached self-management differently depending on whether the patient was newly diagnosed or had been living with the chronic condition for some time, because the PN’s work is based on the patient’s experiences of their illness and their level of trust in the PN. Practice Nurses saw changing people’s behaviours as time-consuming and challenging, and therefore self-management work was sometimes put on hold for another time; however, this time rarely eventuated (Kennedy et al., 2014). Activities requiring face-to-face discussion such as case conferences and management were often lacking in the PN’s work because they were considered time-consuming, given the little time the PN had to do their work (Askerund & Conder, 2016; Poitras et al., 2018). When too little time was scheduled, the PN tended to resort to simple education to deliver the information quickly (Poitras et al., 2018). In addition to case conferences and case management, time was an obstacle for the development of care plans for some PNs and considered an unsuitable activity to take place during a consultation (Doolan-Noble et al., 2015). In the study by Kennedy et al. (2014), PNs felt that when supported in terms of time, self-management was enhanced and the application of different approaches was facilitated, which meant that it was not seen as a disruption to their usual work.

Education

The question of nurse education is vexed. In a UK study by Macdonald et al. (2008), PNs felt that training in self-management skills and techniques was important to assist them to be more reflective about the patient’s illness trajectory, which would enable them to create new strategies instead of resorting to those that were known to have failed in the past. However, these PNs did not always perform assessments for mental health or cognitive conditions, due to lack of familiarity with these conditions and follow-up resources (Macdonald et al., 2008). These authors noted that PNs approached their teaching of self-management by making sense of the patient and their condition, and then categorising them, and finally educating them. This way of working with patients assisted the PN to break down their tasks, thereby promoting shared decision-making and addressing and encouraging active listening (Macdonald et al., 2008). However, the authors report that PNs were more confident in dealing with the newly diagnosed patient because, as the patient/PN relationship developed, it became more complex and PNs seemed to lack other resources to call on to encourage self-care beyond strategies developed on the basis of personal experience and intuition founded in their previous nursing work (Macdonald et al., 2008). Macdonald et al. (2008) go on to say that in the absence of formal education in psychological techniques to encourage behaviour change, PNs relied on repeated information giving, improvised role modelling, and patient education.

Because of the challenges of behaviour change, PNs often resorted to the more didactic way of encouraging self-management by providing education (Poitras et al., 2018). Some PNs found that using a flow sheet to track elements of care provided, assisted in alleviating some of this complexity (Lukewich & Edge, 2014). Systematic approaches to management and follow-up were common in relation to diabetes, hypertension, depression, chronic obstructive pulmonary disease, asthma, dementia, and chronic pain (Lukewich et al., 2018). However, some PNs allowed the patient to talk as much as they liked, claiming this supported an egalitarian change (McDonald, Rogers, et al., 2008).

Conversely, interventions most likely to be effective in the context of primary care and self-management were education and training for GPs and PNs (Kennedy et al., 2014). Practice Nurses who had received adequate training and considered themselves clinically competent appeared to demonstrate their confidence in clinical decision-making (Poitras et al., 2018). Macdonald et al. (2008) note that training for PNs in self-management skills such as cognitive behavioural therapy would enable them to better support people with long-term conditions.

Role ambiguity

Practice Nurses are important members of the primary care chronic disease management team, yet what their role within this team looks like varies (Norful et al., 2017). This is supported by Lukewich and Edge (2014) who claim that although PNs across all three designations (RPN, RN, NP) in Canada perform chronic disease management, their roles are not well defined. Practice Nurses in Canada perform wound care, immunisations, and venipuncture, and initiate referrals to healthcare providers, yet many patients still attend the emergency department for treatment of their chronic disease/s. These PNs also have a role in chronic disease management through routine screening, predominantly for people with diabetes and hypertension (Lukewich & Edge, 2014). In addition, Poitras et al. (2018) surveyed PNs working in

10 Family Medicine Groups in Canada and noted their roles within these multi-disciplinary groups consisted of patient assessment, care management, and health promotion, while also facilitating additional services for patients.

In (2014), Lukewich and Edge noted that in Canada, 40 per cent (n=344) of the PNs surveyed reported that they did not have a clear role description. In 2018, twelve years after the implementation of Family Medicine Groups in Canada to address chronic disease, the role of the PN within them remains unclear (Poitras et al., 2018). Overlap in roles between LPNs, RNs, and NPs in Canada when addressing chronic disease was illustrated by Lukewich et al. (2018) given the poor clarification between role boundaries where all three nursing classifications seemed to be performing the same tasks, resulting in role confusion. In 2013, (Daly et al.) highlighted the lack of any national standard or criteria for the role, especially when nurses working with people with long-term conditions found their professional boundaries blurred when support systems and training were not addressed. According to Askerund and Conder (2016), the development of the PN role was stifled by changing policy: “Continuing to develop new nursing roles, if they are to be undermined by changing policy, leads to a lack of confidence and wasted resources” (p. 17). Practice Nurses in a UK study by Kennedy et al. (2014) claimed that GPs were “ignorant of the work they did” (p. 1108); however, role confusion was reduced when doctors had a clear idea of the role and scope of practice of PNs. When doctors understood the scope of the PN role, they were more willing to involve them in the structuring of patient services which contributed to more independent practice for the PN (Poitras et al., 2018). The recognition of the PN’s role by the doctor allowed for greater communication, and the PN was able to be more involved in chronic disease management and the facilitation of services for people (Poitras et al., 2018). An understanding of roles between the GP and PN meant that the nurse would often manage less serious issues, leaving others to the GP. This was facilitated by joint meetings before and after a patient’s visit to clarify issues (Askerund & Conder, 2016). Poitras et al. (2018) explained that some PNs felt it easier to work with younger doctors who had experience working within teams and who were more likely to refer patients to them once they understood the PN’s role.

Discussion

The review has identified six main themes across nine selected articles: financial incentives, funding, power differences, time, education, and role ambiguity. Each of these themes has been explored in terms of both facilitators and barriers to the role of the PN when supporting people to manage their chronic conditions. Practice Nurses found themselves within a context driven by monetary incentives for the meeting of outcome targets. Practice Nurses in the selected studies working in general practice/family practice across NZ, Canada, and the UK reported a variety of approaches to chronic disease management. However, analysis of the articles found that the variety of approaches to managing chronic disease by PNs was consistent across all three specified countries. Despite this, policy initiatives appeared to be sporadic across all three countries and highly dependent upon funding, with PNs expressing the challenges of supporting patient self-management strategies when funding ceased. Without additional funding, PNs found themselves restricted by a lack of time to address the patient's complex needs, and because of tasks dictated by practice priorities directed at financially incentivised targets, chronic disease management was often performed between other tasks. A dominant aspect within the findings was the need for PNs to have focused education on how to manage the complexity of care for people with multiple chronic conditions. Without specific education and training in the skills and techniques required to successfully provide self-management, PNs expressed an inability to explore new strategies and found themselves resorting to past strategies that may not have previously succeeded. Furthermore, whether the PN worked within a multi-disciplinary team or not, the importance of clear role boundaries and scope were highlighted.

Whatever the initiative, the PN role is guided by various government policies and associated funding, which varies between countries (Hoare et al., 2012). Furthermore, government and health care system agendas drive reform strategies which are often linked to payments and reimbursement. These strategies may dictate the parameters of this reimbursement, the eligibility of the organisations (in this case general practices) who receive it, and the role of the PN within them (Goudrea & Smolenski, 2014).

The work of the PN is influenced by a myriad of factors. Walker et al. (2010) along with Clendon and Munns (2019), describe some of these influences as consumer needs,the PN's education and experience, the working space and geography of the practice, the practice owner's philosophies, the business and management structure of general practice, funding models, policy initiatives, and the professional relationship between the PN, the GP, and other health professionals. Role ambiguity and a lack of role definition provide opportunities for the future development of the role of the PN when assisting people with strategies to manage their chronic conditions.

Conclusion

It is clear from the literature that PNs working within general practice/family practice require focused education and training in the psychological techniques required to address behaviour change through self-management. Given the similarities to Australia, the exploration of the role of the PN in Canada, NZ, and the UK offers opportunity for comparisons to the Australian context. Unless funding is provided to allow the PN adequate time to build rapport, confidence, and therapeutic communication with clients, the PN will inevitably revert to the more simplistic and didactic way of encouraging self-management. This will ultimately prove prohibitive to patient empowerment, and thus, their ability to self-manage their condition. An understanding and appreciation of the role of the PN by all members of the practice team is paramount if the PN’s role of promoting health through self-management is to develop within an environment filled with competing demands based on the meeting of targets and intermittent and finite funding.

Limitations

The studies in this area are primarily qualitative and the findings have been extrapolated from questionnaires and surveys. The quality of these studies was determined using criteria developed by Popay et al. (1998). While all used purposeful sampling and contextualised findings, some articles, notably those using survey responses, lacked the thick description that is a marker of quality in qualitative research.

4.3 Health Care Home variants within New Zealand, the United Kingdom and Canada

The Pediatric Medical Home, developed in the USA in 1967, was one of the earliest models of care from which the Health Care Homes model originated. Initially developed to act as a single source of patient information, this model grew to encompass integrated care with the aim of improving care coordination for children

(O'Dell, 2016; Robert Graham Centre, 2007). In 2007, the primary care physician societies endorsed the joint principles of the Patient Centered Medical Home and many organisations in the USA began piloting it (U.S. Department of Health and Human Services, 2013). The establishment of several HCH variants across many countries followed and had a particular focus on the care of those with complex and chronic conditions.

In New Zealand, as with many other countries, the notion of care planning to address chronic disease as a means of hospital avoidance has been embraced. In 2004, additional funding known as Care Plus was provided to publicly subsidised GPs in addition to the capitation funds provided to them by the government (Doolan-Noble et al., 2015). Care Plus was a means of subsidising extended consultations between the GP or PN for patients with chronic care needs enrolled within a general practice. This initiative was seen as an opportunity to facilitate shared decision-making, and increased patient support through the development of collaborative care planning. In addition, this was also seen as a means for nurses to expand their role and utilise their skills more effectively. Care Plus was established across multiple general practices. Doolan-Noble et al. (2015) reported that the barriers to the successful implementation of care plans for people with chronic disease included a lack of systems to support care planning implementation along with time constraints and the competing demands of other scheduled patient appointments. There was a reported lack of clarity around how these care plans were conducted and their link to improved patient outcomes. While the development of a care plan was part of the Care Plus policy, it was ultimately determined that given the challenges and lack of evidential benefits to patients, that the necessity of a care plan for people with chronic disease should be reconsidered.

In Canada, the development and implementation of Family Medicine Groups was established in 2002 (Carter et al., 2017). According to Poitras et al. (2018, p. 35).

> *A FMG is a group of family physicians who work in close collaboration with nurses and other professionals to offer primary care services to registered individuals working closely with nurses in the provision of services to enrolled patients on a non-geographic basis.*

Family Medicine Groups were considered another initiative in Canada to address a fragmented system, improve access to care, and provide a truly multidisciplinary approach (Pomey et al., 2009). General practitioners within FMGs would enrol between 1,000 and 2,200 patients each and had to ensure these patients received a coordinated level of care from the multi-disciplinary team; suitable patients were those with chronic or complex condition/s or a ‘precarious condition’ (Pomey et al., 2009). In the FMG model, funding was provided through three main sources, direct public funding was provided to cover operating costs such as patient enrolment, fee-for-service funding remained, as did capitation for enrolled patients (Pomey et al., 2009).

The Canadian study by Poitras et al. (2018), classifies the work of nurses into four domains: global assessment, case management, health promotion, and nurse/doctor collaboration. An understanding of the nurse’s role within the FMG was deemed to be a high priority in facilitating their work. Nurses within FMGs performed a great deal of case management and facilitated service provision with community resources. There was a consensus that the nurse’s role was poorly understood and varied greatly across FMGs.

In the UK, the principles underpinning a whole-of-practice approach to chronic disease management were explored by (Kennedy et al., 2014). Kennedy et al. (2014) explored through an analysis of the gap between policy aspirations for chronic disease management and its implementation. They concluded that where self-management was not considered a priority, tools to facilitate this were lacking, and the nurse was reluctant to engage in behaviour change discussions (Kennedy et al., 2014). Nurses’ work in self-management was also deemed to be constrained by financial requirements such as fee-for-service payment structures and an overall lack of shared decision-making, technological support, and competing demands (Kennedy et al., 2014).

4.4 Relevance to Health Care Homes

It is clear that in order to address what appears to be a common fragmentation of primary health care systems across countries, a variety of initiatives and models have been instigated. The Health Care Homes initiative in Australia was initiated in 2018 to address a fragmented and uncoordinated system. Although the HCH initiative ceased in June 2021, it shares many imperatives with initiatives in other countries. Significant aspects of the HCH initiative were the shared care plan, a more collaborative approach by a team of health professionals, and the move away from the traditional fee-for-service funding model, deemed to be unsatisfactory when addressing chronic disease/s.

The assumption of the HCH initiative was that the role of the nurse in general practice would be enhanced and expanded (Parker & Jackson, 2017). Despite this, common impediments to an enhanced nurse's role have been experienced in Australia and across similar initiatives in other countries. These shared impediments or barriers include a lack of understanding of the role of the nurse, not only from the perspective of the nurse but the entire multidisciplinary team as well as patients. A general lack of support for the development of new initiatives consisted of lack of information technology training, especially between allied health professionals, lack of specific education for nurses, and according to some, the inadequate funding that HCH provided. When considering the role of the PN within the HCH context, the above aim of evaluating the changes to the scope of practice is particularly pertinent here in relation to the implications for future practice.

4.5 Implications for the practice nurse role

It is evident that PNs play an ever-increasing and important role in chronic disease management, yet a lack of clarity around their role still exists. However, according to Hajizadeh et al. (2021), few nurses are involved in the policy-making process.

This is in part due to the limited number of PNs invited to contribute to the development and writing of new policies, a lack of skills in policy development, an overarching lack of focused education, and a lack of organisational support (Shariff, 2014). In a 2015 position statement, the Australian College of Nursing supported the notion that funding and policy reform needed to consider the enhancement of the primary health nurse through funding models designed to support the role they play in health promotion and illness prevention (Australian College of Nursing, 2015). Studies from the USA, Canada, NZ, and Australia found that national health policy was often linked to budget cuts which resulted in negative consequences for nurses (Shariff, 2014). Specific to the general practice context, nurse-led chronic disease self-management is becoming less financially viable within the general practice where monetary incentives are inadequate for this group (Chapman & Blash, 2017; Freund et al., 2016).

With an increase in the number of people with chronic and complex conditions, and the associated high costs of care related to hospital avoidance, the role of the medical assistant in the management of people with chronic disease/s has become increasingly popular in the USA, the UK, Canada, Germany, and Australia (Freund et al., 2016). In 2016, the medical assistant (MA) role was the fastest growing profession in general practice in the USA, with Germany having an MA in every primary care practice (Freund et al., 2016). According to the American Association of Medical Assistants (2021, np), “Medical assistants are multiskilled members of the health care team who perform administrative and clinical procedures under the supervision of licensed health care providers”. In Australia, an MA is someone who has completed the nationally accredited Certificate IV in Medical Practice Assisting qualification (Anderson, 2014).

In 2010, a National Nurses Award was introduced covering nurses in primary health care and general practice and also registered nurses, enrolled nurses, and medical assistants, determining the minimum pay for these professionals (Australian Primary Health Care Nurses Association, 2022c). In general practice, private business dictates the flexibility of pay rates; however, this award assists in discussions of rates of pay between the PN and their employer (McCarthy, 2010). According to Australia’s Fair Work Commission, the 2020 pay rates for an MA ranged from $23.25/hour to $24.76/hour, while a registered nurse’s hourly pay ranged from $26.98/hour to $59.89/hour (Australian Government, 2020f).

The employment of an MA opposed to a registered nurse represents a significant cost saving in wages, and according to the Royal Australian College of General Practitioners (n.d.),

> *… medical assistants are trained to confirm physical health status of patients; assist with clinical measurements and procedures; facilitate a coordinated approaches to patient care; manage emergency cases and challenging patient behaviour; apply first aid; handle specimens; comply with infection control policies and procedures; clean re-usable instruments and equipment; and maintain medication stocks, among other duties”.*

In contrast, the Australian Nursing and Midwifery Federation make the following statement:

> *Medical practice assistants are not regulated. This means that:*

> - *they do not have a national standard of education*
> - *they do not practice under a legislative framework*
>
> - *there is no mandate for ongoing education to update knowledge*
> - *there is no safety and quality framework underpinning their work*
> - *there is no transparent way for the public to be assured of their skills or knowledge*
>
> *Medical practice assistants must not undertake clinical care as this is the role of registered nurses, midwives, and enrolled nurses in the general practice setting. Medical practice assistants cannot provide clinical direction, supervision or delegation to registered nurses, midwives or enrolled nurses* (Australian Nursing and Midwifery Federation, 2018).

Further discussion of the role of the MA within the HCH trial is provided in chapter six with the findings from the 'Smith' general practice, and then again in the final discussion chapter.

The following chapter details the methodology and methods used to answer the research question and the associated aims of the study. Rationales for the selection of the methodology and methods are validated, and the challenges and limitations of the thesis provided.

Chapter 5: Methodology and Methods

5.1 Introduction

This chapter provides a comprehensive account of the research methodology and methods adopted for this thesis. Justification for their relevance and significance in addressing the research question:

> **What is the impact of the Federal government's Health Care Homes initiative on the role of the practice nurse?**

is provided.

As outlined in the opening chapter, the thesis question addresses the issue of the HCH trial by:

1. Examining the impact of the shift to bundle payments on the role of the PN, and:
2. Exploring the impact of the trial on the PNs role in the multi-disciplinary team.

No hypothesis is formally presented as the theoretical work of Robert Alford's structural interest theory and Carol Bacchi's policy problematisation framework are used to interrogate influences upon, and changes to, the role. As stated, both these theorists suggest that there will be little change or reform or that the wrong problem is being addressed (Alford 1975; Bacchi 2012)**.**

The significance of the methodological and theoretical components in answering the research question is validated. To illustrate an in-depth account of the research design and applicability, I identify the research participants (while maintaining anonymity) and illustrate the stages and timeline by which the methods were implemented. A description of how the data were analysed to ensure trustworthiness and rigour while considering the theoretical underpinnings of this thesis is included. An account of the ethics considerations and limitations of the study is provided, and the chapter concludes with an outline of the thesis by chapter, providing an insight into the contents of each chapter and its applicability to the research question.

5.2 Methodology

This thesis explores the ramifications of the Federal government's Health Care Homes initiative (2018-2021) for the role of the practice nurse (PN) using case study methodology, with analysis drawing on the theoretical underpinnings of Alford's theory of structural interests in health reform.

Case Studies as methodology

According to Flyvberg (2011), case study methodology has been used since recorded history, however, the origins of case studies as methodology were seen in the early 20th century in anthropology and the social sciences when detailed studies of people's lives and experiences were conducted. As Johansson and Simons note, in Harrison et al. (2017), the aim of case study methodology is to understand how people attribute meaning to the experiences they encounter within their worlds. Considered more rigorous than some other qualitative research designs, case study methodology became popular in the late 1940s and 50s when quantitative methods such as surveys, statistical research, and experiments were used (Harrison et al., 2017). In the 1960s and 1970s, case study research became even more popular as qualitative techniques assumed more importance (Tight, 2017). Today, case study methodology is an established research design used in a variety of disciplines, but especially in the social sciences (Crowe et al., 2011). Case study methodology is increasingly being used by the medical professions to investigate interprofessional communication, education, and collaboration (Bail & Morrison, 2011; Meffe et al., 2012).

Case study research (CSR) is sometimes referred to as 'naturalistic' because of its application to the in-depth exploration of an event or phenomenon in its natural context. This contrasts with 'experimental' design, such as a randomised control trial, where the researcher has some control over, and manipulates, the variables of focus (Crowe et al., 2011). According to Yin & Davis (2007), in (Yin, 2018, p. 15):

> *A case study is an empirical method that investigates a contemporary phenomenon in depth and within its real-world context, especially when the boundaries between phenomenon and context may not be clearly evident.*

Case studies are thus intended to provide a deep level of understanding that allows for intricate analysis of phenomenon within one or more bounded units (the case/s)

(Willis, 2014). These boundaries or cases become the environment in which the phenomenon is explored. Case studies can use several research methods: qualitative, quantitative, hermeneutical, or mixed. Another feature of case study methodology is that the phenomenon explored within the case may be influenced by the evolution of events and influences that occur and change over time which ultimately contributes to the richness and complexity of the phenomenon being studied (Fyvberg, 2011). In essence, case studies are an empirical enquiry to provide an understanding of complex social phenomena (Yin, 2009). A case study "tries to illuminate a decision or set of decisions: why they were taken, how they were implemented and what the result as" (Schramm, in Yin (2009, p. 1071). In epistemological terms, a causal explanation is sought within a given context to explain "what makes it what it is" (Welch et. al; 2011, p. 741). According to Easton (2009, p. 119), case study research (CSR) allows the researcher to "tease out and disentangle a complex set of factors and relationships". One of the unique features of CSR is that even though there may be few cases explored, the variables within them may be many, so that the researcher can examine everything within each case or situation, whether it be individuals, groups, data, or a specific phenomenon (Yin, 2009).

Although case study methodology is most prevalent in the field of business (Tsang, 2013), there are a number of examples of CSR and its application to nursing, such as the work undertaken by Houghton et al. in 2013 which used case studies to explore the education of nurses within a clinical skills laboratory, and Newton's research using case studies of six students of nursing within one nursing student cohort (Cronin, 2014). In addition, there is a plethora of examples of case studies used to explore the impacts of health policy, as illustrated by Dinour et al. (2017) who reviewed a number of articles that used case study methodology to explore public health policy in the United States of America. Dinour and colleagues highlight that the use of case study methodology when researching health policy is particularly valuable as it assists in acquiring the knowledge to compare when, where, and why certain policies succeed and others do not (Dinour et al., 2017).

Case study methodology and its relevance to the research

Case study methodology was chosen for this study to determine any changes to the role of the PN as a result of the Health Care Homes initiative. It is deemed to be the best methodology to explore the many variables of interest from several participants and sources. To answer the research question, the case study methodology was exploratory, explanatory, and descriptive in nature. The study explored the role of the PN within each case study environment, described any changes to the PN role, and explained the influences that relate to these changes. It was assumed that competing interests driven by policy and other demands would influence how a general practice provided care to patients. By placing the nurse at the centre of this, the impact of these influences on the PN role was explored.

Case study methodology is perfectly placed to explore the research question: what the impact on the role of the PN in response to the Health Care Homes trial is (October 2017-June 2021), as according to Sibbald and colleagues (2021), it enables an understanding of how interventions are implemented in different contexts and how these contexts influence the phenomenon of interest. Previous chapters have provided the reader with an in-depth understanding of the nature of the private business context of general practice and have introduced the significance of people and organisations in relation to Alford’s theory of structural interests. Alford (1972), states that health systems are constantly changing and evolving and there are multiple people and organisations involved, illustrating diverse motivations and interests. The case study approach allows for these shifts to be noted and recorded.

Case study methodology is particularly useful when researching the ‘how and why’ of a phenomenon, and it is the associated ‘outcome characteristics’ that provide insight when addressing the research question. Case study methodology offered an opportunity to explore multiple variables of interest from several different data sources.

Because of the associated flexibility of methods that case studies offer, researchers are able to draw on narrative-type descriptions from semi-structured interviews, records, and documents to provide theoretical insights. Evidence from a variety of sources facilitates the rigour of the research project and is central to the case study process as methodology. According to Yin, (2009), case studies should rely on multiple sources of evidence to create a ‘chain of evidence’ that allows data triangulation and comparison between each case study. Difficulties in accessing related documents for this thesis from the general practice sites will be discussed in this chapter.

The study explored four cases, each a general practice within South Australia participating in the HCH trial. Each general practice is ‘a case’, used to explore operational links, policy drivers, and competing interests to offer insights into any potential changes to the PN role.

Each of the four cases share common characteristics and are bound by the phenomenon under investigation. According to Stake, (2006), a multi case study such as this encourages the researcher to consider the uniqueness of each case, while being cognisant that each case belongs to a ‘collection’ of cases. Stake goes on to call this collection a ‘quintain’ of cases, meaning, it is the umbrella under which the collective target for the cases is studied (Stake 2006). The four cases within this study are bound by the phenomenon that is the HCH trial, however, they also share other commonalities such as being situated in a metropolitan region within South Australia, having one or more practice nurses, a funding model based on fee-for-service payments and similar patient demographics. While these similarities are an advantage in collective case study design, given their ability to enhance replication, they also represent some limitations. For example, limiting the cases to South Australia provides a view of the trial from one states perspective, with all cases having the same overarching support network and resources.

While case study research involves a number of approaches, it does focus on the examination of one ’thing’, which can be a person, group, or event, and is more pertinent to the ‘how’ and ‘why’ questions where the researcher has no control over events and there is the inclusion of an interpretive paradigm that allows analysis from a number of perspectives (Taylor & Thomas-Gregory, 2015). Case study research can be retrospective or prospective (Taylor & Thomas-Gregory, 2015) or, as in this case, the research takes place over a set time period (the Health Care Homes trial). Exploration of the cases across the same timeframe, or simultaneously, is what Crowe et al. (2011, p. 3) term a “collective case study”. Although the research takes place across a set timeframe, it is a continuous process of interplay between concepts and data as they evolve over the specified time. The use of multiple cases (four general practices) trialing the same initiative over the same time period, enhanced my ability to compare and analyse the findings.

5.3 Methods

Case study selection

Each general practice chosen as a case for this study was required to:

be participating in the Health Care Homes (HCH) initiative
have at least one PN
have signed up a minimum of 50 patients to the HCH initiative
have had at least 3 allied health professionals within the HCH team

To enhance the rigour of the research findings, the initial intent was to select four general practices, each functioning under a different style of governance. For example, while all four HCH sites met the research criteria, their governing structures were different: a not-for-profit organisation, a corporate organisation, and non- corporate,

privately-owned business partnerships. Considering Alford’s theory of competing interests, and the assumption that there will always be tensions between groups, my preliminary thoughts were that the differences in styles of governance would enable a deeper exploration in terms of the triangulation of data relating to policy, autonomy, and decision-making. Accessing practices with different governance styles was challenging, and ultimately, all practices used for this thesis were privately- owned. While this conflicts with the original intent, it does provide an opportunity for rich comparison, given they all have similar operating systems. The challenges of accessing practices for this research will be further discussed in this chapter.

Choice of methods

According to Exworthy et al. (2012), correctly framing case studies has an important consequence for the ensuing analysis in the same way that the correct choice of methods enables the collection of different data, thus allowing different analyses. This qualitative design used a range of methods to elicit empirical evidence relevant to the research question, including interviews with relevant individuals within each GP practice, and data on shared care plans. Data from the interviews demonstrated what the interviewees both experienced and did during the HCH trial and was applied using a ‘naturalistic’ approach to explore these experiences from the subject’s real-world environment (general practice).

Recruitment

General practices

The first step in recruiting general practices was to approach the Adelaide Primary Health Network (Wentworth Healthcare-PHN Nepean Blue Mountains) for assistance.

The HCH practice facilitator assisted with the names of participating HCH practices within the Adelaide metropolitan region and were able to identify practices meeting the criteria for the research study, as outlined above. I telephoned five general practices, two private businesses, two corporately run and one partially government-funded practice, introduced myself and informed them of my research. I then followed up my phone calls by emailing each practice manager a copy of the information sheet as found in Appendix B. As previously mentioned, the original intent for this research was to collect data from several sources, including semi-structured interviews with staff and patients, and accessing data from the electronic patient management systems and the patients' electronic shared care plan. The two corporately run practices that I approached declined to participate, citing that after consulting with their legal team, they were not willing to share any of their data from either the patients' online care plan or their electronic management systems, and that this data was their intellectual property. One privately-owned general practice agreed to participate in the study and the other withdrew their interest because their PN had experienced an unexpected family trauma. The partially funded government practice declined to participate because they felt their patients would not be amenable to being interviewed.

Having had confirmation of participation from only one private general practice, I sought assistance from one of my thesis supervisors, a GP who suggested contacting another two privately-owned practices who were ultimately willing to participate. The remaining two practices who participated in the research were sourced by me, using the same process mentioned above. Once the participating practices had been established, I emailed them a copy of the general information sheet (Appendix B) and organised a follow-up face-to-face meeting with the practice managers to discuss participant recruitment. In addition to difficulty recruiting practices, the study was limited to South Australia because face-to-face access with interstate practices was not possible during the COVID-19 pandemic. There was also no clear indication of the benefits of using interstate practices, given I had already developed contacts within South Australia. While this may have presented some limitations, the similarity between practices enhanced the triangulation of data.

Participants

In qualitative enquiry, the purpose is to gain an understanding of the phenomenon central to the research. In this case, the PN was purposefully selected as the focus for this study, given the quest to identify changes to their role as a consequence of the HCH initiative. This purposeful selection enables the researcher to best understand the phenomenon (Cresswell, 2012), and sample size should not be regarded as too important, given the importance of case replication (Yin, 2009). Sample size in this study was dictated in part by access to staff members having a role in the HCH initiative. Patients, PNs and GPs selected for interview were done so by the practice manager of each practice and depended upon their engagement with the initiative and each other which allowed for an exploration of the theoretical underpinning of this thesis.

Replicating the study across all four practices was important to confirm or disprove the emergence of commonalities within the research findings. Of particular importance in addressing the research question was examining the role of the nurse within each practice during the HCH trial.

DeJonckheere and Vaughn (2019) state that working with gatekeepers to gain access to interviewees can be beneficial as they are able to direct the interviewer participants that are trusted sources. The selection of interviewees for this study was primarily undertaken by the practice managers of each selected general practice. As discussed later, the selection of participants for interview by the practice manager illustrates a control and potential bias on their part given the overall role of the practice manager and their interest in the success of the practice.

To promote the rigour of this study, additional interviewees were sourced which enabled additional perspectives and enhanced triangulation of the data. These additional interviewees included a PN from a non-HCH participating practice, a PN and manager from a practice undertaking a similar trial to the HCH trial, and an HCH coordinator from the Primary Health Network.

Semi-structured interviews

According to DeJonckheere and Vaughn (2019), semi-structured interviews are the most frequent source of qualitative data for health services research. Semi-structured interviews were chosen as the most appropriate method to elucidate the required data to address the research question because:

> *Semi-structured interviewing can be a powerful tool for family physicians, primary care providers and other health services researchers to use to*

> *understand the thoughts, beliefs, and experiences of individuals* (DeJonckheere and Vaughn 2019, p. 1).

Semi-structured interviews include a mixture of closed and open-ended questions which are often accompanied or followed-up with ‘why’ or ‘how’ questions (Adams, 2015). They were used in this thesis to explore the thoughts and experiences of the interviewees in relation to the HCH trial and the role of the PN. Semi-structured interviews assist in understanding the person’s point of view through their experiences within the world and the particular context and issue under review. By understanding these viewpoints, the researcher is able to uncover the meanings behind them (DeJonckheere & Vaughn, 2019). They were particularly useful for this thesis when exploring the HCH initiative and the role of the PN in gaining an insight into the interviewee’s thoughts, feelings, and actions within the lived experience of the trial. The practice managers from each participating practice identified the nurses, GPs, and patients most suitable to be interviewed. Following participant selection by the practice manager, I contacted each participant working within the selected general practices and provided them with a copy of the information sheet (Appendix B) and an interview consent form (Appendix C). At this point, I reiterated to the potential interviewee that participation in the interviews was purely voluntary and that they could choose to refuse to answer any of the questions posed to them or withdraw from the interview altogether if they wished. A reminder of the promise to maintain anonymity was also given.

Alignment between the participant’s and my own availability determined the interview order, and it was quickly determined that although initially planned, interviews with allied health professionals such as physiotherapists, diabetes educators, or psychologists would not result in any useful content necessary to support the research because of their limited involvement in the trial. Therefore, allied health professionals were not interviewed.

Interviewees were asked to provide their perceptions of the PN role prior to and after the implementation of the HCH trial. Additional information gleaned from the interviews related to potential changes to the PN role in relation to job description, scope of practice, critical thinking/autonomy, and workload.

For the purpose of this study, it was essential that all participants working within a case study practice had a significant role within the HCH initiative. Sample size was thus determined by the participants' engagement with HCH and the practice, and the practice managers' willingness to provide access to staff.

All interview participants were provided with a consent form (Appendix C) and assurance that their input was voluntary and that their anonymity would be maintained. Additional information illustrated the time period for data collection, the types of evidence collected (interviews), and the people being sought to interview. All case study practices were offered $100 for each interview participant where the interview would have an impact on their ability to generate income; for example, GPs whose time may have been spent generating funds through patient consultations. The consent form also contained a commitment that a transcript of the interview would be made available to the participants if asked. The time taken for each interview varied between 30 and 90 minutes, and all interviews were recorded using a voice recorder while simultaneously taking notes. The interview responses were then transcribed verbatim by the researcher. I ensured that I transcribed the data within two to three days after the interview took place; this allowed me to commence the analytical process and compare similarities and differences between interview responses. I was careful to include every sigh, laugh, and other markers in the transcript as this provided important data to review. To ensure accuracy, I also checked each transcript by listening to the audio recording while reading it, which assisted in identifying any potential errors in transcription. Another approach to ensuring accuracy and rigour of the results was the use of member checks. During this process, any section of the transcript that was unclear to me was substantiated by contacting the participant (Taylor & Thomas-Gregory, 2015), who then validated the accuracy of their interview response/s.

To maintain anonymity, each participating general practice was allocated a person's name as the moniker and each interview participant a number, corresponding with the case study. Case studies 1 and 2 were part of a small franchise of practices, and therefore, the principal GP and practice manager were interviewed in relation to both practices. The following table illustrates the number of interviews undertaken per participating general practice and whether they were conducted face-to-face or via telephone:

Table 5.1: Health Care Homes interviews

General Practice	Practice Nurse	General Practitioner	Patient	Practice manager
Case study 1: The 'Smith' general practice	Medical assistant (1) Face-to-face	1 Face-to-face	2 Telephone	1 Face-to-face
Case study 2: The 'Anderson' general practice	1 Face-to-face	Same GP as above	0	Same manager as above
Case study 3: The 'Brown' general practice	1 Telephone	1 Face-to-face	2 Telephone	1 Telephone
Case study 4: The 'Webster' general practice	2 Telephone	1 Telephone	3 Telephone	1 Telephone

A total of 18 interviews were conducted between the four case study practices. Where possible, face-to-face interviews were conducted. According to DeJonckheere and Vaughn (2019), a highly meaningful research project can be presented using the interviews of between eight and twelve participants. During the face-to-face interviews, I had the opportunity to observe non-verbal cues such as gestures and body language which provided support to the information received from the interviewee. This is significantly helpful when using semi-structured interviews because the non-verbal cues assisted in detecting any potential feelings of anxiety by the interviewee, which I could mitigate by providing a safe and comfortable atmosphere (Saarijavi & Bratt, 2021). Cues from the interviewer were also used as a way to delve deeper into a particular issue; for example, a facial expression of excitement or joy prompted me to ask additional questions in relation to the particular topic During the COVID-19 pandemic, general practices ensured that only urgent appointments were undertaken face-to-face, and therefore, eight interviews were conducted via telephone, which proved to be both advantageous and disadvantageous. There was the obvious risk that the interview might have been conducted with a person pretending to be the intended interviewee, and also possible risks with confidentiality if they were unable to substantiate who else might be able to hear the interview being conducted. In contrast, the telephone interviews may have enabled the interviewees to feel less anxious because of the increased sense of anonymity. Responses to questions may also have been less measured, and thus, had greater potential to illustrate the interviewees' in-depth thoughts and feelings. Not being able to visualise the interviewees' expressions also posed an additional challenge, as it was not possible to identify inflections in the responses or to determine whether asking additional questions would be challenging.

The research questions for the semi-structured interviews mostly began with 'why', 'how', and 'where', as this is a way of focusing on the exploration of the research question from the participants' perspectives. The interview involved a series of pre-determined questions, used as a starting focus which were then expanded upon with follow-up questions as required. A copy of the pre-determined interview questions for

the PN, practice manager, GP, and patient can be found in Appendix D.

To gain further insight into the role of the PN, additional telephone interviews were conducted with an HCH facilitator from the Adelaide Primary Health Network, and a PN working at a non-HCH practice. Two staff (one PN and one facilitator) involved with the Quality Enhanced general practice Services Trial (QUEST), a similar trial partially funded by the Royal Australian College of General Practitioners (RACGP) in conjunction with Flinders University, were also interviewed.

The participants of these additional interviews were approached by me. I felt it necessary to interview the PHN HCH facilitator for insight into the preparation, roll out and support provided throughout the initiative. I chose to interview a PN from a non HCH practice in order to provide a comparison of PN roles between a HCH participating practice and a non HCH practice. Given that the QUEST trial was undertaken in South Australia and the aims were akin to those of the HCH trial, I chose to approach the practice manager involved in the trial who facilitated access to their practice nurse for interview. I also approached Flinders University where I was granted access to interview the facilitator of the QUEST trial.

As previously mentioned, the initial intent was to use a variety of methods to address the research question. It was assumed that by using a variety of methods, greater insight into any change in the role of the PN would ensue. The initial plan was to use semi-structured interviews, information gleaned from the patients' shared care plans, data regarding the use of the HCH bundle payment system, and chronic disease management activity undertaken by the PN. How and whether these data were accessed and used is described below.

The online shared care plan

As mentioned previously, all patients registered with the HCH trial were required to have a shared care plan prepared; in some instances, this meant transferring their previous plan to the online system. The development and use of this care plan was to assist the management of care for those with chronic and complex conditions and has been a significant part of the PN role for many years (Verrall et al., 2022). The difference with the online care plan within the HCH trial was that because it existed within an online platform, it could be accessed any time by the patient, any member of

the HCH multi-disciplinary team, and also by any other allied health professional outside of the HCH team as necessary. This was deemed an important aspect of the HCH initiative in promoting multidisciplinary, integrated care and, as such, a significant tool in researching the PN's role and engagement with the trial. The care plan was an important data collection method because it was thought that data collected from the shared care platform would inform the research by identifying how the PN assisted people to manage their chronic and complex conditions, and the engagement of the interdisciplinary team, the GP, and the patient/s during the HCH trial.

Patient Activation Measure (PAM)

Known as a 'Patient Activation Measure' (PAM), the PAM is a 100-point quantifiable measure of patient engagement used in health care (Heath, 2017). The PAM is essentially a patient survey that assists in determining health literacy and the patient's capacity to engage in self-care. The PAM was suggested by an HCH facilitator as being a useful data method for this thesis because it was an indicator of the delivery of care and the education related to this care (Roberts et al., 2016). It was initially deemed a useful tool to enable the collection of data related to PN/patient encounters and the associated role of the PN in CDM.

The PAM had advantages in identifying PN work related to CDM that may not have been evident in the previous MBS model of care. One important example of this is specific nurse/patient interactions related to education and health promotion. I made the assumption that the previous MBS system of using a prepared template to develop a patient care plan did not allow for critical thinking by the PN. The PAM in conjunction with codes derived from information technology systems, was thought to assist in the collection of data to explore this assumption (Ellis, 2019).

PEN Clinical Audit Tool (PEN CAT)

The PEN Clinical Audit Tool (PEN CAT) is an electronic software tool designed to assist in the specific selection of patient data and activity. This tool can be used to extract de-identified clinical data related to patients with chronic and complex conditions. The PEN CAT was initially identified as a method to be used to assist in addressing the research question. This tool would assist in the collection of data from CDM activities, the number of patients seen, the specific chronic conditions experienced by the patients, and the hours spent by the PN, GP, and others in caring for them (PenCS, 2019).

Funding information

It was planned that exploration of any changes to the PN role would be undertaken in conjunction with the HCH payment model known as ‘bundle’ payments. Given that the HCH model relies on this bundle system of payment, MBS items previously claimed for CDM were no longer able to be claimed for patients signed to the HCH model. Allocation of finances from this bundle payment were to be sourced from the general practices’ financial information technology systems, and PN/patient interactions were to be explored in relation to this payment model and PN/patient activity.

5.4 Challenges to data collection

As previously explained, initial plans for data collection included a multi-method approach by incorporating the use of semi-structured interviews, access to the shared care plan, funding data, the PAM, and the PEN CAT. Access to funding information, the PAM, and the PEN CAT was not provided by any of the practices approached for this research. Corporate-owned practices declined to participate in the trial on the basis that they would not agree to provide access to any of their electronic data. According to Youens et al. (2020), general practices produce large amounts of data; however, this is usually used for their own reimbursement purposes, and the Medicare Benefits Schedule (MBS) captures data on all services provided through Medicare. Youens et al. (2020) go on to say that general practice data suitable for research can be found through a practice’s clinical information system software. These systems were initially designed to focus on administrative data such as billing and scheduling and have evolved over the years to include specific clinical data, care plans, medications, pathology, and other data. Much of this data can be used for audits to assist in improved patient care and business opportunities in terms of billing (Department of Health, 2016). Youens et al. (2020) state that there is apprehension from general practices about sharing data with third parties, even if the data is de-identified, while the challenges for researchers from universities in accessing data are often very difficult to overcome. Given these findings, it is not surprising that general practices participating in the HCH trial and associated exploration of a bundle payment system were reticent to share their data.

The uptake of the PAM during the HCH initiative was patchy, mainly due to a lack of awareness and training, available templates, workforce availability, and time, particularly during the HCH initiative when practices were dealing with the new processes and systems brought about by the trial (Health Policy Analysis, 2022).
Given the challenges in accessing the general practice electronic data systems, and the desire to ensure rigorous research, I employed the following additional research methods: additional interviews with an HCH facilitator from the Primary Health Network, staff associated with the QUEST trial, and the exploration of the HCH trial using Carol Bacchi's policy interrogation framework (chapter nine). These are discussed below.

Additional interviews

When considering case study research, the analysis should be a dynamic and interactive process. Interviews were undertaken with two PNs not engaged in the HCH trial to gain further insight into how their role in assisting people to manage their chronic conditions was performed outside of the HCH initiative.

The QUEST trial had similar objectives to the HCH initiative, and a PN working on the QUEST initiative was interviewed to determine her experiences and any changes to her role during the trial period. Insights about the PN role within QUEST were also gleaned from an interview with one of the facilitators of the QUEST trial. These interviews were undertaken to gain insight into the PN role when a similar initiative to HCH was underway. Findings from these interviews provided an important perspective on the contrasting trials and associated role of the PN. Interview responses from an HCH practice facilitator also provided useful data for comparison, primarily in exploring the aims of the HCH trial and potential role enhancement for the PN.

Policy documents

Health Care Homes evaluation documents were accessed to explore and triangulate the research findings. Government documents used to explore and triangulate the research findings included documents from government websites, the Adelaide Primary Health Network, patient information sheets, and HCH evaluation documents from Health Policy Analysis Pty Ltd.

5.5 Policy interrogation as it relates to the role of the practice nurse and Health Care Homes

Finally, chapter nine of this thesis explores the HCH trial through the use of Carol Bacchi's policy interrogation framework to provide a deeper understanding of the nexus between the HCH trial, policy, and the associated impact on the role of the PN. Bacchi shifts the focus from policy problems to policy questioning and argues that change is inherent in the way that problems are initially constructed. Central to her approach is the interrogation of the notion of a 'problem' within the political context and consideration of the way in which policy 'problems' are created and explored (Bacchi, 2010). She asserts that the problem and how to make sense of it is a political process rather than a technical one. Bacchi's framework uses the following six questions to explore policy perspectives and processes, agenda setting, and the meaning of the success or failure of a particular policy initiative (Bacchi, 2016). These questions are:

1. *What's the 'problem'?*
2. *What presuppositions or assumptions underpin this representation of the 'problem'?*
3. *How has this representation of the 'problem' come about?*
4. *What is left unproblematic in this problem representation?*
5. *What effects are produced by this representation of the 'problem'?*
6. *How/where has this representation of the 'problem' been produced, disseminated, and defended? How has it been (or could it be) questioned, disrupted, and replaced?* (Bacchi, 2012, p. 21).

These questions were used to interrogate policy documents relating to the Health Care Homes trial. This included documents from government websites, the Adelaide Primary Health Network, patient information sheets, and HCH evaluation documents from Health Policy Analysis Pty Ltd. This enabled me to think critically about the problems that the HCH initiative purported to address, and to further explore how bias and varying interests directed towards problem-solving influenced the role of the PN.

5.6 Rigour

According to Cypress (2017, p. 253), rigour is defined as “the quality or state of being very exact, careful or with strict precision”. It is a way of determining trust or confidence in research findings (Maher et al., 2018). Strategies to ensure the truth and precision of the findings were employed in this research, and are outlined under the headings of credibility, dependability, conformability, and transferability (Maher et al. 2018).

5.7 Issues of reliability and validity within case study research

Credibility

To establish the credibility of the findings, they must be believable (Houghton et al., 2013). To ensure this, I have conveyed accurate descriptions of the experiences of the interviewees so that other health professionals in similar situations would be able to identify with what has been reported. Member checking (as mentioned earlier) is also a way of ensuring credibility of the results. Thomas (2016) suggests that member checking is an ongoing process that occurs throughout the entire data gathering process. Member checking was undertaken in this study by asking interviewees to expand upon ideas which assisted in confirming the evolving findings of the study.

Purposeful sampling (identifying and selecting people and groups with expertise) was essential to data collection and assisted in writing rich descriptions of people’s experiences (Miller, 2013; Palinakis et al., 2015).

Applicability

Applicability refers to the degree to which the research findings can be applied to other contexts, situations, or populations (Noble & Smith, 2015). The criterion at which applicability is measured is known as transferability when a similarity between different contexts can be found. This thesis includes a chapter outlining a systematic literature review of how PNs in Canada, New Zealand, and the United Kingdom assist people to manage their chronic illnesses. The barriers and facilitators of the PN role are highlighted as well as an introduction to some of the more prominent reform initiatives related to chronic disease management in general practice in these countries. This provides the reader with an opportunity to consider the role of the PN within Australia during the HCH initiative, and how this could be transferred to the international context.

Comparison has also been made between the role of the PN during the HCH trial with another government trial undertaken during the same timeframe. The Quality Enhanced general practice Services Trial (QUEST) was undertaken in 20 general practices in South Australia between November and December 2019 (Flinders University, 2021). Akin to the HCH trial, the QUEST initiative was established to trial a funding system other than fee-for-service to enhance quality continuity of care for patients, one group being those with complex and chronic conditions (Flinders University, 2021). Interview responses from a PN working within the QUEST trial have provided another example of transferability as rigour for this thesis.

Dependability

According to Koch 1994, in Houghton et al. (2013), in qualitative research, dependability is often associated with reliability and refers to how stable the data are. In relation to case study research and this thesis in particular, dependability can be linked to the fact that several participants held the same opinions; for example, issues from the findings were shared across the case study sites. Further to this, I take note of the official findings of the HCH trial funded by the Federal government and in the final chapter align these findings with my own. Specifically, I note any findings from these evaluations that differ from my overall observations. During the data collection process, I kept a reflective diary that enabled me to record people's thoughts and ideas, which assisted in the development of the main discussion points in the final chapter.

Neutrality

Neutrality refers to the exclusion of any bias within the research findings. According to Cresswell (2012), researchers do become immersed in their study over time, which often includes their own beliefs and assumptions. The emphasis of neutrality should therefore be on the interpretation of data rather than on the data itself. Results show the interviewees' voice within the context of the phenomena being studied. Confirmability is the criterion upon which neutrality can be measured and refers to the neutrality and accuracy of the data which can be achieved after credibility, transferability, and dependability have been realised (Houghton et al., 2013). To achieve confirmability, it should be shown that the findings are elucidated from the data rather than through the researcher's own predispositions (Shenton, 2004).

5.8 Data analysis

Triangulation

According to Houghton et al. (2013, p. 13), credibility can be enhanced with the use of triangulation and is "… the process of comparing data gathered from multiple sources to explore the extent to which findings can be verified". Triangulating the data assists in ensuring confirmability; for example, this thesis uses multiple cases and data from interviews, and has provided different perspectives of the people within these cases when looking at the role of the PN within the HCH initiative. By applying critical enquiry, data was analysed within and between each case study, thus facilitating the triangulation of multiple data sources. According to Miles and Huberman (1994) and Yin (2011), in (Miller, 2013, p. 64), triangulation is the "established agreement between multiple data sources". Triangulating this data involved looking for outcomes that were agreed upon by the interviewees, even though they were looking at the issue from differing perspectives (Guion, 2002; Houghton et al., 2013). Further triangulation was achieved through examining the findings in light of the Federal government's evaluation of HCH and the QUEST trial.

The use of theory as analysis

Each of the four general practices chosen as case studies for this thesis provide the context for the exploration of the role of the PN. Each interview undertaken within these cases offers the thoughts and experiences of the interviewees as they occurred during the HCH trial. The analysis of the interview data was undertaken to describe, explore, and explain the impact of the HCH trial on the work of the PN using Alford's critical theoretical framework of structural interests. I found a synergy between the three Interest groups proposed by Alford and the interview responses. This allowed me to further explore the forces influencing the role of the PN and how they either blocked or facilitated any change to the PN role.

Alford's theory focuses on the influence of people's interests and how they affect change. Using his theory to explore the role of the PN within the HCH initiative has allowed me to consider the impact of the power of other health professionals and organisations on the role of the PN when various interests come into play.

5.9 Ethical considerations and limitations

Following submission of the ethics application, approval to undertake the research was granted from the Flinders University Social and Behavioural Research Ethics Committee on January 17th, 2020, with an expiry date of September 30th, 2023. Ethics approval included permission to interview PNs, GPs, allied health professionals, other general practice staff, and patients. As explained by Husband (2020), the process of acquiring ethics approval is often a rigorous one which is underpinned with specific points of consideration for the research participants. Such considerations, as specified by (Husband, 2020, p. 7), include:

> *… that respondents should suffer no loss of professional standing, or suffer personal distress, and be treated equally to each other and without prejudice or discrimination.*

One of the risks of this research is that the respondents may experience feelings associated with potential harm to their employment. Within this context, the PN is particularly vulnerable, given the private business nature of general practice and the unique employment structure where the PN is usually an employee of the GP. As a business, general practices rely on the generation of funds to survive, and therefore, any negativity could place this in potential jeopardy. To mitigate this risk, maintain anonymity, and protect identities, all general practices used as cases were given a moniker in the form of a person's first name and all interviewees a number. All participants were informed they could withdraw from the process at any stage and that there was no obligation to answer any of the questions posed. Another potential benefit of this anonymity and freedom to withdraw was that the interviewees felt safe to provide honest and accurate responses without any repercussions that might pose a threat to their professional standing. The process of member checking, when the interviewer was unsure of the interviewee's meaning or the interview transcript was unclear, also enhanced the accuracy of the responses.

5.10 Conclusion

Despite the many advantages of case study research, there were some limitations.

According to McLeod (2019), because case study research relies on the thoughts and experiences of participants, there is the potential for the researcher to include their own subjective feelings which could contribute to bias and influence the findings. In addition, because case study research deals with a particular phenomenon, it may be difficult for this to be replicated to other contexts and it becomes challenging to determine whether the results are representative of a wider group (Crowe et al., 2011; McLeod, 2019).

A limitation particular to this thesis is that participant selection was provided by the practice manager of each of the participating practices. Crowe et al. (2011) assert that case study participants can be pre-selected for the researcher, especially when decisions could be influenced by key stakeholders. As a private business, general practice is dependent upon the generation of funds linked to patient encounters. Despite all data within this thesis being de-identified, it can be assumed that practices were wary of the adverse effects to their business that the publishing of any undesirable data could have. The pre-selection of interview respondents by the practice managers has potential for bias if interviewee selection was founded on those most likely to provide favourable comments.

This chapter has outlined the methodology and methods used in this study. The next three chapters present the findings from interviews undertaken within the four general practice case studies selected for this thesis and serve to determine the potential influences on the role of the PN during the HCH trial. As noted in this chapter, data were obtained from interviews with general practice staff and patients. Each case study chapter commences with an introduction, providing demographic data within the surrounding areas of each general practice. In order to protect anonymity, the general practices chosen for this research have each been given a person’s surname by way of an identifier.

Chapter 6: Case studies one and two – the ‘Smith’ and ‘Anderson’ general practices

6.1 Introduction

This chapter is the first of three chapters presenting findings from interviews with staff and patients from the four general practice case studies chosen for this thesis. Interview responses from the Health Care Homes (HCH) Primary Health Network (Wentworth Healthcare-PHN Nepean Blue Mountains) practice facilitator and a practice nurse (PN) from a non-HCH practice are also included. All four practices sit within the Adelaide Primary Health Network (APHN) region which covers all of metropolitan Adelaide from Sellicks Hill in the south to Angle Vale in the north and from the western coastline to the eastern foothills, with a population of 1.2 million people (Australian Government, 2022).

Each case study chapter is presented in a similar format and provides demographic data particular to the region surrounding the practice. Both the Smith and Anderson practices are part of a group of six, and while situated in different locations, share a practice manager, who in this case is known as the chief operations manager (COM). These practices also share the same general practitioner (GP) as their majority partner. These practices are discussed separately within this chapter. An overview of the characteristics specific to each practice, including demographic profiles, reasons for each practice participating in the Health Care Homes trial, and factors contributing to the facilitators and barriers of successful implementation are explored. Interview responses offer a depiction of each case from multiple points of interest with the intent of determining any changes to the PN role. The chapter concludes with a summary of the main findings from the interviews which will be further explored in the discussion chapter.

6.2 The ‘Smith’ general practice

The Smith general practice is a privately owned and operated business. It is one of a group of six practices owned by a small number of GPs with one being the majority partner. This practice is affiliated with two universities for the purpose of GP teaching and training. Most services offered by this practice are bulk billed; however, some specialist care may incur a gap payment. While permission to interview PNs at this site was not provided, the medical assistant (MA) responsible for the Health Care Homes (HCH) initiative was interviewed. A discussion surrounding this challenge has been included and is further expanded upon in the discussion chapter.

6.3 Demographics

The Smith general practice sits within a local government area inside of the Adelaide Primary Health Network domain which covers an area of 663.1 square kilometres, with a population of 378,326 and a population density of 570.5 persons per square kilometre (Australian Government, 2020g). Table 6.1 represents some of the more pertinent demographic data for this local government area and provides a comparison with the Adelaide metropolitan region.

Table 6.1: Local government area data – the Smith general practice (Australian Government, 2020g).

	General practices	**General practitioners**	**Practice nurses**	**Community Pharmacists**	**Public hospitals**
Local Government area	82	444	184	102	2
The Adelaide Metropolitan region	319	1623	604	797	9

The average age of a person living within this local government area was 41 years in 2020, with the most prevalent health conditions being asthma, mental health and behavioural issues, arthritis, and heart, stroke, and vascular issues (Australian Government, 2020g). Located approximately 20 kilometres from the city of Adelaide, this practice sits within a designated metropolitan suburb of 7.7 square kilometres, with a total population of 10,737 people (Australian Bureau of Statistics, 2021b). Taken from the Australian Bureau of Statistics 2021 census (2021b), Table 6.2 below illustrates a breakdown of the population by age and sex in the suburb in which this practice sits. Interviews with staff from the Smith general practice were undertaken with the chief operations manager (COM), the GP, the MA and two patients.

Table 6.2: Suburban population breakdown - the Smith general practice (Australian Bureau of Statistics, 2021b).

Age 0-19		**Age 20-34**		**Age 35-54**		**Age 55-74**		**Age 75 +**	
M	F	M	F	M	F	M	F	M	F
1197	1105	1016	1409	1302	1345	1131	1268	396	570

6.4 Staff

At the time the interviews were conducted, this practice had eleven GPs (three females and eight males, of which two were registrars), six nurses (only one working full-time), two medical assistants, and seven receptionists (two working full-time). The practice also had allied health services such as physiotherapy, podiatry, and dietetics, and ran skin and cervical screening clinics. According to the COM, the Smith practice saw approximately 4,500 patients each month. Access to nursing staff at this practice proved challenging and resulted in interview responses from only the medical assistant.

The practice manager – chief operations manager

The Smith general practice is one of six practices within a group and all practices are managed by one business development manager who also calls herself the chief operations manager, who noted that:

> *… my role is overall operations of the practices, that includes staffing … financial management, planning, collaboration … identifying projects, running, and setting them up* (COM).

The business development manager holds a master's qualification in business administration and management and had previously held a position as vice-president for banking operations at a large global bank.

The general practitioner

The GP interviewed at the Smith general practice was the majority partner.

The nurses – medical assistant

As previously mentioned, access to the PNs for interview at this practice was not provided. Instead, an interview took place with the medical assistant as she was the main person involved with Health Care Homes. The PNs were not involved with the Health Care Homes initiative.

The medical assistant, initially a cleaner at the practice and then a receptionist, undertook a Certificate III as a health services assistant to prepare for the HCH role. This involved 18 months of online study and a four-week nursing home placement. According to the medical assistant:

> … *we watched the nurses at the practice do INRs and BGLs a few times then we had a go, and we got a bit of feedback and then it was over to us … we were trained to assist the nurses basically* (MA).

The medical assistant undertook all the Health Care Homes activities, including care plans. She gained consent from the patient to partake in Health Care Homes, prepared a care plan with the patient, and then the GP signed off on the care plan.[1]

6.5 Interest in Health Care Homes

At the time that Health Care Homes began, the chief operations manager of this practice was new to her role. The Federal government had stipulated that 20 practices in South Australia could sign up to the initiative and, at that time, all positions had been filled. When two practices withdrew from the initiative during the patient sign-up period, this practice signed up in February 2018

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[1] In Australia, a Medical Assistant completes the nationally accredited Certificate IV in Medical Practice Assisting qualification Anderson, A. (2014). Introducing medical assistants into Australian general practices: Understanding receptivity and normalisation influences. *Doctor of Philosophy University of New South Wales*. http://unsworks.unsw.edu.au/fapi/datastream/unsworks:12759/SOURCE02?view=true .

According to the chief operations manager:

> *Based on what we heard from the Primary Health Network, for me, it was a question of why we aren't part of it … it was no different to the type of care planning that we had been doing, the only new thing was that it fixed funding … so, I could not see any reason why we shouldn't* (COM).

The GP claimed that the opportunity to experiment with a model that improved patient care was appealing to him:

> *I enjoy thinking outside the box … I was very interested in a model of improving patient care … I like the idea of VIP patients* (GP).

Both responses clearly indicate optimism about the initiative, although from two different perspectives. This illustrates the focus on improving patient care from the GP, while the operations manager had a focus on improving funding.

6.6 Engagement with Health Care Homes

Approximately 300 patients were signed up to the Health Care Homes trial at this practice. This equated to approximately 10 per cent of their visiting patients. With only four of the eleven GPs agreeing to be involved in the trial, this meant an average of 75 Health Care Homes' patients for each participating GP.

6.7 Reservations about engaging in Health Care Homes

Not all the GPs were encouraging about the Health Care Homes trial. According to the operations manager, "It took some coercion". She explained that the practice owners were partners in the business, while other GPs were employed on a contractual basis, giving them "more freedom to say no". The chief operations manager felt there was confusion about the trial between some GPs which resulted in a relatively low participation rate:

> *… firstly, their College was not very clear and there were mixed messages coming from them and it was about, if you want these things done, why don't you increase the payout per consultation and things like that* (COM).

6.8 What did they do? – Preparation for the trial

According to the operations manager, she was "sent on a program" to learn more about Health Care Homes, after which she approached the Adelaide Primary Health Network. Although initially, all the trial positions were full, two practices withdrew, providing this practice with a place within the trial.

According to the chief operations manager:

> *From the time we signed up, we had invited the Adelaide PHN on multiple occasions to speak to the doctors, we ran one on one sessions, we ran group sessions, we hosted events within our practice* (COM).

In preparation for the trial, the Smith general practice also employed a registered nurse who was given the specific role of Health Care Homes nurse. According to the chief operations manager, this nurse resigned soon after commencing:

> *… she was brought in for her skills and time management, but she just didn't want to continue doing this, so that is when we brought the medical assistant on board* (COM).

According to the chief operations manager, the existing PNs were opposed to Health Care Homes:

> *… they didn't want to participate in it, they were very clear … they just felt that, um, they didn't offer reasons, they felt that it would increase their workload* (COM).

Unable to speak with the nurses at this practice, it is difficult to deduce why they did not want to participate in the trial. After unsuccessfully employing a registered nurse for Health Care Homes, and with a refusal by the existing registered nurses to participate, this practice gave the responsibility for Health Care Homes to the medical assistant. Once the receptionist gained qualifications as a medical assistant, she moved directly into the role of preparing care plans for the Health Care Homes patients. She stated:

> *I think they had a plan for me that I didn't know about* (MA).

This indicated the willingness of the medical assistant to perform duties asked of her without question. It is cheaper to employ a medical assistant.

6.9 How did it operate?

The medical assistant was given the role of assisting with Health Care Homes. As she explained, after a GP identified a patient as suitable for the trial, she would then inform the patient about the trial, gain consent if appropriate, prepare the electronic care plan, and then contact allied health professionals to determine their willingness to participate in the patient's plan.

> *The GP might send me a message saying this patient might be a good candidate for Health Care Homes … I would see them then or ring them later … most already had an existing care plan and I would say it is a plan like the one you have, but the government want to see if we can all work off one software program and share information … they are like OK* (MA).

Funding from the Health Care Homes trial was used to pay the participating GPs, and as the chief operations manager explained, the payment system they developed ensured that the GPs were not out-of-pocket:

> *… we link it to what they would have got from Medicare plus their gap fee and they are more at an advantage because our gap fee billing structure is such that if a person is a pensioner or concession card holder, DVA gold, or above the age of 65, we bulk bill them, but into the fee I incorporate the gap fee that they would have got if they saw someone who was not in this category, so therefore, in that sense, they are better off, so it has kind of protected their income* (COM).

Patients enrolled into the Health Care Homes trial at the Smith general practice were provided with a key ring tag with the acronym VIP written on it as well as a dedicated phone number to ring (between working hours Monday-Friday). The medical assistant carried this phone during business hours and addressed any enquiries from Health Care Homes' patients. According to her, common enquiries related to requests for medication prescriptions or for consultations. Hailed as a "brilliant idea" by the GP and the chief operations manager, and as something that the patients "really loved" by the medical assistant, this served two purposes. Firstly, the patients felt as though they were Very Important People (VIP) as they were no longer required to ring reception staff which assisted with alleviating their workload. Secondly, according to the GP, this enabled the practice to bill for work where there was previously no mechanism to do so:

> *Historically, we as a profession have been forced to do things that we were not comfortable about, like if you do a bundle of scripts for a patient based on a telephone request, there is no payment. So, there is some pressure to consciously or unconsciously bring the patient in for reviewing tests, ordering new tests, doing scripts, just routine mundane office work reviews … a Health Care Homes' patient can ring a dedicated Health Care Homes nurse with their request, you get an enquiry from the nurse to do two scripts for Mrs Bloggs, you bill the practice for that work, and so the doctor gets paid, the patient is not inconvenienced, and the service is improved* (GP).

Interestingly, the GP referred to the medical assistant as a nurse.

The Smith general practice also held falls and balance sessions as well as wellness sessions for patients. According to the chief operations manager, these were able to be run because of the Health Care Homes funding.

> *The Health Care Homes helps us fund these, otherwise they wouldn't be possible because we wouldn't have had the funding for them* (COM).

I was interested in whether these sessions might have been provided without the Health Care Homes initiative, and according to the medical assistant, "I think Dr. XXX would have got around to it anyway". The sessions at this practice were available for any patient who had a care plan prepared; both Health Care Homes and non-Health Care Homes patients paid eight dollars per session.

6.10 What was useful?

All practice staff acknowledged the potential benefits to patient care that an electronic shared patient care plan could offer. The electronic shared care plan brought the patient notes all together in one place.

> *… possibly we are getting to a point where some of the IT is a little more organised. We are certainly getting new software. We are getting people on the same software platform about the same patient, so we don't have so much of disjointed records on different databases* (GP).

The medical assistant believed the shared care plan reduced paperwork.

> *I think that having an online care plan where all the allied health services, the specialist, the pharmacist, anybody that is part of that particular patient's care can log into that system and see what's happening. You don't have to be requesting paper forms and notes and things like that, it's all there, if there is anything that they want to know, then they can write a note on that actual software program* (MA).

The chief operations manager appreciated the standardisation of data entry.

> *I am a strong advocator for INCA because it provides encrypted messaging, it also creates one standard platform for care planning so anyone can pick up and run from where someone is, it is a standard approach, so it brings about a greater standardisation* (COM).

6.11 What was problematic?

The chief operations manager at the Smith general practice stated that "the existing nurses do the care plans … the RN does the care plan", and "the medical assistant "coordinates the whole thing". She also stated that the nurses "… just didn't want to be a part of it".

These claims were not supported by the medical assistant who stated that she was "doing Health Care Homes care plans". Comments from the GP added to this confusion when he said:

> … *for nurses, it has meant an increase in their status and ability to coordinate Health Care Homes* (GP).

The operations manager also stated that the medical assistant was "*categorised under the award as a nursing assistant"*, again adding to the confusion related to the role and governance of the medical assistant.

When asked if she felt suitably trained to undertake patient care plans, the medical assistant replied:

> *I could do much better on the care plans because, um, I've seen a couple of the nursing care plans and I just don't have that registered nursing background to be able to fill in all these things* (MA).

In addition, there were problems with the electronic shared care plan, including a lack of participation from allied health providers, in part due to the absence of training on how to participate in the care plan, which culminated in them reverting to their previous ways of engaging, as noted by the COM.

> *Not enough has been done to create an awareness around the allied health community that this is another way of doing things, they don't, a lot are not just happy to just record that they are always very simple and access the referrals through that and provide updates through that, they still want the faxes to come to them, so what we have to, those within our care … we still have some people just refuse to use it, I think a little bit more awareness around the benefits around accessing this* (COM).

The GP provided a similar perspective, indicating that:

> *The bureaucrats have failed to comprehend that no matter what the morality, unless you get the doctors on side, the system will fail. Any professional group will fail to engage in an IT system if they are not involved and approving from the start … it was an expensive failure* (GP).

The perceived benefits arising from patients logging in to access their care plan did not occur. The medical assistant noted that:

> *Most of them [patients] didn't care for it … weren't interested in it … maybe two patients said … oh, how can I do that?* (MA).

Additional issues centred around the inability of the care plan system to interface with current in-house systems, making importing and exporting data challenging, as reported by the COM:

> *… some of the things that still don't happen is once INCA can import from the medical software onto the platform, you can't export from INCA back to the medical software, so what the doctors are saying is, this is not convenient for us, I can't be cutting and pasting, so those are some of the things that I think INCA has got to work on so that you can import and export, so they say there are security concerns, privacy concerns, etc., but if it is a secure platform and you are looking at a way to import, you should also be able to look at a way to export* (COM).

The new financial model of a bundle payment also proved problematic. While this practice developed their own funding model associated with the bundle payments, they expressed concerns with the amount of funding allocated to each patient group (Pelletier et al.), in particular tier one, the lowest amount of funding of the three tiers. The GP and operations manager felt that the money allocated to tier one was not enough to cover additional work such as providing blood results and preparing prescriptions and, as the GP argued:

> *It is not enough money for tier one patients because they still require many of the things that other patients require such as consultations, scripts, blood tests, results etc* (GP).

As the COM reported, the complexity of care required for older people with chronic conditions meant that some of the needs of those allocated to tier one also applied to those allocated to tiers two and three.

> *Right, so, the top two tiers are OK, it's not too much of an issue with that, the issue is in the lower tier, it's, you have those on a care plan anyway, you are very soon going to exceed that, um, I seem to recall that the sheer nature of how patients behave when they are on a care plans, they tend to be older therefore they also need to see the doctor and sometimes seeing a nurse is not sufficient and therefore they keep coming back to the doctor and the doctor still has to take those calls or see them, bring them in for appointments etc, then it becomes quite difficult* (COM).

When accessing the GP or medical assistant for a health issue other than their HCH defined chronic disease, patients did not receive the benefits of the HCH trial, such as greater access to the medical assistant through the specified HCH telephone. This led to patient confusion about the meaning of their VIP status. For example, a VIP Health Care Homes patient could ring the Health Care Homes number and speak to the medical assistant immediately who would facilitate their request, for example, a prescription or an appointment with their allocated Health Care Homes doctor. However, if the same patient required a prescription for an illness that was not related to their chronic condition, they were required to book an appointment via the receptionist and wait for that appointment where they could see any available doctor or, if urgent, visit another specialist care centre. According to the medical assistant:

> *The trick is getting them to realise … if they cut their toe or something they will just have to wait* (MA).

6.12 What did the practice staff think?

The practice manager (chief operations manager)

The chief operations manager felt that the trial provided more opportunity around billing, particularly providing scope to be able to bill for the nurses' work (albeit it was the medical assistant who performed the Health Care Homes duties). Covering costs of work done was seen by the operations manager as a potential benefit of the trial. She felt that the encrypted messaging provided through the online platform was an asset and said:

> … *it provides encrypted messaging … it gives us scope to cover the costs of some consumables and wound care … they want us to use nurses … who pays for those nurses*? (COM).

The nurse – medical assistant

The medical assistant felt that the online care plan was beneficial for the patient, as all health professionals related to that person's care could log on to the system and all the information was in one place. She also highlighted the benefit of patients being able to log on to the system to access and add to their plan. However, she had previously stated that only two of the 300 Health Care Homes patients expressed an interest in doing so.

The general practitioner

The GP felt that the electronic health record was "*an expensive failure*". He also felt that Health Care Homes provided an "*enhancement of the nurses role*", albeit the nurses at this practice did not engage with Health Care Homes, suggesting there may be some confusion between the governance and scope of practice of the medical assistant and nurse.

6.13 What did the patients think?

Patients selected for interview were chosen by the operations manager in consultation with the medical assistant. When asked about the advantages of Health Care Homes, one patient replied:

> *I have no idea really, I just trust them, I don't know what it is about to be honest* (P1).

Nevertheless, it is evident that both patients were very pleased with the care they received from the practice. This patient claimed there had been no change in the way she had received care, although she did mention having a VIP key chain and using the VIP phone number:

> *I have used it sometimes if I need a prescription urgently or anything like that … I ring [name redacted] (*the medical assistant*) the nurse, and she organises it for me … I don't use the other number anymore … I have always rung the nurses* (P1).

Another patient was encouraged to have a care plan made for her so that she could receive free physiotherapy:

> *Doctor [name redacted] asked me if I wanted to go on the plan so that I could get free physio because I had back issues, and he said if you need to contact me, you can do it through the girls* (P2).

This patient also referred to the MA as a nurse, explaining that:

> *If I need anything, I just ring up XX the nurse (actually the MA) and she gets it done for me* (P2).

When asked if she knew about a care plan prepared for her, the patient replied:

> *No, they just automatically do it for me … I haven't noticed any difference in my care, it has always been good* (P1).

It is known that many patients who had an existing care plan had it moved to the online care plan system. This may be the case in this instance, or alternatively, a care plan was created for this patient with minimal input from her, or it may be that she simply cannot remember having one created.

Another patient was more aware of the care plan that she has had for a few years, and it appeared that her existing plan was moved over to the electronic shared system. One of the changes with the Health Care Homes initiative highlighted by this patient was the increased engagement with the ‘nurse’, although once again, this patient did mention the medical assistant by name and referred to her as a nurse. Whether or not the medical assistant corrected the patient is unknown. There are some potential dangers associated with this confusion given the medical assistant noted her own lack of knowledge when referring to the care plans.

6.14 Health Care Homes and the influence of COVID-19

One interesting effect of COVID-19 on the Health Care Homes trial within the Smith general practice related to how participating GPs were paid. During the Health Care Homes trial, participating GPs were paid for the patient consultation plus any gap payment. Once COVID-19 commenced, most GPs used telehealth and phone consultations to see patients. With telehealth initially bulk billed, the non-Health Care Homes GPs experienced a decrease in their pay, while the pay for GPs participating in Health Care Homes remained the same. According to the chief operations manager, this caused some unrest:

> … *the doctors who were initially not in favour of Health Care Homes were all of a sudden saying, we were never told this and we were never told that, we didn’t know this, we didn’t know that because when they saw that the income of the participating doctors was protected and their regular source of income was affected, it was oh no … but it was too late* (COM).

Prior to the COVID-19 pandemic, the Smith general practice hosted approximately six falls and balance programs and eight wellness programs for groups of patients each week. These sessions were organised by the medical assistant and visiting health professionals such as physiotherapists would conduct them. Any patient with a care plan was invited to attend, whether they were enrolled in the Health Care Homes trial or not. All patients were charged eight dollars for a 45-minute session. It is unclear whether, or how much of, the Health Care Homes funds were used for these sessions, although it can be deduced that there was no additional benefit for those enrolled with Health Care Homes.

In an attempt to mitigate the transmission of the COVID-19 virus, these face-to-face sessions ceased.

> *We were able to keep the exercise physiologist and engaged during the COVID period getting them to prepare a one-page document of exercises and activities*
>
> *that people can do in their homes, and whenever possible, we were able to send it out so that kind of kept those people engaged even more* (COM).

The chief operations manager did have some concerns about how these sessions were funded:

> … *the funds from this helped us pay* (COM).

When asked if these sessions might be re-established after COVID-19 and the end of the Health Care Homes trial, the chief operations manager stated:

> *It would have to be purely based on the bill to sustain it going forward … we are right now just charging a nominal fee, so we don't make anything from that, so that is something that we pay out, um, as part of the program* (COM).

It appears that non-Health Care Homes patients benefited from the Health Care Homes funds in this instance.

6.15 Summary

The Smith general practice was one of the last practices to sign up to the HCH trial in South Australia. This is a large practice, seeing approximately 4,500 patients each month. Only four of the eleven GPs working at this practice agreed to participate in the trial, and it was the chief operations manager who organised for the participating GPs to receive the usual Medicare fee plus a gap fee to ensure that their 'income was protected'. Once the COVID-19 pandemic commenced, and telephone consultations were bulk billed, the participating GPs were at a financial advantage, which appeared to cause some antagonism from those GPs who did not sign up to the HCH trial.

According to the COM at the Smith practice, the PNs were not involved with the HCH initiative, although the GP seemed to think otherwise. Having the MA run the HCH trial had the potential to undermine the role and scope of the PN when the MA was creating care plans and patients were of the understanding that she was a nurse.

The chief operations manager selected which patients from the Smith practice could be interviewed. This led to an assumption that they were chosen because they were happy with the care they received during the trial. One patient was asked if she wanted to be on a care plan to receive free physiotherapy, and the other stated, “they just did it for me”, when speaking about the commencement of a care plan. One could ponder whether one of the unstated aims of the initiative by the government was to increase the overall number of patient care plans. These two points led to questioning the motives and interests of those involved.

6.16 The ‘Anderson’ general practice

6.17 Introduction

Along with the ‘Smith’ general practice, the ‘Anderson’ practice is privately owned and sits within a group of six practices. Both practices have the same chief operations manager and one general practitioner as the majority partner.

6.18 Demographics

The Anderson general practice is situated within a local government area inside of the Adelaide Primary Health Network domain which covers an area of 631.1 square kilometres, with a population of 488,297 and a population density of 774.7 persons per square kilometre (Australian Government, 2020g). Table 6.3 provides information on some of the more pertinent demographic data for this local government area and a comparison with the Adelaide metropolitan region.

Table 6.3: Local government area data (Australian Government, 2020g).

	General practices	**General practitioners**	**Practice nurses**	**Community Pharmacists**	**Public hospitals**
Local Government area	95	451	174	202	2
The Adelaide Metropolitan region	319	1623	604	797	9

The average age of a person living within this local government area was 36 years in 2020, with the most prevalent health conditions being asthma, mental health and behavioural issues, diabetes, and arthritis (Australian Government, 2020g).

Located approximately 18.7 kilometres from the city of Adelaide, this practice sits within a designated metropolitan suburb of 2.7 square kilometres, with a total population of 3,733 people (Australian Bureau of Statistics, 2021b). Table 6.4 below illustrates a breakdown of population numbers by age and sex within the suburb in which this practice sits. Data from the Australian Bureau of Statistics 2021 census (2021b) show the population by age.

Table 6.4: Suburban population breakdown Re the Anderson general practice (Australian Bureau of Statistics, 2021b).

Age 0-19		**Age 20-34**		**Age 35-54**		**Age 55-74**		**Age 75 +**	
M	F	M	F	M	F	M	F	M	F
394	348	575	588	415	401	352	404	105	151

At the time the interviews took place, this practice had six PNs (three enrolled and three registered nurses), fifteen GPs, and was supported by onsite pathology, podiatry, audiology, dietetics, physiotherapy, and diabetes education. Particular to this practice is that it was a bulk billing practice, open seven days a week. Staff interviewed for this practice included the GP, the COM, and one PN.

6.19 Staff

The practice manager – chief operations manager

The COM for this practice was responsible for the operations of six general practices within this group and mentioned that this was a large practice that saw “approximately 5,000 patients each month” (COM).

The general practitioner

The GP interviewed for this practice was the majority partner of all six practices.

The nurses

The PN interviewed for this practice was a registered nurse who had been working at the ‘Anderson’ practice for three years, having previously held a PN role as chronic disease nurse at another practice for seven years. All six nurses within this practice rotated between chronic disease management, treatment room care, and home visits.

6.20 Interest in Health Care Homes

As previously explained, the ‘Smith’ and ‘Anderson’ general practices were the last two to sign up to the HCH trial in South Australia. This was because initially, the 20 allocated HCH positions were full and 2 practices withdrew, allowing these practices to join. The COM stated that because of the fixed funding and reasonably large volume of patients, she could not see any reason why they would not partake in the trial (COM). The GP was keen to explore a model that had potential to improve patient care. The PN explained that she volunteered to be the main HCH nurse at the practice given her previous experience assisting people to manage their chronic conditions.

6.21 Engagement with Health Care Homes

The ‘Anderson’ general practice is a large practice that saw approximately 5,000 patients each month. Having an older practice population demographic, most HCH patients at this practice were classified into the tier three level.

At the ‘Anderson’ practice, one GP enrolled 95 per cent of the HCH patients and, according to the COM, some of the other GPs were skeptical, claiming that the GPs said:

> *… if you want these things done, why don’t you increase the payout per consultation* (COM).

The COM went on to say:

> *I am quite confident that each location we could have enrolled more if more GPs were involved* (COM).

The PN confirmed that there were a few GPs involved with HCH; however, there was one GP who enrolled the majority of the HCH patients:

> *He has 400-odd patients himself and that is because he deals with a lot of retirement villages, so a lot of the retirement villages around here, he is their primary doctor, so he visits them and for us it was much easier for us to put*

> *them on Health Care Homes because we could talk to them on the phone rather than having to send a nurse out to them all the time which is what was happening before* (PN).

As the HCH nurse leader, the PN explained that she was the one

> *… always in the doctor's ears … we need to do this … we need to do that and following up on things* (PN).

She explained that all the patients in the 'Anderson' practice were moved to the online shared care plan.

6.22 Reservations about engaging with the Health Care Homes trial

The only reservations about engaging with the trial at the Anderson site were around the bundle payments, with some GPs concerned that the HCH payments would not be enough money for the work required. As the COM explained:

> *What a lot of people don't understand is, within general practice, the doctors are contractors, they are not employed, very few practices have a situation where the doctors are employed. Also, for us, we don't have all our doctors be partners in the business, um, so just only the owners who are partners in the business, and the others continue as contractors, so again, they kind of have the freedom to say no* (COM).

6.23 What did they do? – preparation for the trial

The PN explained that as part of the preparation for the trial, online educational modules were offered; however, she found them very lengthy:

> *… they were quite lengthy, um, the modules were obviously tailored to somebody who likes to sit down and read and read and read and watch the occasional video which is not really me* (PN).

The COM also held multiple in-house practice meetings to inform staff and encourage participation.

6.24 How did it operate?

The PNs at the 'Anderson' general practice moved all patients requiring care for their chronic conditions across to the shared care electronic platform. The PN explained that she would take patient phone calls and triage any patient issues that were beyond the capacity of the reception staff. She would also liaise with the GP on behalf of patients if they needed a new prescription. The PN at this practice did, however, explain that this was something that she was doing prior to the trial. She also noted that the HCH trial encouraged the use of standing orders. According to Leubner and Wild (2018, p. 14), standing orders are "written protocols that authorise designated members of the health care team (nurses and medical assistants) to complete certain clinical tasks without having to first obtain a physician's order". As the PN explained:

> *It meant that the GPs had free time because we could just deal with that patient, do whatever they needed, and then give the doctor a handover of what's happened and what we have done* (PN).

Because of this, the PN felt that although it did not increase her scope of practice, standing orders contributed to an increase in her capacity to provide care. Despite this, standing orders could have been instigated regardless of the HCH trial.

If an HCH patient needed a face-to-face consultation, they would usually see their regular GP and not necessarily the 'HCH GP'.

> *We try and get them to see their regular doctor, and if their regular doctor is not available, then they will see who is the best doctor, it doesn't need to be an HCH doctor* (PN).

6.25 What was useful?

Along with the implementation of standing orders, the PN found that the online care plan was useful:

> *Now it's the same document and you just change what you need, it's much easier to read, when it's printed out for patients its easier for them to read and they can access it themselves whereas before, it was paper and we would be getting, can you print that for me again, I have lost it, and then you have thirteen pages you have to print and hand them, which is obviously not good* (PN).

The PN explained that during the HCH trial, patients were more likely to call her with any issues managing their chronic condition/s. She felt this was because the patients were aware that there was previously no payment for this. She explained that:

> *A lot of things we were already doing, we were getting payments for doing those sorts of thing"* (PN).

6.26 What was problematic?

There was a lack of engagement with the care plan from allied health professionals, according to the PN due to "resistance to change", claiming that:

> *… we get it with our doctors all the time (laughs), so to try and convince an allied health provider that it is actually going to benefit them because it is one extra thing that they need to look after and that move away from practice has been quite difficult* (PM).

The PN also felt some resistance to change, explaining that one GP

> *… is very set with … I need to see my patients every six weeks, um, and that's been I guess a little bit detrimental to the patients because they don't need to see the doctor just for a B12 … that didn't work very well with HCH* (PN).

There were some issues with information technology associated with the care plan, as the PN explained:

> *We have had times back when CDMnet would not connect to our server, um, we haven't had that anywhere nearly as much with INCA, and there still is the occasional time that the doctor is like … I can't log on, but we still write the summary in our notes, so we know what's happening* (PN).

The PN felt there was a lack of engagement with the care plan from patients when:

> *Some of them are just using it to see who their specialists are to see addresses, phone numbers, contact details* (PN).

Although some patients engaged with the plan by entering blood pressure readings and blood glucose levels, the PN felt this lack of engagement was primarily due to a lack of training and awareness:

> *You need to have time to go back and train patients in how to use it, um, and it is just an added thing that you don't necessarily have time for because you need to sit down with them, and some of these people could take an hour on training how to use technology because they don't use it a lot* (PN).

Nevertheless, the PN felt that:

> *We do need to change, we can't stay in the old care plan system; we can't stay on a faxing system, we need to move forward* (PN).

This practice provided the HCH patients with a specific phone number and email to use; however, according to the PN:

> *We did have a mobile number and we had an email address, but we found that our patients just weren't using them, we still have the email address open but patients are more than happy to call through on the main line, um, and they get answered fairly quickly, so they are not worried about having to wait or anything like that* (PN).

6.27 Health Care Homes and the influence of COVID-19

The COVID-19 pandemic influenced the care of patients during the HCH trial in a number of ways. Due to the different billing systems for HCH and non-HCH patients, HCH patients were not required to see a doctor face-to-face for a prescription to be written, but other patients were.

Also, prior to HCH, this practice ran group sessions for patients, including education about falls and strength, dietetics, and general physiotherapy. Health Care Homes patients were not charged; however, non-HCH patients were charged a nominal fee. This service ceased due to the COVID-19 pandemic.

The PN explained that because they were providing phone consultations prior to COVID-19, there was little change:

> *We didn't have to adapt as much because we were already doing phone consults. So, with COVID we obviously saw an increase in phone consults for our general care plans and we could actually do them but we were already doing them for Health Care Homes um so it made it much easier* (PN).

Before the COVID-19 pandemic, one GP was telephoning patients for test results; however, there was no mechanism to bill for that, as the PN explained:

> *He was calling his patients if they needed results and things like that and couldn't come in, but he couldn't bill for that because there was no scope before COVID. So that was obviously not something that was helping our business*

> *side … we have to consider at what point do we say no, and for some, we have needed to say, hey look, you need to come in for a consult because the doctor is not going to get paid unless they see you* (PN).

6.28 Summary

The ‘Anderson’ general practice is a large practice and was one of the last in South Australia to sign up to the HCH trial. A bulk billing practice open seven days a week, it has a large compliment of GPs and PNs. Interestingly, 95 per cent of HCH patients at this practice were enrolled into the initiative by one GP, although this meant that not all HCH patients were able to see this particular GP and often saw their usual GP who had not signed up to the trial.

The most significant change to the role of the PN in the ‘Anderson’ practice was the establishment of standing orders. According to the PN, this provided her with more capacity to work to her scope of practice. Despite this, standing orders were able to be initiated regardless of the HCH trial. The PN felt that her role in care planning did not significantly change, although she was in favour of an online system having all information in one area. She expressed some frustration about the lack of education for allied health professionals and patients in relation to the online care plan, although felt it could provide positive change if embraced in the future.

Another major consequence of the trial expressed by the nurse as positive was the ability for the practice to bill for her and the GPs’ work that had previously been unbillable.

The next chapter, chapter seven presents the findings from interviews at the third case study practice, the ‘Brown’ general practice. For ease of readability, and by way of comparison, all case study chapters follow the same format.

Chapter 7: Case study three: the 'Brown' general practice

7.1 Introduction

This chapter explores interview responses from staff working within the third case study selected for this thesis. The chapter commences with contextual demographic data related to the practice, rationales provided by the practice for their involvement in the Health Care Homes (HCH) trial, and the facilitators to its successful implementation. The chapter concludes with a summation of the main points derived from the interviews which serve to provide a basis for the final discussion chapter.

7.2. The 'Brown' general practice

At the time of the interviews, the Brown general practice had 26 GPs (10 male and 16 female) with most working part-time, 6 female PNs, 17 reception staff (not all full-time), and 1 full-time business manager (BM). The Brown practice is a large practice owned and governed by three directors, all of whom are GPs at the practice. Psychology and physiotherapy services are onsite and additional allied health professionals visit as required. The practice is located on a main road with easy access to parking and sits in close proximity to supporting services such as pathology and radiology.

Interview responses have been provided by a GP, the business manager, two patients, and one PN. Only one PN was interviewed at this site because she was chosen as 'the HCH nurse' and deemed the most suitable to provide the information required to address the research question.

7.3 Demographics

The Brown general practice sits within a local government area inside of the Adelaide Primary Health Network domain which covers an area of 258.9 square kilometres, with a population of 526,908 and a population density of 2,035 persons per square kilometre (Australian Government, 2020g).

Table 7.1 provides some of the more pertinent demographic data for this local government area and provides a comparison with the Adelaide metropolitan region.

Table 7.1: Local government area data (Australian Government, 2020g).

	General practices	**General practitioners**	**Practice nurses**	**Community Pharmacists**	**Public hospitals**
Local Government area	142	728	246	371	5
The Adelaide Metropolitan region	319	1623	604	797	9

The average age of a person living within this local government area was 40 years in 2020, with the most prevalent health conditions being asthma, mental health and behavioural issues, diabetes, and arthritis (Australian Government, 2020g). Located approximately 3.7 kilometres from the city of Adelaide, this practice sits within a designated metropolitan suburb of 1.4 square kilometres, with a total population of 5,112 people (Australian Bureau of Statistics, 2021b). Table 7.2 below illustrates a breakdown of population numbers by age and sex within the suburb in which this practice sits. Data from the Australian Bureau of Statistics 2021 census (2021b) show the population by age.

Table 7.2: Suburban population breakdown, re: the Brown general practice (Australian Bureau of Statistics, 2021b)

Age 0-19		**Age 20-34**		**Age 35-54**		**Age 55-74**		**Age 75 +**	
M	F	M	F	M	F	M	F	M	F
566	530	510	542	727	766	492	587	161	231

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7.4 The staff

The business manager

As previously mentioned, the role of the practice or business manager varies greatly between practices, depending on the size of the practice, the qualifications of the practice manager, and the expectations of the GPs (Wood et al., 2016a). A practice manager generally performs the day-to-day running of a practice, and according to Oversby (2018), a business manager may also engage in business development, planning, and implementation. Although the two terms are often used interchangeably, a business manager is more commonly seen in larger practices such as the Brown practice. The business manager from the Brown practice was asked about his role and qualifications and responded:

> *I am the business manager and years and years ago, I did a Bachelor of Business with a major in Marketing, um … but predominantly, I actually came to the role through, um, I have been doing some finance work, I was the finance manager here before I took on this role, so I concentrated on the finance section, but I worked pretty closely with the previous business manager and one thing led to another* (BM).

As this is a relatively large practice, the business manager is supported by an office manager and an operations manager. The operations manager performs the higher-level operations which includes book-keeping, while the office manager runs the front-line functions of the practice such as reception, appointment book management, general practice administration support, and the other day-to-day functions of the practice. The office manager reports to the operations manager, and the operations manager to the business manager.

The general practitioner

The general practitioner was asked about his time at the practice and stated:

> *I am a general practitioner, pretty much full-time, and I have been here for 14 years in this practice* (GP).

The nurses

The business manager explained:

> *We have six registered nurses, two are for care planning specifically* (BM).

This practice allocated nurses to dedicated positions in chronic disease management, indicating their acknowledgement of the nurses' role in managing chronic disease and the benefits this affords, as the PN noted:

> *We have three treatment clinic nurses that work full-time in those clinics and also help out and we have two care plan nurses, me, and another nurse that do the care plans that is CDM and the health assessments and we have another nurse that fills in for holiday relief* (PN1).

When asked about her nursing history, the PN explained that she had previous experience assisting people to manage their chronic conditions:

> *Mainly, my nursing has been in aged care, about 16 years in Adelaide and about 4 years ago I went into Home Support services where I did CDM or telehealth through that, and so I've been at the [name redacted] practice for about 2½ years now and I have been doing care plans and a bit of clinic work when needed, I have been doing General Practice Management Plans and, um, I took over the HCH role soon after I started as the nurse here* (PN1).

7.5 Interest in Health Care Homes

From my experience working at a Division of General Practice, a commonality exists where the same group of practices tend to express interest in new initiatives. These practices have usually developed a good working rapport with the primary health network and demonstrate a team approach through their willingness and flexibility to trial new initiatives, as the BM said:

> *Umm, well we always want to be progressive and forward thinking and we try to a … our mindset is to be a flagship practice and also, um, to be a sort of a leader and, errm, what's my word … trying to put our hands up and be progressive, and we thought that if Health Care Homes continued beyond its trial period, we wanted to be on the ground floor so that we knew how best to manage it and what the requirements were, because also in the initial phase you know, um, we also got a bit of a you could put your hands up and give a bit of feedback and probably there was a stage where everything was settling in and if it was going to be introduced, we wanted to be ahead of the game* (BM).

When asked about the decision for the practice to partake in the Health Care Homes trial, the GP stated:

> *I am not involved with management decisions in any way, I simply work here, ummm, my guess is that they thought that was where the future of medicine was going, and they wanted to have their foot in the door, really, that's probably why I think they got involved* (GP).

This suggests that the GP either consciously chose not to be involved in whole-of-practice decisions, or that the decision to partake in the trial was made by others in the practice. This may be the case given that the GP refers to the decision-makers using the pronoun 'they', suggesting that there is some distance between him and the decision-makers. What is clear is that the focus of this GP was on improving the care provided to patients, and that he saw the HCH as part of the future direction of care; however, he expressed some disappointment that the trial did not achieve this.

> *I thought it may somehow provide more services for the patient, at the end of the day, I found it no more useful than a health care plan, and that was my criticism, I couldn't see the point* (GP).

7.6 Engagement with Health Care Homes

Similar to the previous two practices discussed in Chapter 6, not all GPs signed up for the HCH. This meant that while the practice had over 10,000 patients, only 150 were signed up, with less than one-third of the doctors engaged. As the BM noted:

> *… with a cohort of approximately 10,000 eligible patients, only approximately 150 were signed up to the trial, we had 26 GPs, and while 9 or 10 of these saw 1 or 2 Health Care Homes patients, approximately 4 carried the rest of the load* (BM).

The reasons for this are unclear; however, it may have potentially been related to hesitancy about the trial expressed by the RACGP, or its impact on the practice, their patients, and other workload commitments, or reluctance of the patients to participate. One strategy used by the business manager to encourage GP participation was to ensure that their payments were not compromised; in fact, the business manager provided an additional incentive payment, as he noted in the following comments:

> *They got paid the same because we also built in a responsibility fee so they got*

> *a payment, they continued to get paid as they normally would have been paid and then had a responsibility fee for the ongoing fee, and I think that assisted the doctors, it was just like a recognition of the additional work they were doing* (BM).

The BM went on to say that:

> *The nurses did not receive a change in pay rate because of Health Care Homes* (BM).

7.7 Reservations about engaging with the Health Care Homes trial

This practice had an established positive relationship with the Adelaide PHN, and according to the BM:

> *We always want to be progressive and forward thinking, we put our hands up … we wanted to be ahead of the game* (BM).

None of the staff at the Brown practice expressed any reservations about the trial prior to its commencement, although as previously mentioned, 4 of the 26 GPs at the practice took on most of the HCH patients.

7.8 What did they do? – preparation for the trial

In preparation for the trial, practice staff were supported by the Adelaide Primary Health Network to attend a conference in Melbourne. The PN also undertook online training:

> *We went over to the conference that was sort of … um, November 2019 I think in Melbourne … the conference was good for team building and I completed some online modules which were OK* (PN1).

One of the two existing PNs who was performing chronic disease management at the time was asked and agreed to be the Health Care Homes nurse, as she said no other PN wanted the role:

> *No-one else wanted to do it basically, so I was asked if I would do it and I said yeah that was fine, there was really only one other nurse that did care plans and she just wasn't interested in doing it* (PN1).

The business manager was also prepared from a financial perspective, indicating a view shared by the GP that bundle payments were possibly the way of the future, and consequently, useful for the practice to be prepared:

> *Well, we always thought that there was always going to come a day when it is a funding model for all patients similar to the Health Care Homes, and really what occurred probably more so was that it was presented to us and we worked towards putting a model together that we felt would work best for us and provide all the services that were required by the patients, so it was a funding model that worked with our workload, but also provided the best outcomes for patients … we had our own billing numbers attached to Health Care Homes … we did allocate a pool of money to establishing and decommissioning the program so to speak, because there were all those considerations of how to set up the workflow, the funding, um, that was all built in to how the funding was utilised* (BM).

7.9 How did it operate?

The Brown general practice used the Risk Stratification Tool to assist in determining each patient's care needs and associated funding tier, although the BM noted this was time-consuming:

> *… initially I started reconciling off each patient, but as it went on, we didn't continue that because that took a lot of time, um, but I have a sense that we probably robbed Peter to pay Paul within the model a bit* (BM).

The time-consuming nature associated with applying the Risk Stratification Tool to each patient resulted in this practice not completing the stratification for all Health Care Homes patients. This resulted in an uneven distribution of allocated funds between some patients. However, given the flexibility of bundle payments, it is doubtful that this had any effect on patient care.

The PN moved all patients enrolled with Health Care Homes across to the INCA care planning platform, including patients who previously had a care plan as well as those newly identified as suitable for the trial, as the PN noted.

> *I used the INCA template for the care plan and moved all the information over except the progress note, because you had to cut and paste it to go to the Medical Director* (PN1).

This also proved to be time-consuming for the nurse, and support was provided by the practice through additional funding.

> *… there was additional work moving them to the online platform and also, I guess explaining the system to the patients, onboarding them, and additional hours and funding was provided for this* (BM).

Despite this additional work, the PN felt that the number of care plans she prepared did not change during the trial, which indicates that almost all Health Care Homes patients at this practice had an existing care plan.

> *I was probably doing the same, because those HCH patients would have been captured in our care planning system anyway, and they just moved them across* (PN1).

The business manager explained that the administration staff were also involved with the trial, booking care plans, and organising reminders for patients, as he said:

> *… we did also have admin people involved, we had nurse admin, we have a nursing administrator, and they book care plans and assist with follow-up and reminders so, from that point of view, we had admin involved* (BM).

It is not uncommon for some general practice reception staff to be ex-nurses who do not currently hold registration with the nursing regulatory body, and therefore, cannot work as a nurse. The business manager has described one of the reception staff at the Brown general practice as a ‘nurse admin’. It is unclear whether this person is registered as a nurse, or whether they perform nursing duties. This illustrates the potential blurring of roles within the private business context of general practice, and associated issues with scope of practice and supervision for nurses.

In addition to the process associated with the online care plan, according to the BM, any Health Care Homes patient wanting to ask a question about their health, or requiring a prescription for example, could email the PN who would facilitate their request.

> *… there was more open communication, more accessible communication I think with the nurse* (BM).

Although this was not confirmed with the PN, the BM indicated that it differed from those patients not enrolled in Health Care Homes. They were required to phone the reception staff who would usually book them in for an appointment or occasionally transfer the call to the PN.

> *… it would be largely between reception, although sometimes the nurse will triage, but that is more so for childhood illnesses. But if they were an HCH patient, they would get dealt with by the nurse immediately. If it was an emergency, they might have been triaged by the nurse, or the receptionist would have reached out to the doctor* (BM).

7.10 What was useful?

One of the most frequently stated advantages of the Health Care Homes trial related to the flexibility of the bundle payments, as the BM stated:

> *I think there was adequate funding because we were able to continue to give the patients the care that they required, and we didn't find ourselves in a position where there wasn't adequate funding; however, there was a threshold, if there was just ten patients, I'm not sure that the tiers were appropriately funded, but if you could pool the money and you had enough patients registered, then it was a good model. For us, I think it was viable, but whether the funding in the tiers was correctly allocated, I'm not sure about that, but as a whole, we were able to make it work* (BM).

For the PN and the GP, this meant that tasks that were previously unable to be billed were now funded, a point raised by the PN:

> *There were some good things that I loved about it, because as nurses, we actually got paid for what we do. If I spoke to someone for 10 or 20 minutes, I got funding, so they put nursing time in the bucket of funding, and I think all practices could organise it how they wanted to, there were no rules about how to organise it in your practice, what we did was we got a code for billing HCH patients and the feeling was we just categorised that down into care plans, um, or the amount of time that I spent with them, so I could actually claim my time which was huge and that patients could just ring and talk to me and they didn't have to see the doctor first* (PN1).

Another advantage raised by the PN emerged because of the COVID-19 pandemic and the initiation of telehealth rather than the actual Health Care Homes trial.

> *When COVID came in that basically replaced HCH because it did the telehealth which they couldn't do before, so the telehealth meant patients could ring me and didn't need to speak to the doctor, and they could get their scripts and stuff was really good and the patient could email you and you got that payment, it depends how they use it. Most of us in general practice are experienced nurses and we use our experience, it gave you that independence when the patient didn't have to go in and see the doctor, I knew all the patients, some used the telephone and emails* (PN1).

In addition to the added ability to allocate billing to tasks, the nurse expressed a sense of increased job satisfaction and role enhancement when her skills and experience could be applied when consulting with a patient without the need for a GP consultation.

7.11 What was problematic?

In addition to the time-consuming nature of applying the Risk Stratification Tool and transferring patient care plans to the online system, there was a general feeling that the online shared care planning originally purported to benefit care by enhancing interdisciplinary communication, did not achieve its goal. According to the PN,

> *It was sitting there but it never got used* (PN1).

When asked about the level of patient engagement with the online care plan, the GP claimed:

> *I did not even know that patients could be involved in putting information in the system at all, I just wasn't prepared* (GP).

The business manager's response was:

> *No, I don't think there was that level of engagement* (BM).

The nurse explained:

> *Our patient base is in their 80s and that technology is beyond them, with HCH it was all about the IT program and people would ring us and say we just had an email from INCA, and they didn't know who it was* (PN1).

Before Health Care Homes, the PN would print off a care plan to give to the patient.

She explained that regardless of whether the care plan was online or not,

> *Not all patients bring them in, so whether it is HCH or not, many don't bring one in* (PN1).

Moving care plans to an electronic system may not benefit many of the patients with chronic conditions, as they are often elderly and not comfortable with new IT systems. Another problem with the electronic shared care plan faced by practice staff was the difficulty brought about by using two systems simultaneously. For example, non-Health Care Homes patients' care plans remained on the original practice software, while Health Care Homes patient care plans were transferred to the INCA system.

> *I have to say Health Care Homes wasn't loved by the practice here, the doctors were, the frustrating thing was they had to double write, if they wrote in INCA, they had to write in Medical Director, um, it wasn't taken up here, everyone was really happy when it finished* (PN1).
>
> *We had a sort of parallel system with HCH, but 90 per cent of people were on the old system* (GP).

The necessity to write the same information in two different systems came about because of the uncertainty of the trial. It was unclear whether the trial would continue and, as a safeguard, information was entered into both systems. Not only did this add time and potentially reduce productivity, it also caused some confusion and frustration for the GP.

> *I became quite negative to Health Care Homes, and I was quite happy to sit here and do my work really … mainly because it just seemed to be duplicating work, there were two different screens, I never got my head around Health Care Homes and the set-up, luckily the nurses were here to do that because I could never get my head around it, and I seemed to be flicking from one entry to the other, and all I thought was double entry, double screen, double work …umm, pain in the arse …* (GP).
>
> *It was also a time issue for me, and I thought you have to have the old and the new systems running in parallel, I felt you had to document the patient had been seen in the old system, but thinking about it, I think it was just HCH, but I felt that if we got audited by Medicare, that we needed proof that I had seen the*

> *patient, so I used the old system and I was always looking from one screen to the other … I found it cumbersome* (GP).

The PN also expressed issues with ease of use of the online care planning system yet seemed to accept that the initiative was a trial and teething problems were bound to occur.

> *It is a great practice, HCH, I have done lots of things over the years with programs and it didn't worry me, but the biggest thing was you had to cut-and-paste the progress notes, it didn't transfer over, all the vital sign stuff went over, but the progress notes couldn't* (PN1).

A lack of knowledge and education about the online shared care plan also contributed to a lack of engagement by the interdisciplinary team. This ultimately resulted in people reverting to the previous way of recording patient care plans and the failure of the online care plan to enhance interdisciplinary communication:

> *It was just like the old system, the EPCs and the everything to the specialists could have been faxed or emailed or posted, but after HCH was going, I still have allied health that didn't know how to access the shared care plan, a week wouldn't go past that we didn't get a call from allied health saying you haven't faxed through the EPC, and we would say, if you are under INCA, you need to go in and there seemed to be … we had some meetings with local GPs in the area and, um, the first pharmacist had no idea, the communication was, I think to the GPs was good, but to the allied health was lacking, so in theory the platform was good, but I don't think I ever saw one specialist write on it, the podiatrists were probably the best at it, um, the theory is good, but the practice about having that shared care didn't take off, and they only got it into Lyell McEwin, and they wanted to get into Flinders and the RAH, so if someone came in with HCH they could use it, but they didn't* (PN1).

After the trial ended, the PN transferred the INCA care plans back onto their previous system.

> *We just put everyone back into our previous system which was through Best Practice software, and now we have transferred it back and we are still doing the care plans, the information is exactly the same* (PN1).

> *Yes, we moved the care plans back and explained to patients that Health Care Homes had come to an end, but they were still going to get the care* (BM).

Another issue related to the temporary nature of the trial was expressed by the GP, who was unsure whether the trial would continue, so in his view, effort spent learning new systems was potentially wasted.

> *I very quickly thought I am not going to double-entry anything, and if it wasn't for the nurses, I wouldn't have had one patient I don't think. I thought, I don't want to learn a new system, particularly that is going to be temporary, and I was reasonably negative, probably didn't give it a good fair go and quickly formed the opinion of … what's the point of this, and I never changed that opinion and that was the ultimate disappointment, and that led me from a skeptical point of view in the beginning to … why am I bothering with this extra work, extra entry, trying to get my head around a new system when I see no benefit for me, the patient … it just seemed to become a more cumbersome care plan* (GP).

7.12 What did the practice staff think?

The business manager

The business manager acknowledged that the success of the trial at the Brown practice was largely due to the work of the PN. He also attributed its success to the engagement and support of the participating GPs and the 'clear vision' of the medical director, saying:

> *I don't really have a lot more to offer, but from my perspective, the success was the drive of our nurse and her coordinating the care of the patients with the doctor and her being proactive, so I think we were fortunate in that we had a director who was engaged and had a clear vision at the beginning, and we have pretty good doctor engagement and support here* (BM).

While the business manager illustrated the trial in a positive light, the same enthusiasm was not shared by the GP interviewed at this practice who, as reported above, thought HCH would result in more services to his patients. This highlights the lens through which each practice staff member viewed the trial and its outcomes, and the differing expectations linked to each of their roles.

The business manager acknowledged that, in his view, the trial increased the patients' access to the PN through more frequent email and phone communication. The inference is that the additional funding allowed for this; however, it was not a direct benefit of the trial per se, but rather came about as a result of the increased funding.

> *I do think it opened up the lines of communication and the capacity for the nurse to have more regular contact with the patients via telephone and email because there was that opportunity, the fact that the model allowed that* (BM).

When asked if he would have liked the trial to continue, the business manager responded:

> *Um, this sounds silly, but I feel neutral about it quite frankly, um, it is probably unfair of me to say I feel neutral about it, no, I do think it did work for us, and it worked for our patients, and it was of value* (BM).

When asked if he felt the trial enhanced interdisciplinary care for the patient, the business manager replied:

> *Because I was in a finance role, I can't answer that* (BM).

It would seem that each staff member was focused on how the Health Care Homes trial would influence their role.

The nurse

When reflecting on the trial, the comments made by the PN demonstrate an overall increase in job satisfaction; mostly related to the autonomous nature of the role:

> *I think it has enhanced it, because it gives you another look at a program and with any system you take the good things out of that and I suppose we went to conferences and there is team building and talking about the model of the shared care, I think down the track, we will have little hubs and do more education with patients. I enjoy getting my head around new things, and I had a lot of control because I could say OK let's do this, obviously I would talk to the doctors about it because they had ultimate control, but we could do the talk to the patient, it probably gave the nurse a lot more accountability (*PN1).

The nurse seemed to be pleased with the work she had done during the trial, saying:

> *I think I did really well, I got every patient to have their review on time* (PN1).

Despite having performed care planning before the trial, the nurse explained that the frequency of care planning increased during the trial period.

> *I was doing a lot more work under HCH because I was doing them more often,*
>
> *we did the level 3s three times a year, but under GPMP not Health Care Homes, it was only twice a year … I felt the fact that I was doing all the care plans I was ahead of them, it took me a while, but I get up-to-date. I think with HCH, we were given a pile of money and we could do what we liked with it* (PN1).

Working as the sole Health Care Homes nurse, provided this nurse with the opportunity to have more control over the process, demonstrating her ability to be self-directed when given the opportunity, but as the GP noted, there did not appear to be any additional services provided to the enrolled patients.

Although she felt there was no change to her relationship with the GPs, she again expressed a sense of both self-appreciation and being appreciated by others.

> *My relationship with the GPs was the same, the GPs liked it when I initiated the huddles and talked about 5 patients, those things were benefits* (PN1).

When asked how her role had changed during the Health Care Homes trial, the nurse responded:

> *We had an email set up and the Health Care Homes patients could use that if they wanted to contact me, they could also ring and speak to me, but in the clinic situation, we would do that all the time anyway. I would say out of about 100 Health Care Homes patients, only about 5 per cent of them did that* (PN1).

The general practitioner

The GP acknowledged the difficulty in providing comprehensive care to a person with chronic and complex conditions based on the fee-for-service structure. He expressed frustration with the limited available time and some despair that a solution may not be found.

> *I saw about 20 or 30 Health Care Homes patients. Now my, um, patient load has moved to a much older group of people, chronic disease in 15 minutes is*

> *really a nightmare, and you are basically trying to pick out the important pieces of what someone is saying, and it is just impossible really to provide anyone with a complex medical problem in 15 minutes, and you try your best around that. Did I see that the HCH offered any way around that? I didn't to be honest, um, I guess most GPs try to hope that they have the few really complex ones that go over time during the day counter-balanced by a couple of earaches or something quick. I'm not sure what's going on with health, but every GP I know is just overwhelmed and I think the nurses here are too, I don't see a solution* (GP).

The GP felt that the Health Care Homes trial did not offer a solution to the care restrictions linked to the fee-for-service system. He implied that his role was poorly understood by the government and, in part, by the nurses. His comment suggests he felt he was being coaxed into experimenting with new fiscal processes by the Federal government who had little or no understanding of his role, while at the same time acknowledging that in order to provide adequate care, a large amount of money was required.

> *Um … I think constantly we are being engineered in some way, um, my frank answer to that is that I don't know if the government or anyone truly knows what a GP actually does. I know that some of the nurses here are stunned about the diverse conditions and people we see, and the reality is that I don't think the government can provide anywhere nearly enough money* (GP).

Conversely, he also noted the 'value for money' that the fee-for-service structure provided.

> *My opinion is that general practice is great value for money, and they constantly want to fiddle with fee-for-service, and I am not sure how they can improve in the great value for money from general practice. I bulk bill children and older people, and pensioners have a 20-dollar gap, others are not bulk billed. I don't know how a surgery survives on only bulk billing; I suspect they do 100 per cent care plans, ha-ha* (GP).

He went on to support the notion that the fee-for-service system provides value for money and that he believed the Health Care Homes trial provided the false perception to patients that health care should be free or of minimal charge.

> *I don't think the public have an appreciation that it is fair to pay for your health care, and I think those sorts of models just encourage that thinking and because we are a billing practice, we find some patients are so indignant that there should be a fee for the service provided to them, but what they forget is that the*
>
> *doctors have trained for years, they have HECS debts, they have so much liability, they don't, they have been brought up to think that it is a right and not a privilege, um, so I am quite passionate about that one as you can hear, ha-ha* (GP).

The GP went on to make some international funding comparisons.

> *The other problem is that health is a bottomless pit when it comes to finance, I don't know what an administrator does at a public health level because you could spend our whole GNP on health … look at the USA, spends over 20 per cent on health and their outcomes are no better than ours, we spend about 12 per cent I think and our outcomes are no better than England that spends about 8 per cent of the GNP on health, um so um, it's very difficult. Certainly, the beauty with fee-for-service is that you have doctors motivated to actually see patients and I am going to be a little bit critical of people who work in a paid system … like talk about a private versus a public hospital in elective surgery, I can't give you exact figures, but friends of mine are anaesthetists and they might do 4-5 cases in the public hospital and 10 in the private in the same amount of time, there seems to be all these inefficiencies when it comes to people just being paid a wage, I think so you can say fee-for-service doesn't really work, but sitting around and not actually seeing people isn't the answer either, we are still here to try and help as many people as we can* (GP).

The focus from this GP was clearly on improving and ensuring optimum patient care. There is an indication that he felt the Health Care Homes trial to be futile in terms of enhancing patient care. He admitted that he had a poor understanding of the potential benefits that the bundle payment would bring, suggesting the possibility of poor education and/or communication about the trial, or possibly a reluctance by the GP to become involved. The other possibility is that he felt that bundle payment arrangements were not within his remit, and he was waiting for the benefits to emerge.

> *Again, perhaps from a manager's point of view … I didn't really see … I never*

> *really understood what you could do with this bundle. Initially, I thought, oh there is going to be more money available for services for the patients, they are going to have possibly improved outcomes because you can spend more money on their care. If they need more podiatry, or more input from some allied health professionals, there was going to be funding for that, now I … it seemed to quickly degenerate into just 5 health professionals the same as the care plan, and if there were any extra funds available, I didn't see any anyway … perhaps it went to management* (GP).

He also claimed that he was unaware that the trial promoted the GP as the leader of the interprofessional team:

> *I had no idea, that the patient could select the GP as the leader of the team, I don't even know what you are talking about* (GP).

Asked for his overall impression of the trial and whether it enhanced patient care, the GP replied:

> *I would say to you that I have a good relationship with the nurses here, and we communicate well … I wouldn't look at HCH again unless someone could convince me that there were actually benefits for the patient, like the person with a leg ulcer could get 30 visits with the wound specialist etc … I couldn't see any change or benefit for the patient with HCH. The trouble the government has is that if you say you can have 30 visits to the podiatrist, then everyone wants it and it would be nice if we could differentiate the people with special circumstances. There needs to be more provision for more visits for people who for example, need a diabetes educator and are newly diagnosed, there was no improvement. With everything that happened with Health Care Homes, nothing changed* (GP).
>
> *From that system, I was completely reliant on the nurses because I didn't really get my head around the software, so um yeah, it would have been no input from me at all if it was left purely to me to handle the system. My understanding is that the nurses were instrumental … I might have been the second most involved GP, but there weren't many of us involved* (GP).

7.13 What did the patients think?

One patient was aware that they had been signed up to participate in the Health Care Homes trial; however, they said that the only change to their care was the increased number of teleconferences; otherwise, there was no change to their care given that they already had a care plan in place, noting that:

> *I have always had a care plan and I think they mentioned would I mind being a trial for this particular aspect of it* (P1).
>
> *I think everything I was doing before, nothing changed, I would have had a few more teleconferences, someone would have rung me up from Canberra or something like that to do a survey* (P1).

The inclusion of telehealth commenced with the Health Care Homes program; however, it quickly became a common method of consultation because of the COVID-19 pandemic. When asked whether they felt there was a change with the way they interacted with the nurse, the patient replied:

> *No, no changes, I always had an interview with the nurse, you know for the 12-monthly plan, and it was reviewed every 6 months and that didn't change* (P1).
>
> *No, I would always ring the receptionist and make an appointment with the doctor and that hasn't changed. Nothing changed for me really, and I couldn't see what the benefit was for me* (P1).

This patient experienced difficulties because of the lack of engagement by the allied health professionals with their electronic care plan. When the patient visited another health professional for care, they did not have the appropriate information from his GP, necessitating a telephone call to the Brown practice to ascertain further information about the patient. The patient reported:

> *One problem I had with it was that the people that participate in the system, like I get referred to a podiatrist and a physiotherapist and they have problems recognising how to get the refund or whatever they do, it's not user-friendly on the computer. My GP puts the referral out and I have two visits to a podiatrist and three to a physiotherapist, and they find it hard looking up what the doctor has put on the system and usually they have to ring the practice to get further information* (P1).

The second patient interviewed expressed similar issues and frustration with the electronic care planning process. As a result of a lack of engagement with the electronic care plan by allied health professionals, this patient facilitated the communication himself by obtaining a hard copy of the care plan containing the referrals made by the GP, noting that:

> *Well, they both said to me that they had trouble accessing it and couldn't get access to any referrals or information and what I ended up doing was getting a hard copy of the referrals that the doctor gave me so that they could see them, I don't think they were accessing the site, I certainly didn't. I got a hard copy of the plan … I think they could have saved a lot of money* (P2).

Although this patient stated there was 'no change' to his care, he did mention that he felt a benefit from having regular check-ups, although this was not a direct consequence of the Health Care Homes trial, given that he mentioned there was no change.

> *Fortunately, I am in reasonably good health, so I have maintained my health and I think it has helped me maintain my level of health and I would say it has assisted my lifestyle and general health by having regular check-ups, but I have always had this* (P2).

7.14 Health Care Homes and the influence of COVID-19

One of the benefits for patients during the Health Care Homes trial was the use of telehealth and the ability for these patients to be offered telephone consultations. With the event of COVID-19, all patients were offered the same opportunity, as the practice manager said:

> *Um, so indeed, yeah I guess it kind of negated the advantages of HCH, um, but because we were able to continue to do it, I don't think it disadvantaged the HCH patients, we just carried on as usual for the HCH patients although their ability to come into the clinic would have been reduced, but it didn't impact their care, in fact, it was probably more of an advantage for the other patients who initially couldn't have been telehealth* (BM).

Telehealth meant that the PN's working hours were more flexible and she reported that:

> *Now, we are working from home now and doing care plans via telehealth …*

> *COVID has brought the good things about HCH* (PN1).

When asked if working from home might be a permanent option, she replied:

> *I hope that working from home continues because I can be so much more productive at home, it is nice too* (PN1).

7.15 Summary

Despite the Brown practice being a large practice with a cohort of approximately 10,000 patients eligible for HCH, only approximately 150 were signed to the trial. A total of 9 or 10 GPs from a total of 26 agreed to participate in HCH, with only 4 of these seeing the majority of the HCH patients. Overall, staff at the Brown practice did not see any advantages of the HCH trial for themselves, nor did the patients. The patients claimed that 'nothing changed'. There appeared to be a lack of awareness of the trial and what it involved for the GP, who claimed that he relied heavily on the nurses to assist with the online shared care plans and could not see any advantage for the patients as hoped. Despite this, the GP had high expectations of the trial, hoping it would result in more services for patients. However, he also saw that the HCH funding arrangement provided free health care; a position he did not agree with.

Patients themselves experienced a lack of engagement with the online care plan from other participating health professionals. Patients were forced to provide a hard copy of a referral to allied health professionals because they were unaware of how to use the online system. The PNs felt there was no change in how they were performing chronic disease management, albeit it was now on a shared electronic platform. This platform was troublesome for some staff at the Brown practice as running two systems was time-consuming and cumbersome. Participating GPs at the Brown practice were given an additional 'responsibility fee' for seeing patients, while there was no change in pay rates for the PNs. One PN did however appreciate the added team-building meetings held by whole-of-practice staff.

The next chapter provides the findings from the fourth general practice used as a case study for this research, the 'Webster' general practice. The case is introduced, demographics specific to the practice provided, and the interview findings presented. The chapter concludes with a summary of these findings.

Chapter 8: Case study four - the ‘Webster’ general practice

8.1 Introduction

This chapter presents the findings from interviews with staff working within the fourth and final reported case study, a general practice site within metropolitan Adelaide. An overview of characteristics specific to the practice, including a brief demographic profile, the imperatives of the practice to participate in the Health Care Homes trial, and the facilitators to successful implementation provide context for the reader. The chapter provides a picture of the PN role during the Health Care Homes initiative from multiple points of interest. The chapter concludes with a summary of the main findings from the interviews which will be further explored in the discussion chapter. To maintain anonymity, the practice will be referred to as the Webster general practice.

8.2 The ‘Webster’ general practice

The Webster general practice is a privately owned and operated business. It is one of a small number of practices owned by the practice manager and is co-owned by one of the GPs. Like all general practices in Australia, the Webster practice relies on government remuneration through Medicare, and uses a mix of bulk billing and gap fee charges, which is common among mid-sized private practices (PHCRIS, 2016).

As the practice manager noted:

> *We consider ourselves a private business, we are a private medical centre … we are a mixed billing practice and use a private business model, so we charge a 15-dollar gap, um, patients over the age of 60, pensioners, concession card holders are bulk billed and the rest we charge a 15-dollar gap (PM).*

8.3 Demographics

The Webster general practice sits within a local government area inside of the Adelaide Primary Health Network domain which covers an area of 631.1 square kilometres, with a population of 488,297 and a population density of 774.7 persons per square kilometre (Australian Government, 2020g). Table 8.1 represents some of the more pertinent demographic data for this local government area and provides a comparison with the Adelaide metropolitan region.

Table 8.1: Local government area data (Australian Government, 2020g).

	General practices	**General practitioners**	**Practice nurses**	**Community Pharmacists**	**Public hospitals**
Local Government area	95	451	174	202	2
The Adelaide Metropolitan region	319	1623	604	797	9

The average age of a person living within this local government area was 36 years in 2020, with the most prevalent health conditions being asthma, mental health and behavioural issues, diabetes, and arthritis (Australian Government, 2020g). The practice is located approximately 16.3 kilometres from the city of Adelaide and sits within a designated metropolitan suburb of 6.2 square kilometres, with a total population of 13,794 people (Australian Bureau of Statistics, 2021b).

Table 8.2 below illustrates a breakdown of population numbers by age and sex within the suburb in which this practice sits. Data from the Australian Bureau of Statistics 2021 census (2021b) show the population by age.

Table 8.2: Suburban population breakdown Re the Webster general practice (Australian Bureau of Statistics, 2021b).

Age 0-19		**Age 20-34**		**Age 35-54**		**Age 55-74**		**Age 75 +**	
M	F	M	F	M	F	M	F	M	F
1760	1657	2109	1863	2008	2027	956	1029	158	231

As presented by the above table, the highest percentage of people residing within this local government area in 2021 were within the 35-54 age group (Australian Bureau of Statistics, 2021b). This is a relatively young population, as later identified by the GP.

8.4 Staff

At the time the interviews were conducted, the Webster general practice had 13 GPs, (part- and full-time; 11 female; 2 male), 1 practice manager (PM), 3 female PNs, and a small number of visiting allied health professionals including a podiatrist, physiotherapist, and diabetes educator. Interviews were held with 1 GP, the PM, 3 patients, and 2 PNs. The practice is located on a main road with easy access and parking, has on-site pathology services, and is a teaching practice, often hosting medical students undertaking placement.

A notable characteristic of this practice is that its main focus is on child and women's health as well as chronic disease management and preventative care. As identified by the GP, many patients are working professionals with young children which aligns with the demographic data from the region. Interestingly, the GP indicated that the practice tended to see children as well as their parents and the children's grandparents, suggesting that families lived relatively close together within the region surrounding or reasonably close to the practice. The GP noted that while many were young professionals, several under the age of 50 had complicated medical conditions, with the majority of HCH patients being signed up to tier 2:

> *We have a young patient population, a lot of young families with young kids and then I have a few elderly patients, but not as many as the other practices I would say, a lot of our patients are under 50 and most are working professionals … we do a whole lot of shared care and early childhood health, so we typically tend to see lots of young families; however, we also see their parents and grandparents and so on, so we have quite a lot of patients who are in their 50s, 60s, 70s as well and age does not necessarily correlate with severity of illness, and off the top of my head, I can think of several patients who might be in their 50s who are quite complicated and people in their 60s who have diabetes, and others in their 30s with other chronic illnesses, so although they are young, they are not necessarily healthier … Actually, we have more patients in tier 2, but I would not be able to tell you about the numbers off the top of my head* (GP).

The practice manager

While the practice manager owns a small number of general practices, (including the Webster practice), she only managed two sites, spending most of her time at the Webster general practice. It is not uncommon for a practice manager to work across more than one site, and this reflects the variation in her role between the two practices, depending on the way that each practice operates. As she noted:

> *I mainly manage this practice, but then I facilitate other practices as well, sometimes I do it over the phone or remotely and help them out. So, they don't have a practice manager as such, but there is a person who has been there for the last 20-30 years, so she is pretty heads-up … we also have a practice principal* (PM).

The general practitioner

The GP was the principal within the practice, and noted his interests:

> *I am the practice principal and have an interest in lactation and child health* (GP).

The practice principal is usually a GP of authority who holds a supervisory position. In this case, the practice principal GP has been practicing medicine for more years than any other GP at the practice and is also a co-owner.

The nurses

Three registered nurses worked at the practice, with an additional registered nurse employed using Health Care Homes funding once the trial began. The PM noted:

> *We have three nurses, but at a time there will be two nurses working, so um, when we started with Health Care Homes, we increased another nurse and then at the same time we could use that nurse for other things as well, um, so since we started Health Care Homes after six months or so, we just got another nurse, usually two nurses at a time they, one will be in the treatment room and one will be in the chronic disease management room, and they block out some chronic disease management time for the Health Care Homes patients* (PM).

Health Care Home funding allowed this practice to employ another nurse whose time was spent on 'other things'. The inference here is that the nurses were either burdened with HCH-associated work which required an additional nurse, or that the practice had previously wanted to employ another nurse, but without additional funding, it was not financially viable to do so. It was not clear whether the additional nurse (employed with HCH funds) was performing HCH-related work only, a mix of HCH-related work and other duties or providing additional non-HCH duties.

The two original nurses had both been practicing for over a decade, with one in particular having additional qualifications that complemented the care requirements of this predominantly young practice demographic.

> *I trained at UniSA and then I did a grad dip in midwifery through UniSA as well, and I have worked predominantly in midwifery, apart from four years in paediatrics, um, and then I did extra training in lactation and in 2014* (PN1).

Despite also having significant experience, the second nurse had more experience working within the acute care system, in particular emergency and intensive care nursing, as she outlined in the interview:

> *I trained at UniSA, spent some time as an assistant in nursing in a renal ward, then did my grad program then in ED for about 5 years, ICU, and the wards, some first-aid training … then I came here in 2014 … I didn't have any experience in general practice* (PN2).

Prior to their appointment at the Webster practice, neither nurse had worked in a general practice environment or had managed chronic disease. For one nurse, the initial motivation to apply for their position in general practice was based on a dislike and incompatibility for shift work, as she said:

> *I was just sort of looking for non-hospital, non-shift work to be honest, because I was really noticing myself that I was struggling, and I looked around and I was lucky enough to fall into this particular practice, but I didn't have any experience or training in general practice* (PN1).

Anecdotally, it is known that practice nursing is seen as an attractive career choice for many older nurses struggling with the physical demands of shift work in the acute care system. With greater opportunities for part-time work, practice nursing often facilitates additional time for home and family life and associated activities such as caring for grandchildren. With an average of 21 years working as a nurse, and 11 years in primary health care, (Australian Primary Health Care Nurses Association, 2022a), the average PN has considerable experience, knowledge, and skills.

The PNs within this practice operated as a team, with all nurses able to perform any task from working in the treatment room to care planning for chronic disease management. During the HCH trial, no single nurse was identified as the ‘HCH nurse’, and this multi-tasking by all nurses illustrated both their adaptability and range of skills. This ability for all nurses to multi-task exemplified their ability to adapt to changes in work pressures and mitigated the need for the practice to employ agency staff to cover sick leave. While this nursing model can be seen as an advantage, a lack of hierarchy can also pose disadvantages. The nurse explains that although the nurses worked in an environment devoid of nursing hierarchy, there was a strong medical hierarchy at this practice, as she illustrated:

> *The thing with GP land is that it is predominantly medical hierarchy, and then you have the practice manager who predominantly does accountancy, um, or an IT background, and then there is no hierarchy in the sense of nursing, we just you know all help each other and lead each other* (PN1).

With no definable nursing hierarchy and no dedicated Health Care Homes nurse, Health Care Homes patients were assigned to a particular GP for their care but saw any available nurse. This does suggest a possible lack of continuity of care in relation to the nurse-patient relationship, potentially devaluing the nurses’ position when they are relegated to a more task-driven way of working rather than working as a significant team member engaged in care planning, as outlined by the PN:

> *Generally, one if us will be manning (sic) the treatment room, and that can be quite busy while the other one is doing chronic disease management, and I think that is another issue that I found as a nurse actually, and it is just that if the doctors can follow-up on that patient uniquely because they are the doctor for that Health Care Homes patient, the nurse I guess it will just depend who the nurse was who booked in for that care plan review … We don’t have a dedicated Health Care Homes nurse, but that would be very hard, I think ideally it would be helpful to have a dedicated Health Care Homes nurse, but it is just not feasible* (PN1).

8.5 Interest in Health Care Homes

One of the PNs was hopeful that the HCH trial would streamline care and empower patients through the use of the shared care plan. This PN

> *Hoped that the plan would empower the patient to see what was due for their care* (PN2).

8.6 Engagement with Health Care Homes

The Health Care Home initiative is one of many attempts to address the fragmentation of the health system. As noted in the previous chapter, it is common for the same group of practices to engage with the Primary Health Network (Wentworth Healthcare-PHN Nepean Blue Mountains) for more than one initiative. This continued engagement from specific practices over time is facilitated by not only a trusting relationship between them and the PHN, but also a willingness to engage in new initiatives.

As one PN explained, demonstrating this trait:

> *… a good thing about working for this practice is that they are always willing to take up anything new that they think is going to be helpful* (PN1).

The practice manager expressed not only a willingness to collaborate with the PHN, but also an appreciation for their involvement in assisting with the setting up of the HCH trial. The importance of ascertaining information about the trial and obtaining buy-in from practice staff was evident from the practice manager's comments. The practice manager explained that the success of the trial was dependent upon the number of patients signed up to the trial, and therefore, it was imperative to encourage staff to engage with the program.

> *When we initially heard from PHN about the HCH trial, we were interested so we went to many pre-HCH sessions that they had, and at the start no-one really knew what's going to happen … the PHN has been brilliant, especially [name redacted], at the time they were the HCH practice coordinator and they were working with us to develop a model about how can we do this without the traditional way, and so we had numerous meetings to get everyone on board and how to convince the doctors and everyone to be enrolling patients, and at the start we had a lot of meetings to work out how it is going to happen* (PM).

This practice had a high percentage of relatively young doctors, who, according to the practice manager, were often open to new ideas and ways of working.

> *… the practice is more open to new ideas, the doctors here are all very young doctors and they are very easy to have any changes* (PM).

After researching the HCH trial, it was acknowledged by the GP that one of the main advantages for this practice was the additional funding used to employ another nurse, thereby facilitating the enhancement of their CDM role, something that could not otherwise have been achieved with only two nurses. The GP also identified a desire that the HCH trial would enhance interdisciplinary communication between health care providers involved in care planning, and again, intimating that this would be possible with additional funding

> *… we were wanting our patients to have better communication between all health care providers, that was one of the main things, but also our practice has for a long time involved our nurses in EPCs and this funding was going to allow us to do that to the extent that we wanted to* (GP).

8.7 Reservations about engaging with the Health Care Homes trial

While the practice manager acknowledged extensive pre-trial preparation, she did have some reservations, including questions about how to identify and manage HCH patients and non-HCH patients concurrently. She indicated that she had reservations about the specific internal processes needed to introduce the initiative:

> *There were a few things we were worried about … how are we going to provide the service, how is the system going to work, with other patients and all sort of things … how we gonna deal with the issues and how well can we identify the patient, so a lot of questions were there* (PM).

As with many general practices, the Webster general practice relied heavily on information technology for billing services, patient appointments, care planning, and other clinical information. It was therefore logical that they had queries about how the HCH patient cohort would be integrated into their established system without causing additional work.

8.8 What did they do? – Preparation for the trial

As previously mentioned, in readiness for the trial, this practice held numerous meetings with practice staff and the PHN HCH coordinator to develop a HCH model that met the specific needs of their practice. One aim of these meetings was to encourage whole-of-practice engagement considering this was a new initiative and there would likely be uncertainties and challenges. In addition to the practice meetings, some staff attended a funded interstate education session about HCH to gain as much information as possible prior to commencement. One PN explained that although she was relatively new to general practice, she had many years working as a nurse and midwife, which enabled a greater awareness of her own educational needs. She was proactive in attending some CDM events held by SA Health as well as undertaking the HCH-specific online modules provided by the PHN and other organisations. As she noted:

> … *there are so many other offerings now through ANMF and APNA, there is quite a lot and I think you would be hard pressed to say that there wasn't enough opportunities to learn, it is just what you know are your areas you need to learn* (PN1).

The impression is that this practice very much acknowledged and appreciated the skills and experience of their PNs which, over time, developed into a respectful trust. The GP felt that the HCH trial coupled with the general practice's encouragement of the PNs to work to their maximum ability, enabled them to demonstrate their superior abilities through role enhancement. As the GP noted:

> *At our practice, we are very much in favour of utilising our nurses to a greater extent, they have skills that they are not able to use as much as they could, and yes, you kind of gauge how much each nurse knows over a period of time and you learn a bit about how they work ... it is allowing nurses to work to the top of their capacity and it has made a great difference with Health Care Homes that they have been able to do that to a greater extent, and it is the practice that allows that* (GP).

8.9 How did it operate?

As explained by the practice manager, the main users of the electronic shared care plan were the nurses:

> *The nurses were the ones working more on INCA than the doctors or anyone, so the doctor would probably go in and check a few things on the dashboard or enter in the notes, but the nurses are the main ones that do the care plans and make sure that the providers are there, so they are the main people who are driving that INCA* (PM).

One PN noted that her role was to create the online care plans. A GP would first identify if a patient met the HCH criteria, and then referred them to the PN who would explain the HCH initiative to the patient, and if the patient agreed, the nurse would create an online care plan for them. In other instances, this process would occur opportunistically when a patient attended the practice for reasons other than CDM. The GP would identify the patient as being suitable for the HCH trial and refer them to the PN who would inform them of the trial and enrol them if appropriate. In other instances, patients who already had a care plan were moved across to the HCH trial; however, according to the PN, it is not known whether they were aware of this or not:

> *… there were other patients who were used to the old way … and already had a care plan, we then individually without the patient present went into their notes and created a structure of a care plan within CDMnet and moved it over* (PN1).

Establishing the electronic care plan for HCH patients was solely the responsibility of the nurses at this practice.

As previously highlighted, one of the major changes associated with the HCH trial was the move from fee-for-service payments to a bundle payment system for those signed up to the initiative. Designed for episodic illness, the fee-for-service model has been entrenched in general practice since the inception of Medicare and poses barriers to effective care for people with chronic and complex conditions (McKittrick & McKenzie, 2018). According to the PM, approximately 20 per cent of the total patient population at this practice needed more than the allocated funding according to their tier, while other patients did not require as much; therefore, the PM was able to use some of these surplus funds to employ a PN full-time for two years.

> *… about 20 per cent of our total patient population need more than what their budget amount is, and the others, there are some that don’t need as much as*

> *what they offered, so I could take that money from some patients towards others and so far it has worked out for us alright, and so far I was able to last 2 years I had a nurse full time I was able to employ within that budget* (PM).

As seen above, there is some flexibility in the way that HCH funding could be used, and this was consistent with the original intentions of the trial. In this instance, HCH funding was used to employ an additional nurse and an additional receptionist to meet some of the added demands associated with HCH; however, while it is assumed that the nurse was employed using HCH funds, she was not always performing HCH-associated activities.

> *… the bundle pays for my additional staff … that nurse doesn't need to spend all her time on HCH, so she could spend time with the other patients as well … they can concentrate on clinical issues* (PM).

Health Care Homes funds were also used to enhance the PN's role in CDM. The PNs initiated a system each week they called the 'ward round'. They would select 10 HCH patients each week and examine their notes to determine if anything required follow-up, if so, they notified the GP and, in many instances, would then contact the patient and follow-up any issues:

> *… so, since we have the HCH, we do a ward round, so every week the nurses pick 10 patients from the list and they would go through the notes and see what needs to be followed-up … and the nurse would call the patient and do it, whereas before, they would not have done all of this* (PM).

This demonstrates initiative on the part of the PNs to ensure that all data was up-to-date, and it can be assumed that this would not have been the case without the additional PN employed through the HCH funding.

8.10 What was useful?

One of the main benefits of the HCH trial for this practice was the ability to bill for the nurses' work, where previously, there was no opportunity to do so. For example, the GP stated that the nurses would previously perform wound care; however, there was no mechanism to bill for that. The HCH initiative has afforded an opportunity for the practice to bill for the PN's time when performing duties such as wound care, as the GP explained:

> *… these days, a patient has greater flexibility for appointment only with the nurse say for wound care for example, and that is the sort of thing that I might have done in the past and I had no mechanism to bill that, whereas with Health Care Homes, I can bill that* (GP).

One potential benefit of the online care plan for the patient was the ability to add information to the plan such as their blood pressure readings or blood glucose levels. A perceived benefit of this was that all participating health care professionals could access this clinical data in real time. The added benefit for the patient was that they did not need to remember these parameters/results or write them down to bring to their next appointment. Unfortunately, very few patients used this facility and very few health professionals accessed the plan, mainly because they were unfamiliar with it, as the PN explained:

> *The patients that did engage with INCA, and there were a couple that did well, they had benefits from being able to see their information and being able to mark in their own home measures, like writing a note to the doctor in the progress notes, you might see that their blood pressure was low on that day, so when they came in, they already had their information there, and they didn't have to think back or bring in a piece of paper with the information on it, and some just weren't interested in having another aspect to their health care and didn't find it worth engaging with* (PN2).

Employing an additional nurse during the HCH trial period appears to have been one of the most useful benefits for this practice. The practice was able to enhance care by undertaking more of the patient care activities they were already performing, including 'data cleansing' or ensuring that all electronic data was up to date as well as undertaking timely care plan reviews. This does not reflect any enhancement or expansion of the nurse's role given these tasks were already being performed before HCH, but it did save the GP from the task of ensuring patient records were up to date, thus increasing the time the GP had to see patients, as explained by the PM:

> *… the problem is with only two nurses, the doctors couldn't see as many patients as they can now, I would love to see every single patient before they see the doctor to see the nurse first so they can all be updated regularly and the data with PEN CS, so things are updated, but it's not perfect, we don't get*

> *to see every patient, but we do see more patients* (PM).

It appears that while the HCH trial may have afforded opportunities for the expansion of the PN role, in this instance, the nurses were not undertaking any expanded roles, rather there was increased capacity for the nurses to undertake activities previously performed by them.

> *… a lot of CDM work is work that the nurses do as well, so that would be like motivational interviewing, like dressings and SNAP and lifestyle factors, and that has allowed me more time to devote to pregnancy-related care or early childhood care* (GP).

It is also clear from this, and the previous three case studies, that no additional services were provided to patients that might have enabled them to manage their chronic condition more readily.

8.11 What was problematic?

The practice manager explained that establishing an electronic patient system with the capacity to highlight HCH patients, enrol them into the HCH trial, and register them on the system was a slow, time-consuming process. Throughout the trial, approximately one-third (180) of all patients meeting the HCH trial criteria were signed up to HCH. The initial set-up process for HCH within this practice was seen as slow and time-consuming. Adding to this were difficulties with the format of the care plan itself, and the time taken to learn the new electronic system, and to move existing CDM patients from their previous care plan to the HCH INCA care plan platform, as the practice manager explained:

> *Initially, we did the registration and slowly we were getting all previous care plans from medical director to INCA, so that was a big process, they have to change everything, and back then, INCA didn't have the proper format for the care, and we had to work with them and to get a GPMP, that is what we wanted on INCA* (PM).

These issues were compounded by the uncertainty that a trial brings; for example, it was not clear whether the trial would continue beyond the initial timeframe, and therefore, there was uncertainty about whether to move all patients to the INCA system. This prolonged the time the practice ran two different systems concurrently:

> *… at the moment, we are not quite sure what is going to happen with HCH because INCA is paid by the PHN, so to move the normal patient to INCA, there is a fee involved because we have to pay for the regular software that we have and then you have to pay for the INCA on top of that; at the moment, we are using medical director for other patients and INCA only for HCH patients. We are not sure what is going to happen after this trial* (PM).

When the HCH trial ended, all HCH patients' care plans were moved from INCA back to the previous Medical Director platform. This work was done by the PNs who voiced concern over the considerable workload associated with this. One PN reported that this workload was compounded because some GPs were not familiar with the online care plan process, and would ask the nurses to make the necessary adjustments to the plan on their behalf, defeating the purpose of the interactive nature of the electronic care plan system, as the PN noted:

> *There are a few doctors who might have one health care home patient and they are like … can you look into their INCA and can you do this and change that, because they are just not familiar with it enough for them to do it themselves, and they see us as the go-to people for Health Care Homes* (PN1).

There were also issues with some allied health professionals not using the online platform because they were unfamiliar with it, which meant they reverted to their previous paper-based way of communicating. Using both systems simultaneously added to the workload of the PN and potentially had a negative impact upon patient care. Despite the intent for the online system to enhance interdisciplinary communication and care, staff at this practice felt this did not occur. Both the GP and PN at this practice acknowledged that the HCH initiative was a trial and, as such, it would take time for people to become familiar with the changes that came with it.

> *Some allied health providers, but not specialists, they are very reliant on paper … I am sure that we will get there, it's just been a couple of years rather than the 5-10 years that it usually takes to get these things rolled out* (GP).

A common criticism of trials is the lack of time needed to prepare and upskill all involved for successful implementation to occur. This was especially noted in relation to the HCH trial given the desire for an interdisciplinary approach. As the PN said in commenting on the failure of some GPs and allied health professionals to engage:

> *I completely respect why they wouldn't interact with it because no-one has really explained it to them, and it is just because we are part of the pilot program that we know all about it* (PN1).
>
> *I would love to see lot more specialists and allied health using INCA, as that would make it easier for everyone's sake, but they don't want to go in to new things … I had many discussions with them letting them know they could use it and the PHN helped a lot with this* (PM).

8.12 What did the practice staff think?

The practice manager

The practice manager used HCH funds to employ an additional PN and receptionist. The PM saw the advantages of an additional PN as they were able to conduct more data cleansing and, in addition, the additional PN also assisted with non-HCH clinical care.

The nurses

One of the predominant activities of the PN in CDM is care planning. As the nurse explained, during the HCH initiative, despite using an online care planning system designed to enhance interdisciplinary care, the process of care planning did not change. The time taken to prepare the plans increased because of the need to explain the new plan to the patient as well as the intricacies of learning and using a new system, but the actual care plan process did not change, as the PN reported:

> *… to be honest, it is the same because we are talking about the same type of things really, you know, what is their main goal, looking at what their chronic health issue and what we need to monitor and how they are going with that, I don't think the process of the care plan has changed much, but obviously because it is a trial, it has taken longer because we have grappled with the software, and there is all the explanatory time with the patient that you wouldn't have had before* (PN1).

There was a similar assumption made by the GP, who noted that:

> *The care planning is pretty similar to what it was before* (GP).

As one of the main users of the electronic care plan at this practice, one PN reported that she saw no benefit in interdisciplinary care because of its use.

> *I didn't find any benefit from them adding anything into INCA at all … I don't think there was any benefit on the topic of interdisciplinary care* (PN2).

From the nurses' perspective, there was no enhancement in terms of interdisciplinary care for the patient.

> *Essentially, it is the same because we personally use the software without them, produce the document, then we still print it off and fax it to them, um, which was the old way essentially because as not all of … in their defence, I can totally see why that is because how are they meant to know about Health Care Homes unless someone actually tells them … we were still doing things the old way for some people, but the pharmacists were good at accessing the new system, but we would never see notes from professionals like podiatrists and then the due dates for tasks would never be updated* (PN2).

No noticeable change to the PN role was identified as a result of the shift to bundle payments by any of the interviewees; however, the additional HCH funding allowed this practice to employ another full-time PN as well as a full-time receptionist which translated into increased time to allow them to perform activities, albeit activities that they had previously been performing. While the PNs interviewed in this case did not have any prior experience working in general practice, they held significant experience in other areas of nursing. When confronted with transferring and developing electronic care plans for 180 patients, the nurses at this practice developed a questionnaire to distribute to participating HCH GPs to ascertain their priority patients, demonstrating the proactive nature of the nurses within this practice and an awareness of the significant task before them. As one PN noted, outlining the collaborative working arrangements nurses at this practice enjoyed,

> *Another nurse and I put our heads together and developed a questionnaire and gave that to the doctor and gave them a summary of the process and asked them how they have found it and whether it was helpful or not, um, and out of that process, we decided that each doctor would give us their priority list, so you know we might have 4 doctors who might have one Health Care Homes*

> *patient, and another doctor might have 40, and you have a smattering of doctors with a couple, so we got each of them to give us their priority list and that is where we have started* (PN1).

The nurses also acknowledged that HCH funding could now be used to bill for their time, something that was not possible prior to the trial. This enabled them to spend more time talking to patients about their CDM goals and providing patient education, knowing that this could be billed through HCH funding.

> *Now they can actually have an appointment with the nurse, they don't have to see the doctor … it is more a matter of talking them through a few things on the phone, but also if X,Y or Z happens, we need you to ring back and talk to the doctor, it is more about talking them through their action plan and now we have the time … our issue is that we have time as a precious commodity and the doctors are needing the nurses for different things, and if I was randomly on the phone for half an hour educating a patient, you know what I mean, they are not going through that normal process, the doctors aren't getting any reimbursement for my time* (PN1).

When asked if they felt their role in telephone triage had changed during the trial, there was a discrepancy between the two nurses' responses:

> *We are doing more phone triage because before health care homes, the receptionist would probably have just booked them in to see the doctor* (PN1).

Contrary to this, the other nurse said:

> *It is the same as before and the receptionist will triage, and they will do what they did before like the usual route. You know we are lucky because [name redacted] the receptionist is also a nurse, and she has got a nursing background and she would talk to patients; I don't think we are doing any more telephone triage* (PN2).

The PNs were also asked to reflect upon their relationship with the GPs during the trial, and one PN explained:

> *I haven't seen anything change in relation to our engagement with the GPs, it's just something that has always been there with this practice* (PN2).

The PNs were asked if they performed any tasks during the trial that they had not previously performed, such as group sessions:

> *We don't actually, but that is one potential that I could see with Health Care Homes, and you could … it gives you more freedom to do things that are more relevant for the people that you see, and a group would be awesome, but as I said, our particular cohort are more, they don't actually come to the practice very much, so that wouldn't really be helpful for them. I know when I went to that conference, I heard about people from around the country doing things like that which I thought was really great, but no, it's not our particular thing, the only thing that we could come up with was this reviewing process which, for want of a better name, was called the ward round, um, that would actually fit in with you know who the clients are and what their issues are, and also suit the doctor's needs, you know, to make sure that things are not falling through the cracks* (PN1).

The general practitioner

When asked about the shift in funding and whether it covered costs, the GP noted that:

> *MBS is underfunded, and I think people were expecting the Health Care Home funding to be 20-30 per cent better, and we are not there yet. It is a trial and if we can keep on adjusting until we can get to some sort of happy balance, then I think we will get there in the end* (GP).

The GP also acknowledged that the role of the PN was essentially unchanged during the trial. He also acknowledged the ability to use HCH funds to bill for the nurses' work.

> *The nurses are still doing similar things as to what they were doing before we were enrolled in Health Care Homes, like SNAP prevention and motivational interviewing, but we were not billing for that* (GP).

When asked if HCH had any impact on the GP's time, the GP explained:

> *Yes it has, because now the nurses are spending more time doing things and the doctors are there to see anything that… …… so um, the doctor could give a standing order to the nurses, these are things I would love to see done for*

> *particular patients or the patient with a certain condition, and then the nurses would go and do all that, so the doctor doesn't need to be involved or anything like that, they could report back to the doctor the information and the doctor makes the final call and so they are spending less time with those patients and the nurses are spending more time with those patients and it gives the doctors more time dealing with the things that no-one else could do* (GP).

8.13 What did the patients think?

All patients interviewed within this case were selected by the practice manager who contacted the patients deemed most suitable who were also willing to be interviewed. In response to the online care plan, patients had mixed views, with some patients not interested in using the platform, and others interacting with it. According to the GP, approximately 3 out of 80 patients over the age of 65 would engage with the online care plan. The PN felt this was most likely due to their lack of ability and confidence with information technology. For one patient at this practice, accessing the care plan proved challenging:

> *I tried to access the online care plan, but I got stuck somewhere, and then I had to call someone to help, and I didn't end up calling anyone and I didn't benefit as much as I could have because I didn't really go ahead too much with it* (P1).

And another stated:

> *No, I didn't access the plan because I didn't need to* (P2).

While one patient seemed to understand the intent of the online shared care plan, it appears that another was not clear about what the HCH initiative actually was, although she commented that her husband had signed up to the trial:

> *I have been really happy with them, in fact my husband was with another practice, and they weren't looking after him very well and he now goes to this practice, and last week he signed up to the trial* (P1).

Given that the trial had already ended, it can be assumed this patient meant that her husband had signed up to this practice, but not the HCH trial.

One patient felt there was increased contact with the nurse; however, it appears this was mainly in relation to the care plan, as explained by the patient:

> *I started seeing a nurse more, and I am not sure if it was because of Health Care Homes or if it was because of my health care plan, um, so I'm not sure* (P2).

Another patient noted that engagement with the nurse had not changed during the trial:

> *The doctor or the nurse or the receptionist would always call me back if I needed to talk to them, and one of the receptionists is a nurse too … it's always been that way, I haven't noticed any difference … I mean, the nurse is always there* (P3).

8.14 Health Care Homes and the influence of COVID-19

The emergence of COVID-19 in early 2020 had a significant impact on how the Webster general practice provided Primary Health Care. Conscious of the need to mitigate the potential spread of COVID-19, especially for people over 65 years, and in line with the temporary telehealth MBS items introduced in March 2020, this practice encouraged the use of telehealth for all patients, where practicable. In addition, if patients were required to visit the practice, one GP was designated to consult with the 'sick' patients while other patients were seen by other GPs. The practice allocated one consulting room close to the entrance of the practice where the 'sick' patients were seen. The PM described this as:

> *… sort of like a clean doctor and a dirty doctor, and she used one room closer to the entrance during that time from March onwards, she was doing swabs and things like that* (PM).

Ongoing attempts to reduce the effects of COVID-19, coupled with the possibility of people contracting influenza, meant that the Webster practice ensured that providing influenza vaccination was a priority, rather than the ad-hoc, opportunistic means previously employed. The practice ensured that one day a week was dedicated to the administration of the influenza vaccine, and while the GP led this vaccination clinic, the PN administered the vaccines.

> *… we needed to get all our flu immunisations out there quickly, so we sort of shut down a whole section of a day and one of us would be doing flu clinics, so basically the doctor led that and said this is what I want to focus on … a lot of*

> *them would just roll up in the car park and the doctor would talk to them, then we would check their temperature and give the immunisation … it was difficult to work out who were the HCH patients and who were not, but they all had vaccinations this way* (PN1).

The HCH initiative offered practices the opportunity to negotiate the mode of care with, and for, their patients based on their circumstances, clinical need, or preference. This could take the form of face-to-face (discouraged during the COVID-19 pandemic), e-health, or phone consultations.

When the Australian government announced temporary telehealth MBS items in response to the COVID-19 pandemic, the practice was already offering, and in most cases, providing telehealth to all HCH patients, as the PN noted:

> *Before COVID, we were doing phone consults for the Health Care Homes patients, because there might be some days when they were due for review of their care plans, which we know can be done with Health Care Homes anyway and they could only do that by phone, so I would do it that way and Dr [name redacted] would do the follow-up on another day* (PN2).

While telephone consultations were encouraged as a direct result of COVID and the desire to minimise the risk of infection, patients preferred the convenience of a phone consultation rather than face-to-face consultations.

> *I think it was basically that I could, um, I guess be a part of my health care plan while at home, I didn't have to go into the practice* (P1).
>
> *… to be honest, I didn't hear much because of time, and I think it was good for me, like if I had to ask the GP to send me a referral, like, I could ask on the phone and I don't need to see in person and because of COVID, I could have telephone appointment, so it was a good point* (P2).

Many patients enjoyed the convenience that telehealth afforded, as they were able to be screened, speak with the doctor without the need for a face-to-face consultation, and have prescriptions and referrals written for them.

> *I don't really know much about Health Care Homes at all, but I suppose it was*

> *good because I didn't have to go in for my scripts, they could just fax them through and I could just go and pick them up … sometimes, I can have a phone consultation and I don't have to go in which is really good* (P1).

A high percentage of patients visiting this practice were employed and working full-time, and according to the GP, the flexibility of telephone consultations was particularly enticing for this cohort as the consultation could take place during their lunch break.

> *Most who have fed back to me have been happy about the fact they don't have to take time out of work and family life for appointments* (GP).

While it appears that most patients preferred the convenience of phone consultations, this was not the case for all of them:

> *I guess I don't think I like the idea of having an appointment over the phone even though it might be convenient, I prefer to go in … it's better for me if I see them face-to-face* (P2).

The PM acknowledged that there were also instances of the GPs preferring to see the patient face-to-face, and this was facilitated by using one consulting room close to the entrance of the practice where all patients were seen by one GP.

The PN acknowledged that COVID-19 was a 'blessing' for them because the system of telehealth was already in place through the HCH trial, and when telehealth was facilitated by COVID-19, patients and staff were already familiar with the system. Another advantage was that associated changes to Medicare enabled phone consults to be billed for all patients, regardless of whether they were HCH patients or not.

The option of a telephone consultation was very attractive for many patients. The COVID-19 pandemic made this possible, despite it also being one of the options within the HCH trial.

> *We were doing phone consults for Health Care Homes patients before COVID, and almost every patient wanted to join Health Care Homes because they wanted phone consults, we also have a great service with really good doctors, our practice is genuinely brilliant* (PN2).

8.15 Summary

The Webster general practice has a relatively young practice population. They used some of the HCH funding to employ an additional PN and receptionist. This PN was then able to spend time on clinical work as well as HCH duties, although there does not appear to have been any additional services provided to patients, just more surveillance. The PNs were the main users of the electronic care plans, and despite this, their role was essentially unchanged during the trial. Patients had a similar view regarding their care.

The main benefit for patients was the ability to have a telephone consultation rather than having to go to the practice. Although this was a feature of the HCH trial, once the COVID-19 pandemic began, telehealth became commonplace.

The next chapter presents an analysis of the HCH trial using Carol Bacchi’s six questions of policy interrogation. The chapter includes an overview of two trials funded by the RACGP and the Federal government designed to explore alternate funding models within general practice. Findings from interviews with a trial manager and a PN involved with one of these trials assisted in providing a contextual comparison with the HCH trial.

Chapter 9: Using Carol Bacchi's "What's the problem" framework to critique and evaluate Health Care Homes and the imperatives of corporate rationalisers.

9.1 Introduction

This chapter explores the Health Care Homes (HCH) trial using Carol Bacchi's "What's the problem" framework to interrogate policy. The aims of the HCH initiative will be highlighted, and Bacchi's framework utilised to identify the policy 'problems' and how they are conceptualised and addressed. The chapter uses Bacchi's six questions of policy interrogation to examine the HCH initiative while considering the influence of the three interest groups identified by Alford: corporate rationalisers, professional monopolists, and the community. The chapter includes a focus on the HCH evaluation and highlights the main outcomes of the trial along with aspects deemed successful and factors identified as contributing to its discontinuation.

I also provide an overview of two trials with similar aims to the HCH trial, undertaken to explore funding models in general practice. Funded by the Royal Australian College of General Practitioners (RACGP) and the Federal government, these trials also focused on people with chronic and complex conditions. To further interrogate the HCH trial and its relevance to reform, I supplement this data with findings from interviews undertaken with a practice nurse (PN) and the trial manager involved in one of these trials.

9.2 The Carol Bacchi framework: "What's the problem represented to be?" approach to policy interrogation

The 'What's the problem represented to be' (WPR) approach to policy interrogation was developed in 2009 by Carol Bacchi, a Canadian-Australian political scientist (Cairney, 2019). Bacchi's framework provides a way of examining how the corporate rationalisers design and implement policy. Her work draws on the idea that policymakers attempt to address problems and fix them (Bacchi, 2012); for example, what is identified as a problem will generate a specific solution. When this is applied to the HCH initiative, her framework allows critical analysis of how the 'problem' is represented within the initiative; for example, what problem is the HCH initiative designed to address? The policy becomes the postulated solution (Bacchi, 2012). This approach has been adopted to examine the HCH initiative and is aligned with Alford's theory of structural interests to explore the manner in which vested interests have an impact on policy.

Bacchi's framework uses the following six questions to explore policy perspectives and processes, agenda setting, and the meaning of the success or failure of a particular policy initiative (Bacchi, 2016). These questions are:

1. *What's the 'problem'?*
2. *What presuppositions or assumptions underpin this representation of the 'problem'?*
3. *How has this representation of the 'problem' come about?*
4. *What is left unproblematic in this problem representation?*
5. *What effects are produced by this representation of the 'problem'?*
6. *How/where has this representation of the 'problem' been produced, disseminated, and defended? How has it been (or could it be) questioned, disrupted and replaced?* (Bacchi, 2012, p. 21).

Analysis of the HCH initiative using Bacchi's framework allows a deeper examination of the way the corporate rationalisers 'think', and their priorities and associated actions in relation to HCH. According to Alford, the corporate rationalisers are the bureaucrats in various government departments that fund health care, and who are constantly exploring ways to increase cost-effectiveness. In her book, *Policy Paradox*, Stone (2012) talks of the tension within policy for people to have both private and collective benefits and how these often work against each other. She claims that the "interaction between ideas and alliances is ever-changing and never-ending" (Stone, 2012, p. 34). She goes on to say that it is common within policy for there to be conflict when people fight for and against ideas. Every idea has boundaries that tell us who is included and who is excluded; a manifestation of power through interest, cooperation, and loyalty (Stone, 2012). This is the perfect analogy to Alford's structural interest theory and provides a sound basis for the exploration of HCH using Bacchi's framework and Alford's theory of structural interests.

9.3 Health Care Homes and the Federal Government as a corporate rationaliser

In Australia, there have been long-standing tensions between the Australian Federal government and general practice. According to McDonald et al. (2011), collaborations are usually initiated to meet common goals, yet challenges may be present when there are incompatible ways of working between private and public services. Private service providers such as GPs seek positive patient outcomes within a framework of profit, whereas governments are more focused on a population health approach, and GPs often have difficulty in negotiating existing bureaucratic systems (McDonald et al., 2011).

According to Williamson (2008), the corporate rationalists' interests are focused on populations, planned and efficient use of resources, guidelines and protocols, pro-patient choice, and a belief that money is a strong motivator, and their actions often result in an abolition of clinical autonomy. Fear of losing autonomy has created much opposition to the actions of the corporate rationalists from organisations such as the AMA and RACGP, which can be understood as professional monopolists. Tension between the Federal government and general practice is exemplified by Dr David Mountain, who was AMA president for Western Australia between 2010 and 2012:

> *The Federal government is one without any track record in policy implementation or delivery. They endlessly over-promise and ask for people to trust them. They say it will be alright when we get around to sorting out the detail … the Government cannot see sense in consulting those who know most about health … It's time to stand up to the bullies in Canberra, defend our patients and the role of GPs as the real co-coordinators of effective primary care and resist the bureaucratisation of general practice* (Mountain, 2011).

As stated by Meyer et al. (2013), there is evidence to support the notion that a lack of trust in government programs has significant implications for their uptake and implementation; providing some strength to Alford's theory and its association with the failure of health reform.

The Federal government's Health Care Homes initiative commenced in October 2017, was extended in November 2019, and ended on 30th June 2021 (Australian Government, 2021b).

The initial plan was to involve approximately 65,000 patients across 200 general practices and Aboriginal Community Controlled Health Services in Australia (Royal Australian College of General Practitioners, 2016). Patient enrolment was slow, and in August 2019, 131 practices throughout Australia had signed up to the HCH trial which encompassed 10,161 patients (Health Policy Analysis, 2019a). Reasons for the reduced patient and practice numbers have been attributed to the extensive effort required by practices to both enrol patients and set up the HCH trial simultaneously, as well as GP's attitudes towards the bundle payment (Health Policy Analysis, 2020a, 2022). By August 2019, 107 practices had withdrawn; the reasons for this included:

- *the practice closing/changing ownership*
- *key staff leaving (i.e., staff in key roles championing HCH or trained in HCH)*
- *having too few patients enrolled to invest in making changes and/or for the program to be financially viable for the practice*
- *perceived lack of a clear value proposition for GPs and/or patients*
- *GPs' disinterest or dislike of the model*
- *inadequacy of the bundled payment*
- *inability of the practice to share care with external providers in the way that the program intended* (Health Policy Analysis, 2020a, p. 11).

Bundle payments were eventually indexed to ensure consistency with the MBS (Royal Australian College of General Practitioners, 2018b), which aligned with an increase in funding, something that the RACGP and the AMA had been lobbying for. Concerns about the lack of funding associated with HCH as well as the monitoring of billing practices by the government were highlighted by the AMA: "everyone is aware that the Department of Health is monitoring billing practices under the trial and no-one wants to fall foul of billing processes" (Kidd, 2018, p. 20). This represents a clear push- back by the professional monopolists against the actions of the Federal government, which sits within the group Alford calls the corporate rationalisers.

9.4 Question 1: What's the problem?

The Health Care Homes initiative was developed to better manage care for those with chronic disease. In Australia, the provision of chronic disease management is guided by a complex myriad of health reform initiatives and plans and service delivery models (Burgess et al., 2014). This is compounded by a shared responsibility for health services between the states and the Federal government, particularly when one jurisdiction may make decisions without fully understanding the implications for the other (Meyer et al., 2013). There is also often the assumption that issues within the health system can be 'fixed' when governments act (Meyer et al., 2013).

According to the Australian Government Department of Health (2020e), the aims of the HCH initiative (for people with chronic and complex conditions) were to:

> *Improve the patient care experience*
> *Improve health outcomes and population management*
> *Improve cost efficiency and sustainability in health care*
> *Improve health care provider experience (Australian Government, 2020e, p. no pagination)*

Adding to the already extensive criteria, general practices adopting the HCH initiative were to:

> ***Involve patients, families, and their carers as partners*** *in their care. Patients are activated to maximise their knowledge, skills, and confidence to manage their health, aided by technology and with the support of a health care team.*
> *Provide* ***enhanced access*** *to care in-hours (including to PNs and other staff), which may include support by telephone, email, or video-conferencing, and effective access to after-hours advice or care.*
> *Provide* ***flexible service delivery and team-based care*** *that supports integrated patient care across the continuum of the health system through shared information and care planning.*
> *Deliver* ***high-quality and safe*** *care. Care planning and clinical decisions are guided by evidence-based patient health care pathways, appropriate to the patient's needs.* (Primary Health Care Advisory Group, 2015, p. 4).

While the aims of the HCH initiative were primarily focused on CDM within the general practice setting, the broader aims included “reducing emergency department attendances and hospital admissions” (Health Policy Analysis, n.d.).

When applying Bacchi’s WPR framework, the implication is that the elements identified as aims are lacking and considered to be the problem/s; she suggests that the WPR framework assists in analysing associated policies through the application of critical scrutiny to discern how the problem/s are represented within them (Bacchi, 2012). For example, these problems do not sit outside of policy processes, but rather are produced as problems within policy proposals, and therefore, the analysis should focus on how the problems are constituted within the policies (Bacchi, 2016).

When applying Bacchi’s framework, HCH aims (presented as benefits of the trial), provide an underlying premise that there are associated problems that need fixing. These problems can be seen as:

- *uncoordinated services*
- *inequitable access to care*
- *high hospital demand*
- *sub-optimal patient outcomes*
- *time-poor GPs and PNs*
- *inability of general practice to meet the needs of all patients*
- *restrictions to MBS and the associated limitations to a collaborative team-based approach and information-sharing*
- *sub-optimal provider satisfaction* (Australian Government, 2020e).

9.5 Question 2: What presuppositions or assumptions underpin this representation of the ‘problem’?

As Bacchi states: “There is an assumption that there is some readily identifiable social/economic problem that needs ‘addressing’ and that policy-makers can get together and do their best to come up with a policy that will ‘deal with’ this problem” (Bacchi, 2016, p. 1). She notes that there is an assumption that there is a real world that is accessible to objective description and analysis; she calls this comprehensive rationalism, or the rational comprehensive model which is a form of reasoning. operating within policy (Bacchi, 2012). This gives rise to the question: how does the

HCH initiative give meaning to the issues it claims to address?

Information provided by the government to potential patients of the trial claimed that the trial would place them at the centre of care, able to choose the leader of their health care team, and that the development of an electronic care plan that could be easily accessed and shared among their health care team would encourage them to have a greater say in their care (Australian Government, 2018b). As Bacchi (2016) suggests, policy is often associated with research, and one way of distancing this from those involved, and thus, promoting more meaning, is to concentrate on the experience of the person. Again, the implication is that while these proposed initiatives are presented as benefits, there is an underlying assumption that services are uncoordinated, there is poor communication between providers, and that the patient experience is lacking; these are seen as 'problems' needing to be 'fixed'. In one of the HCH information sheets provided to health professionals, the Australian Government Department of Health identified the Australian Primary Health Care System as needing to be fixed, stating that it "does not always meet the needs of people with chronic and complex health conditions … it can be difficult getting appropriate care … with poor communication between health professionals" (Australian Government, 2018b). These issues are translated into policy via the HCH initiative which is presented as a means of 'fixing' the issues they have highlighted. Therefore, the corporate rationalisers (in this case, the Federal government) highlight the problems and then propose solutions to fix them. The HCH initiative or policy as presented by the Department of Health is then assumed to be justifiable, fair, and patient-focused, with a promise to address the current issues or problems they have identified, thus presenting those who claim to 'fix' the issues in a positive light.

According to Janet Quigley, from Health Systems Policy, there is an assumption that in order to provide more effective care for people with chronic conditions, practice level innovation must be encouraged to allow new ways of delivering this care (Australian Primary Health Care Nurses Association, 2017). In 2017, Karen Booth, the president of the Australian Primary Health Care Nurses Association, made the assumption that the HCH initiative would "help lesser achieving practices build up systems that they can use to achieve better outcomes" (Australian Primary Health Care Nurses Association, 2017). She went on to make the point that while PNs were already working to their full scope in many areas, the HCH initiative was assumed to provide an avenue to showcase the skill-set of the PN and provide an opportunity for a greater evaluation of the effects of nursing care on patient coordination, outcomes, and satisfaction (Australian Primary Health Care Nurses Association, 2017). The presupposition then was that PNs were already providing valuable care coordination, yet their role was poorly recognised. The HCH initiative was seen as a valuable avenue to showcase their role.

9.6 Question 3: How has this representation of the ‘problem’ come about?

This question asks how the problems are constituted within the policy recommendations. Bacchi (2016) proposes that governing takes place through the formation of problems; for example, “problem representations are treated as political interventions that need to be contested at the level of what they produce” (p. 12). Aligning with Alford’s Structural Interest Theory, Bacchi states that an “awareness of the forms of power involved in the shaping of problem representations” is important when considering how the representation of the problem has come about (Bacchi, 2012, p. 23). According to Cairney (2019), issues can be present for many years before governments decide to ‘solve’ them. Issues such as high hospital demand, a fragmented and uncoordinated health system, and time-poor GPs have been highlighted in the HCH trial as needing to be solved; however, they were not new.

The HCH initiative was based on the Patient Centred Medical Home (PCMH) model, first established in the United States in 1967, with the American Academy of Family Physicians introducing the first PCMH in 2006 (Metusela et al., 2020). The PCMH was seen as an avenue for providing team-based, patient-centred, whole-of-person care across the health system (Jackson, Powers, Chatterjee, Prvu Bettger, et al., 2013). With a goal to enhance communication between the health care team and to improve patient access to care, the PCMH was seen as a means of addressing the problems associated with an uncoordinated and fragmented system, and thus, was heralded to transform primary care.

It is evident that Australia shares many of the same issues when delivering primary care to those with chronic conditions. In 2009, Dr Kellerman wrote in the Australian Family Physician:

> *The PCMH is an advancement in PHC delivery, and its adoption in Australia would mean … the potential to facilitate team care arrangements for patients*

> *with chronic disease to reduce fragmentation of medical records, empower patients, and enable them to have greater access to, and ownership of, their medical information, and more specifically, targeted educational material and personalised self-management programs* (Kellerman, 2009, p. 279).

However, as was the case in Australia, adopting any variant of the PCMH would necessitate changes in practice accreditation and a move away from the traditional fee-for service funding model. With those who adopted the PCMH model and variants of it, there appeared to be no single common funding model, with enhanced fee-for-service, capitation, and external funding all represented (Jackson, Powers, Chatterjee, Prvu Bettger, et al., 2013).

Problems within the health care system were represented within the HCH initiative as needing to be fixed, and although not new, some solutions were presented as such. These ongoing attempts to address issues within the health system represent a clear synergy with the premise behind Alford's theory that the failure of health reform is associated with a structurally embedded conflict between the corporate rationalists and the professional monopolists (Checkland et al., 2009a). The corporate rationalists (government) through the HCH initiative proposed new ways and rationales to solve these ongoing issues. For example, the Enhanced Primary Care Package of 1999 saw the introduction of a number of MBS items (including care plans) initiated to enhance integrated care for people with chronic conditions (Department of Health, 2014c).

While care planning in general practice has been present for many years, in the case of HCH, the corporate rationalisers present online care planning as a 'new' and innovative approach to interdisciplinary care because it has moved to an electronic format and could be accessed by all members of the interdisciplinary team, including the patient. This 'new' approach to care planning was purported to 'fix' the issue of uncoordinated care and promote the interdisciplinary and integrated care approach needed for people with chronic and complex conditions. The Australian government Department of Health stipulated that only accredited practices who agreed to implement both the electronic shared care plan and My Health Record for HCH patients were eligible to participate in the trial. Both of these systems were not controlled by general practice; My Health Record was operated by The Australian Digital Health Agency and owned by the Australian Government (Australian

Government, n.d.), while the electronic shared care platform was funded and governed by the PHN. This represents another form of control by the corporate rationalisers. The PHN, (also considered a corporate rationaliser), uploaded the information technology software necessary to support the HCH trial onto the general practice systems. This included the online shared care plan, My Health Record, and the risk stratification tool used by practices to assist in determining patients' levels of care complexity, and thus, the level of associated funding (Dera, 2019). Other software programs uploaded by the PHN to existing practice systems provided the PHNs with a way to collect data from the practices related to HCH evaluation, and although this was seen as advantageous for the practices, it could also be perceived as another form of control and governance. Also highlighted by Alford, the dominant interests of certain groups means that their "dominance can be taken for granted as legitimate, and the only possible way in which these health services can be provided" (Alford, 1975, p. 17).

Another long-standing 'problem' identified within the HCH initiative relates to funding. The difficulty involved in providing interdisciplinary care for people with chronic and complex conditions within the MBS framework is well known. Previous reforms had resulted in slight 'tweaking' of MBS CDM strategies; however, despite it being time-consuming and complex, the traditional fee-for-service model remained (Welberry et al., 2019). Medicare Benefits Schedule financial reimbursement for care plans such as the GP Management Plan and the Team Care Arrangement is consistent for all patients regardless of complexity. This means that while additional time may be necessary to prepare a care plan for a patient with multiple co-morbidities and excessive complexity, the same funding is received for the preparation and review of a care plan when a patient has less complex needs, requiring less time (Swerrisen & Taylor, 2008). Once again, the proposal of a risk stratification tool to assess patient complexity and associated MBS reimbursement is not new, as evidenced by Swerrisen and Taylor's (2008) article promoting its use. The HCH initiative supported the use of a similar system, yet framed it as 'new', because of the remuneration of a quarterly bundled payment for each enrolled patient in each level of complexity (Jan 2017). In a 2018 GPnews article, Paul Hayes, managing editor for the RACGP, reported the following:

> *Patient eligibility for a CDM service should be determined by a GP, using their*

> *clinical judgement … Where a patient's 'condition' would not obviously come within the MBS definition, a GP may still consider whether the patient's condition and circumstances are such that they require a care plan because of factors such as non-compliance, inability to self-manage, or functional disability* (Hayes, 2018).

This appears to send a message from the professional monopolists (the RACGP) that GPs are the ones in charge of determining CDM eligibility rather than the corporate rationalisers. This implies that the patient risk stratification tool, seen as fundamental to patient eligibility (and funding allocation) through the HCH initiative, is superfluous and provides another example of ongoing tensions between the two interest groups.

9.7 Question 4: What is left unproblematic in this problem representation?

When Bacchi asks what is left unproblematic in the problem representation, she is really asking about the power of who is challenging whether a problem exists or not. For example, can the problem be identified in a different way thereby creating a shift in focus between different causes of the problem itself? In relation to HCH, the problems needing to be fixed have been framed by the powers that assert the benefits of the HCH initiative. For example, a greater emphasis on a solution to a problem may be illustrated by those who have the greatest potential to gain. Another example was that of the bundle payment system within HCH being an attempt to explore alternative funding models, yet it was only offered for patients with chronic and complex conditions, suggesting only a partial attempt to address the fee-for-service model.

There can be many causes for the identified problem; for example, uncoordinated care can be caused by fee-for-service MBS items, poor communication mechanisms between the multi-disciplinary team or time poor GPs, the absence of a PN, system failures, or to some extent, all of these. This section focuses on the concerns of the professional monopolisers and the wider community. Analysing all these factors can potentially illuminate which of these reasons dominate within the HCH initiative, and which power group has the most to gain from resolving the issue. By identifying what is left unproblematic, we can gain a greater understanding of the imperatives of the policymakers. This may be further explored by noting which groups have been excluded or, as Alford states, which groups have been repressed because of a lack of involvement in decision-making (Checkland et al., 2009b).

The HCH initiative was always purported to be patient centred; however, it seemed to dictate what patients required, providing an external view of patient needs rather than seeking the patient's perspective. During a personal conversation with Jo Root, the Policy Director of the Consumers Health Forum Australia, she advised that prior to the initiation of the HCH initiative, there "wasn't really any direct consumer involvement" (Root, personal communication, 15th June, 2022). She went on to say that in March 2016, a public survey was sent out to 10 consumer focus groups via the Primary Health Care Advisory Group. This survey presented the HCH initiative, with the aim of seeking feedback (Root, personal communication, 15th June, 2022). According to Leanne Wells, CEO of the Consumers Health Forum, prior to the commencement of HCH, most of the survey respondents said that: "we have to start somewhere" (Australian Primary Health Care Nurses Association, 2017). Therefore, while an improvement in patient care for those with chronic conditions was at the heart of the HCH initiative, the problems presented as needing to be fixed to achieve this were dictated to consumer groups by those who had initiated and carried out the trial. This represents a lack of consumer involvement in the development and identification of core issues and associated solutions.

The HCH initiative also promised to provide greater interdisciplinary integrated care through joint care planning facilitated by the shared electronic record. There was an assumption that all interdisciplinary care members would be willing to be involved. Furthermore, despite an improvement in the system interface, there were ongoing issues as well as a lack of involvement from interdisciplinary team members who experienced difficulties accessing the care plan, mainly because of a lack of training for the new system. This meant they quickly reverted to previous systems, hindering the government's promise of enhanced interdisciplinary care (Thomas et al., 2019).

As essential members of the interdisciplinary team, PNs were largely absent from decision-making and planning for HCHs. Inconsistent nomenclature in some government reports relating to the nursing role suggested a lack of knowledge and understanding of the PN's role and scope of practice.

As one PHN HCH practice facilitator said:

> *… there is a whole lot of confusion out there about the registered nurse, enrolled nurse, medical assistant, nurse practitioner, they don't really*

> *understand I don’t think* (PHN HCH facilitator).

By virtue of this misunderstanding, it places the nurse in a situation of diminished power which adds to the debate that PNs, along with patients, while differently placed, are considered to have repressed interests.

9.8 Question 5: What effects are produced by this representation of the ‘problem’?

The discussion that follows explores the intended and unintended consequences of the establishment of HCHs, drawing upon data from evaluation reports (Health Policy Analysis, 2019b, 2020a, 2022). It identifies who benefited from the current definition of the problem and who might have benefited from a new way of framing the problem.

The Australian Government Department of Health engaged a consortium to evaluate the Health Care Homes program. This consortium was led by Health Policy Analysis; an independent consulting firm specialising in the analysis of health data to evaluate the effectiveness of funding and costs and to measure performance outcomes (Health Policy Analysis, 2021). Members of the consortium included the Centre for Big Data Research in Health (The University of New South Wales), the Centre for Health Economics Research and Evaluation (University of Technology, Sydney), and several “Australian and international experts” (Health Policy Analysis, 2020).

According to the Australian Government Department of Health (2018a), a multi-tiered system of advisory groups was established to work with the Department of Health to report and advise on issues related to implementation and evaluation. An overarching Implementation Advisory Group (IAG) was established along with a patient identification working group, an evaluation working group, a guidelines education and training working group, and a payment mechanism working group; the latter being disbanded prior to HCH implementation (Australian Government, 2018a). Each of these groups comprised nursing representation with the exception of the evaluation working group, albeit a different nurse was represented in each group. It is unclear whether the nurses, or in fact any members of these groups, were invited to become members, were appointed, or whether they volunteered.

The following provides an illustration of the data collection rounds and timeframes produced by the evaluation teams:

Data collection round	Timeframe
Data collection1	October 2017 to 30 June 2018
Data collection 2	1 July to 31 December 2018
Data collection 3	1 January to 30 June 2019
Data collection 4	1 July 2019 to 30 June 2020
Data collection 5	1 July 2020 to 30 June 2021 (Health Policy Analysis, 2019a).

The entire HCH evaluation was conducted from 2017 to 2021 and focused on:

- *How the stage one rollout affected the quality of care and the experience of care for patients with chronic and complex conditions.*
- *The experience for practices of HCH, including changes to the practice, quality improvement system development, models of care, service delivery and business models.*
- *The use of health services by patients, particularly potentially preventable hospitalisations.*
- *The cost of care for the government, providers, and patients* (Australian Government, 2021a).

The HCH evaluation was drawn from interviews with practice staff, patients, and allied health staff, focus groups, case studies, and electronic data related to patient numbers, and data from Services Australia from hospitals, emergency departments, aged care facilities, and fact of death data (Health Policy Analysis, 2020a). The evaluated data was planned to be disseminated through a variety of means including ministerial and government briefings, publications and conference presentations, media releases, interim reports, and a final report released in mid-2022 (Health Policy Analysis, 2019a). Reports from 2019 consisted of three volumes from three different reporting periods. Each volume reported the process of the HCH initiative implementation, characteristics of the practices and patients, experiences of enrolling patients, and how change was managed (Health Policy Analysis, 2019b).

Table 9.1 below illustrates some of the issues experienced as well as perceived improvements as reported in the 2019 interim report:

Table 9.1: Reported issues and perceived improvements during the HCH trial – the

2019 interim report (Health Policy Analysis, 2019b).

Reported issues	**Perceived improvements**
Practice processes	
Difficulty enabling change management	Improved systems for follow-up of HCH patients
Increased workload associated with patient enrolment; More time is needed for practices to transition to HCH	Some GPs felt more supported when working as a team which enabled better prioritisation of care
The need for assistance with strategies to recruit patients	More regular contact and monitoring with care plans and reviews; An overall increase in communication with patients
Patient responses	
Some HCH patients were unaware they were enrolled and expressed little change in their care	Patients who noticed a change in care, noted increased access to the nurse or GP via telephone or email
	Some patients felt the nurse had a more active role in their care
	Some patients felt that by seeing the nurse, they were not wasting the GP’s time and were able to ask more questions about their health
	Some patients expressed the advantage of being able to refill scripts without a GP consultation
Online care planning	
	Patients reported that a few of the services they received (such as allied health) commenced after the
	HCH trial began, mostly prompted by the care planning process
	Some patients engaged with the online care plan, inputting physiological measures to assist in monitoring their conditions
Ongoing issues with implementing and using shared care planning software	
Lack of knowledge between external providers	
Ongoing problems communicating with external providers about shared patients through the software; Many providers use different software	
Ineffective use of shared care plan	

Limited functions of the systems to support key patient activities such as monitoring physiological symptoms or setting and tracking goals	
The software was different from their practice software, creating additional work learning how to use the new software and duplicating data in the new system	

Bundle payments and billing

For the benefits to be realised, a threshold number of enrolled patients would mean more financial flexibility to hire more staff or redirect tasks: too few patients meant the initiative was not financially viable	
Some GPs said it had negatively affected their roles due to confusion around billing and determining what is considered acute versus chronic care	
Difficulty keeping track of services provided to patients	
Difficulty determining what part of a patient's chronic condition could be billed and what could be billed separately	
Fewer face-to-face interactions with patients without the discipline of claiming individual services through Medicare	
Some staff felt that they had a greater workload and were unsure if that could be compensated by the bundle payment	
Some felt they were losing money under HCH and suggested an increase in funding	Some felt that they were either better off or broke even with the bundle payments compared to fee-for-service payments
Some felt that running dual finance systems (bundle and fee-for-service) was too difficult	

Influences on the role of the nurse

GPs not willing to let nurses take greater responsibility for their patients	
Some patients expected to see a GP every time	Patients became used to seeing the nurse as well as the GP at their visits

	Greater input from the nurse in chronic disease management; Reassigning work from a GP to a nurse or medical assistant
	Some nurses felt that the bundle payment system assisted in justifying their time

The three volumes of the 2020 Health Policy Interim Report focus on summarising and presenting the findings up until June 30, 2020. The 2020 Interim Report drew on the responses from the 2019 Interim Report by using this information to inform more detailed and specific questions (Health Policy Analysis, 2020a). The reports from 2020 also contain three volumes: Volume 1 (summary report), Volume 2 (evaluation report), and Volume 3 (progress report), and report on the period after patient enrolment (patient outcomes not evaluated in these reports) prior to the introduction of telehealth items related to COVID-19. Evaluation data was derived from interviews and focus groups with patients and patients' carers/families, GPs, and other primary care staff.

The evaluation data found in Volume 3 (Health Policy Analysis, 2020b) also contained clinical data including patient measurements such as blood pressure, cholesterol, smoking status, height, and weight. Volume 3 also considered information from focus groups with patients and patients' carers/families. The following table (Table 9.2) provides information on some of the issues experienced as well as perceived improvements as reported in the 2020 interim report.

Table 9.2: Reported issues and perceived improvements during the HCH trial – the 2020 interim report (Health Policy Analysis, 2020a).

Reported issues	**Perceived improvements**

Practice processes

The extensive training required, including the online shared care plan was prohibitive to setting up the HCH system in a timely fashion	
	Improved systems for follow-up and recall of HCH patients

Patient responses

Patients who noticed a difference in their care frequently cited increased access to a practice via telephone or email as one of the major benefits, but this was the only change they noticed	Patients who noticed a difference in their care frequently cited increased access to a practice via telephone or email as one of the major benefits, but this was the only change they noticed

Online care planning

The process for creating care plans was essentially unchanged from the previous way of doing things	
External providers lacked knowledge about the way the care plan worked	
Limited functions of the systems to support key patient activities, such as monitoring physiological measures or symptoms, or setting and tracking goals	
Some practices expressed issues with the bundle payment system such as difficulty in distributing the payments between HCH providers and taxation requirements	
For the benefits to be realised, a threshold number of enrolled patients would mean more financial flexibility to hire more staff or redirect tasks: too few patients meant the initiative was not financially viable	
	Some practices used the HCH funding to employ medical practice assistants and coordinators which were new roles to their practice. This added to their team specifically for managing HCH patients

Influences on the role of the nurse

The need to re-educate GPs to allow nurses to take on the responsibility of some patients, it was difficult to navigate around	The ability to do a phone conversation to check in on them
The need to employ more nurses to navigate the demographics of the practice	The need to employ more nurses to navigate the demographics of the practice
No change at all to the nurse's role as they already had a wide scope of practice, we have been managing chronic disease here for years, nothing has really changed there	The only difference now is that chronic disease management is more formalised and now the pay structure relates to it

No change at all really, the patients aren't treated any differently	The doctor would mention the program to the patient at a routine visit and the nurse would then explain the details to the patient
It didn't really free up the nurse to take a more hands-on role in care coordination as hoped	More regular contact and monitoring, frequent care plan reviews, pastoral care calls, and an overall increase in communication patients
	GPs were beginning to assign some more work to the PN or medical assistant
	Nurses were providing more personalised patient care, and enhancing patient monitoring and recalls

Following the 2020 reports, it was recommended that the HCH trial be extended for a further 12 months. Data collection ceased in June 2021 and the final report was published in August 2022. The following table (Table 9.3) describes some of the issues and recommendations from the final report.

Table 9.3: Reported issues and future recommendations, the 2022 final report (Health Policy Analysis, 2022).

Reported issues	**Recommendations**
Practice processes	
Some GPs were reluctant to delegate responsibilities to nurses	A team consisting of a GP, PN, and PM would be most effective
Allowing practices to develop their own models to meet local needs was time-consuming	A greater lead in time and education needed
Many practices felt that the $10,000 set up incentive was not enough for IT and other set up costs. Some practices cited these costs as reasons for them withdrawing from the trial	
The online training modules were time-consuming to complete and low engagement impacted an overall understanding of the model	Training materials should be more concise with more practical examples of relevance, supplemented with other modes of delivery
There was not enough time to prepare practices for the trial	Practices will need 6 to 12 months to prepare

While the bundle payment resulted in an overall higher payment to practices than MBS alone, and some felt that there was greater funding predictability, not all felt that funding was adequate. Most felt that the payment amount for tier 3 patients was inadequate and they avoided enrolling these patients. Some practices found it difficult to determine what was covered by the bundle payment and what was not	Finer payment tiers should be developed, especially for patients with very complex conditions. A clearer definition of what the bundle payment covers should be used in future. Possibly a blended payment system with a modified fee-for-service, alongside a bundle payment
Smaller practices had more flexibility to implement change but less resources. Larger practices had the resources but were challenged with engaging a larger group	Barriers should be identified and addressed

Patients

Some patients were reluctant to join the initiative	Design and implement ways to encourage patient participation and achieve higher levels of patient activation
In case study interviews, no practices mentioned including patients and their families in identifying strategies for change	Patients should be consulted on all care delivery issues in order to implement change
Having too few GPs and patients involved made it difficult to enact whole-of-practice change	Future initiatives should include target numbers for GP and patient participation
Uptake of the Patient Activated Measure (PAM) to improve patients' knowledge and skills to manage their conditions was patchy	Strategies to improve staff to enhance patient activation are needed
No significant change in patients' perception of person-centred care	

Online care planning

	Systems should be better integrated with existing practice systems. Additional incentive grants might assist with this
Shared care with external providers did not change during the trial. There was a lack of familiarity between providers due to the variety of software tools used	More awareness and training of the required systems needed for allied health in the future

Although some practices reported more comprehensive care planning and greater patient engagement, they still printed the care plan for patients because they found very few patients actually accessed the online plan, mainly due to the association between their age and IT useability	My Health Record should be considered as a key repository for the shared care plan
Influences on the nurse's role	
Improved access to the nurse with more care planning, more regular recalls, and the ability to call the nurse at any time	
Some patients were confused about the care plan and what it involved	Sometimes nurses lacked the confidence to explain the initiative to patients, and some patients felt confused about what the trial involved
Little change in the way that nurses and GPs worked	

Some intended aims of the HCH initiative were realised; for example, some GPs assigned more work to the nurse, although as one nurse explained, this was not always without some challenges:

> *We've had to, probably, re-educate GPs to allow the nurses to take on the responsibility of care of some of the patients. So that was probably a really difficult thing to navigate around, but we got there eventually. But yes, probably having to put a lot more nurses on to be able to manage the demographics of our practice* [Practice Manager, R4, Practice 4]. (Health Policy Analysis, 2020b, p. 25).

One unintended consequence of the HCH trial was that, in some instances, there was no change to the role of the PN, either because the practice was still trying to work out how to involve nurses more, or the nurses already had a wide scope of practice prior to HCH. As quoted in the report by one nurse:

> *To be honest with you, not a lot has changed. The patients aren't treated any different, that I've noticed. So not a lot of change at all really* [Nurse, R4, Practice 10] (Health Policy Analysis, 2020b, p. 21).

Further unintended consequences of the HCH trial are highlighted above and relate to the difficulty and increased workload associated with recruiting participants and the confusion experienced by staff when running two different systems. For example, once risk stratification of patients had taken place, a bundle payment was provided to practices. This bundle payment was to be used for care associated with HCH patients, yet not all patients attending the practice were HCH patients, and some were billed for both CDM through HCH funds as well as MBS for non-CDM care. Challenges ensued when two payment systems for HCH and non-HCH patients were operating simultaneously (Thomas et al., 2019). Added challenges were brought about by the difficulty apportioning the bundle payments to the various GPs within the practice, especially when HCH patients did not always see their preferred, or the same, GP (Thomas et al., 2019). There was difficulty in adapting current billing systems to accommodate the HCH bundle payment system, as one PHN coordinator stated:

> *No matter how intelligent the people were, and no matter how motivated they were, they could still not put this in place based on the business models that they were operating under* (PHNCOO).

Another unintended consequence of the trial was that the online care plan was not well used by many interdisciplinary providers, hindering the overall aim of enhanced integrative care. A lack of engagement with the trial by some GPs and the part-time working conditions of others meant that the patient would often see GPs not involved in the HCH trial; an unintended challenge to the overall aim of team-based care (Health Policy Analysis, 2022). Although the HCH trial evaluation claimed some improvements in patient access and chronic disease management processes, there was no significant change in the patient experience and health care use outside of primary care or health outcomes (Health Policy Analysis, 2022).

Poor uptake of the trial, a limited timeframe, and staff attitudes, especially in relation to the bundle payment system, hindered any meaningful conclusions about the success of the HCH initiative (Health Policy Analysis, 2022).

9.9 Question 6: How/where has this representation of the ‘problem’ been produced, disseminated, and defended? How has it been (or could it be) questioned, disrupted, and replaced?

One strategy for production and replication of problem representation is policy sharing. Policymakers in many countries have attempted to respond to the increased prevalence of chronic disease by improving care coordination and enhancing access to a multidisciplinary team through the provision of high quality equitable and accessible care (Maier et al., 2018). According to Kuluski et al. (2017), primary care reforms in developed countries such as New Zealand and Canada have attempted to move towards a more integrated care approach by implementing some form of HCH variant, with 'policy sharing' occurring when one country adopts or modifies ideas from another. Similar trends in models of care improvement and reforms have been seen in these countries (Finlayson et al., 2012), and although they have different geographical areas and different health system structures, this policy sharing has been facilitated by relatively common demographic characteristics and burdens of illness (Papanicolas et al., 2018). They also share the problems identified by the HCH initiative such as uncoordinated care, issues with funding not conducive to CDM, time- poor GPs, inequitable access, and poor patient outcomes linked to an overburdened acute health system.

In Australia between 2015-2018, the Gold Coast Integrated Care Programme was conducted. This trial was aimed at enhancing care for those with chronic and complex conditions by addressing fragmentation of the health system and improving the integration of care between disciplines and sectors (McMurray et al., 2021). This programme too shared similar problems to the HCH trial. Problems with the electronic communication platform and the frustration of having to duplicate entries, patient hesitancy to engage with electronic records, uncertain future funding, and practice staff (nurses, practice managers, GPs, and allied health professionals) with high workloads throughout the trial period (McMurray et al., 2021).

Representations of a problem can also be disrupted. Bacchi argues that rather than just accepting the problems identified within policy, researchers should challenge their origins, purposes, and effects (Cairney, 2019). This was the purpose of the QUEST and EQuIP-GP trials conducted by the RACGP, and as outlined previously, initiated by the professional monopolisers to demonstrate what was happening in the corporate rationalists' proposal for HCH.

The Quality Enhanced General Practice Trial (QUEST) and EQuIP-GP trials.

According to the RACGP, the amount of funding associated with the HCH trial was inadequate, and this set up the trial to fail from the outset (Lyons, 2017). The AMA expressed similar concerns about the poor funding associated with HCH, stating that the model was “concerning” … and at risk of failing because it was underfunded (Australian Medical Association, 2016a).

The Quality Enhanced general practice Services Trial (QUEST), along with the EQuIP-GP trial ran concurrently between 2018-2019, commencing when the HCH trial began. Both of these trials are examples of how the HCH initiative was questioned by medicine (professional monopolists). The RACGP approached the then health minister, Mr Greg Hunt, with their concerns, and $5 million dollars was provided to the RACGP to investigate improvements in general practice care, ultimately used for the two trials. General practice networks around Australia were approached by the RACGP with a list of preferred interventions. These included patient enrolment to a preferred GP, longer GP appointments, follow-up after significant health events/post discharge, and same day appointments for children and young people experiencing acute conditions (Flinders University, 2021; Peterson et al., 2019). As a response to the RACGP’s view that HCH was underfunded, both trials investigated new funding models in general practice, with patients enrolling in the initiative and nominating a preferred GP, with one of the cohorts of focus being people with chronic and complex conditions.

Both the QUEST and EQuiP-GP trials were undertaken by university academic staff and based on randomised control trial studies incorporating an intervention group of general practices (16 practices in EQuIP-GP and 10 in QUEST) and a control group of practices where care was unchanged (17 in EQuIP-GP and 10 in QUEST) (Bonney et al., 2022; Reed et al., 2022).

In an attempt to challenge the proposed inadequate funding model associated with HCH, both trials introduced alternate funding models for their intervention group. This funding did not replace existing funding models (as seen with the HCH trial); instead, it provided additional funding on top of the current funding model. The EQuiP-GP trial used an incentive-based payment system, and for those aged 18 years and over with a chronic condition, these incentive payments were linked to consultations longer than 15 minutes as well as the number of people seen within one week following hospital discharge (Peterson et al., 2019). The trial was set up to provide both evidence related to improvements based on incentive payments, and as a way to compare block-funded payments for performance models used in the UK and the bundle payments used in the Australian HCH trial (Peterson et al., 2019). Intervention practices in the QUEST trial were provided with an additional $1,000 dollars for each eligible patient (eligibility determined by the GP) (Reed et al., 2022).

It was concluded that the year-long timeframe for both of these trials was too short to deduce any meaningful data. Although there was some benefit to quality adjusted life years (QALY) for patients in the QUEST trial, it was not seen to be cost-effective, suggesting that the $1,000 dollar payment per patient should be significantly reduced to ensure cost-effectiveness (Reed et al., 2022). Those associated with the EQuIP-GP trial noted that they were unable to find any significant improvement in patient self-reported experience measures or patients' self-reported health (Bonney et al., 2022). Bonney et al. (2022, p. 373) went on to say: "We advise caution with policies incorporating patient enrolment and financial incentives", appearing to support the RACGP's initial hesitancy about changes to funding in general practice, and in particular, those associated with the HCH trial.

In order to further explore the role of the PN during the HCH trial, interviews were undertaken with two members of staff associated with one of the general practices participating in the QUEST trial (referred to as the Davies practice). The trial manager, who was an academic staff member from a large university, and one of the PNs working in this practice were interviewed.

According to the QUEST trial manager:

> *… we were told the kind of aims of the trial and what interventions they wanted tested in the trial, so the intervention components if you like were voluntary enrolment to a preferred GP, um, longer appointment times and follow-up after a hospitalisation, and then for children and young people, same-day appointments for acute illnesses, and then the aim of it, the outcomes were around improved patient outcomes and improved service utilisation, so in particular, lower hospitalisations* (QUEST TM).

The QUEST trial – how did it operate?

Both trials were undertaken and evaluated by groups of academic university staff. The manager of the QUEST trial at the Davies general practice, originally a psychologist, felt that:

> *There was a flavour in the RACGP at that time was that they supported strongly the academic university, um, approaches to things, whereas if you look at the Commonwealth, they seem more open to, well, universities and academics are good at some things … I think the RACGP come from an approach where the if you have a researcher question or thinking about a trial, the university is probably best placed to try and do it* (QUEST TM).

Neither of the two trials had any involvement with the Primary Health Networks (PHNs), as the QUEST trial manager explained:

> *We don't need PHNs, we have our practice, general practice research and teaching network, we have got existing relationships with the practices, why create essentially a middleman to get to who you want to get to? … we needed to get to the practices, so unlike the Commonwealth who don't have direct relationships with the practices, and that's why they have to work through a PHN, we are on the ground and if you remember that is how the RACGP designed the criteria for who could apply for the trial, it was general practice research networks who could apply, so a PHN couldn't really apply or somebody else couldn't apply, so like a private company might have thought it would be great to apply or do this tender, they wouldn't have been able to* (QUEST TM).

He went on to say:

> *It is just a different, ah, mindset; I know a lot of people think, oh, I am going to do some work in primary care and general practice and think straight away, oh, I should talk to the PHN, that is one mindset, I don't believe the RACGP have that mindset* (QUEST TM).

Patient selection

As previously mentioned, practices participating in the HCH trial were encouraged to use the Risk Stratification Tool (Wright & Versteeg, 2021) as a way of determining patient complexity of care, and thus, eligibility for the trial. As my findings have shown, this tool was found to be time-consuming, and consequently, was not always used. According to the trial manager at the Davies practice,

> *The GP used their clinical judgement to identify patients who were at high risk*

> *of poor health outcomes and likely to benefit from the intervention* (TM).

In contrast to this, the PN claimed that she was the one to initially identify potential patients for the trial:

> *I went through each GP's patient list and I tried to pick patients that had complex needs and multiple chronic diseases and hospital visits as well, because I didn't want to pick the easy patients, I wanted to pick the ones that needed more support from their GP to see if there was any changes, so I did some reports and highlighted which ones I thought would be good and then showed it to the GPs and let them see and select as well* (PN).

Practice nurse involvement

When asked about the involvement of the nurse in the initial setting up of the trial, the trial manager responded:

> *No, there was no nurse involved, you have to remember that it was the RACGP who got the money from the Commonwealth, right at the start we contemplated and thought, shouldn't the RACGP get together with APNA and try to come up with something, but that is way outside our area of control, so the RACGP don't pay attention to what we say down here, they tell us. I wouldn't be surprised to learn that APNA didn't even know that the trials were occurring because at the start of it, it was very confidential, so those requests for proposals were confidential, so it's not like they were advertised* (QUEST TM).

The PN at the Davies practice felt that:

> *… what QUEST was asking was not anything different to what we already did, we already had patients registered with their usual GP … we already did those things* (PN).

This nurse felt that the initiative would work best when there was a team approach that involved the nurse, as she said:

> *I knew a little bit about Health Care Homes and thought the idea was fantastic, but it took a lot of people planning … I was excited about QUEST in the beginning, but the best thing was having a GP and a nurse for the patient* (PN).

> *I knew which nurse worked best with which GPs, so I put the groups together*

> *and it also needed to depend on who was working on what days, so there was a bit of coordinating, but it worked well* (PN).

The nurse was aware that not all GPs worked full-time, and developing a GP and PN team provided an opportunity for added continuity of care, as she noted:

> *It was probably more to do with the fact that they were not here as often, I think that the GPs did put their hands up to be in it if they were here 4-5 days a week, so they could have a decent patient load and see the benefit in it. They would all have had the opportunity, but not all GPs had the capacity* (PN).

Nurses became part of the patient's care team and if the GP was away, the nurse knew the patient well.

> *… if the GP was away and the patient needed something or had a question, then that nurse knew them well, the nurse had done their care plan, was seeing them every three months for their care plan review before they saw the GP, and*
>
> *we tried to get more of a team seeing the patient, and the patients really loved seeing their nurse, and I still have patients that will say "She is my nurse"* (PN).

The nurse explained the benefits of the nurse's involvement in the patient's care team:

> *… we are more a part of the care team and not just the person that the GP refers the patient on to … I think the patient also had a feeling of belonging and it certainly increased their engagement* (PN).

Another initiative shown by the PN at the Davies practice during the QUEST trial was her decision to allocate patient appointments ahead of time. She noted:

> *I went back and looked at how many times they attended the clinic in the last*
>
> *12 months, so if they attended say 24 times, they could potentially need an appointment once a fortnight, so what would happen when they came in for their care plan with the nurse was the nurse would tell them they need to book in appointments in advance, so that if they needed it they could keep it and cancel if not, but it held it there if they needed it, and they could continue to be seen regularly. Some it was once a month, some it was once every three months, but it was really helpful having those appointments booked ahead of time to avoid if something went wrong and they would have to be squeezed in*

> *… they would often have a list of things for the GP, so sometimes having those appointments was beneficial for them (PN).*

When asked about the impact on her role and on patient care, the PN replied:

> *I don't feel that there was an improvement in patient care, but there would have been an improvement in their engagement with the clinic, or them feeling like they were … or the support they received, because we opened up, it was wider, so their belonging to the clinic would have felt more … they could ring up and ask for "their nurse" rather than "a nurse". I think QUEST could have done a lot more, and if we just followed what they requested of us, the nurse's role wouldn't have changed at all. It was really just me saying how am I going to work with this and make the nurse's role more inclusive* (PN).
>
> *I think the nurse's role was overlooked by QUEST when they were planning it, and I think they were very focused on the GPs and wanting the GPs to get money for, um, CDM and complex patients, but they didn't look at the bigger picture, they didn't look at the team and all the skills they have around them and how the patient could benefit from a team, it was GP-centric. I am lucky I work at this clinic, and I could work with the business manager and partners and create a structure. It's hard to put it out there, it seems hard to explain it now, but it was really lovely having that, um, real team-based approach to be able to support patients* (PN).
>
> *To be honest, the QUEST trial was disappointing, what they did and what their goals were, they weren't, they didn't expect much at all, so I don't know how they could have improved much* (PN).

Despite these reservations, one of the benefits arising from the QUEST trial resulted from the team approach instigated by the PN:

> *Because of the team structure, everybody saw us differently, the patients saw our role slightly differently, and the GPs saw our role slightly differently because we were part of that team, we weren't … just go see the nurse and the nurse will do that … that sounds bad and our clinic isn't like that, but it is our role, see the nurse for a care plan … whereas the whole mindset with QUEST was we were part of the team …* (PN).

The idea to develop a GP and PN team was initiated by the PN who acknowledged that:

> *The benefits of increased patient engagement were not because of QUEST, but because of the way we did it. There are some GPs that work as a team, and others that do everything for their patients and rarely refer on, they would even do the care plans themselves and this changed that a bit. Those GPs must have those kind of perfectionist traits where they always wanted to do it their way, not because they didn't trust the nurse, but they always did everything for the patient* (PN).

When asked whether the PN had any final thoughts, she replied:

> *I think the QUEST people were interviewing the GPs and the business manager, and nobody ever reached out to interview me, I think the GPs said it would be good to interview me, but nobody ever did, it was all focused on the GPs, they didn't engage and I think we did well with QUEST here and we had a decent patient load and it really was me running the show here and they didn't acknowledge it. I was really disappointed with QUEST, not the way we did it, but the … just their planning and follow-up was disheartening as a nurse to feel motivated and valued to keep going when you feel overlooked* (PN).

Final thoughts from the QUEST trial manager were:

> *I'm not really sure where we think the best, um, bang for buck might lie, ahh, I think, I think, there was a very clever professor from England whose name escapes me who presented years ago to us, and at the end of the chat, he said something like "Australia will never get anywhere when you have got this Federal state divide between states running hospitals and the Federal government running primary health care, because you are just going to think around the edges and not achieve anything", and at the time, we thought maybe, maybe not, and I think over time, I am increasingly thinking he could be right. Ultimately, it gets back to that state/Federal split, and unless until you get smarter with that, I'm thinking all these programs are probably tinkering not changing, not really solving the problem* (TM).

9.10 Where to now?

With the disestablishment of HCH in June 2021, many of the issues it purported to address remain. These issues have again been highlighted in the Future Focused Primary Health Care Consultation Draft 2022-2032. This document proposes new innovations to address ongoing issues. The aims are directed at enhancing the performance of the health system in order to:

- Improve people's experience of care
- Improve the health of populations
- Improve the cost-efficiency of the health system
- Improve the work life of health care providers

Associated objectives of the plan are:

- *Access: Support equitable access to the best available primary health care services*
- *Close the Gap: Reach parity in health outcomes for Aboriginal and Torres Strait Islander people*
- *Keep people well: Manage health and wellbeing in the community*
- *Continuity of care: Support continuity of care across the health care system*
- *Integration: Support care system integration and sustainability*
- *Future focus: Embrace new technologies and methods*
- *Safety and quality: Support safety and quality improvement* (Department of Health, 2021a).

Akin to the HCH trial, the PHC consultation draft proposes a significant shift in the way that PHC is provided by placing people at the centre of their care, reforming funding models, and enhancing technological approaches and workforce leadership and culture (Department of Health, 2021a). While the plan acknowledges that it has been developed to build upon previous reform strategies, it proposes better digital health infrastructure, a greater focus on allied health, and the continuation of COVID-19 MBS-funded telehealth and Voluntary Patient Registration (VPR) as a way to facilitate new funding models (Department of Health, 2021a). Voluntary patient registration, also known as nomination or empanelment (Wright & Versteeg, 2021) appears to be an attempt to replace the now failed patient enrolment system within the HCH initiative. It involves people enrolling with their GP of choice at their preferred general practice, and while not new in Australia (previously proposed by the Primary Health Care

Advisory Group, the MBS Review Taskforce, and within Coordinated Care Trials), there is no formal mechanism of funding for this to occur (Wright & Versteeg, 2021). Under the proposed scheme, “doctors could get incentive payments to improve patients’ health, in addition to Medicare rebates, with telehealth restricted to those who sign up” (Daniel, 2021). General Practitioners from RACGP-accredited practices could sign up ‘regular’ patients 70 years or older, or if Indigenous, 50 years or older; a regular patient being one who has seen the same GP three times or more in the previous two years (Medical Director, 2020). In 2021, the vice-president of the Australian Medical Association, Chris Moy, stated that he was in favour of restricting phone and video telehealth to registered patients, because “the doctor should know your history” (Daniel, 2021).

According to Danny Haydon, the chairman/principal of Bretnalls Health, one of the challenges with enrolling patients in the HCH trial was identifying them in the electronic practice management system (Haydon, 2022). The implementation of VPR and the associated development of new funding models has been signaled as a facilitator for reform; however, it is unclear what these funding models will look like, and there is some indication that access to MBS services for CDM will be limited to enrolled patients (Haydon, 2022). It may take some time for the implementation of VPR. The AMA is lobbying, however, for a VPR system that will maintain the current rebate for telehealth and increase funding to pay PNs (Torvaldsen, 2021).

9.11 Summary

Carol Bacchi’s policy interrogation framework has been used to examine the HCH initiative. Rather than focusing on policy problems, Bacchi provides a framework incorporating six questions used to explore how the policy is represented. I have used these questions to interrogate the HCH trial and have highlighted two similar trials and made comparisons between them and HCH to highlight how the aims of the trials have been presented within them. Key objectives from the Primary Health Care Consultation Draft 2022-2032 have been illuminated to illustrate their alignment to the HCH and other attempts at reform.

The final chapter of this thesis presents the salient points derived from the research used to answer the research question: What is the impact of the Federal government's Health Care Homes initiative on the role of the PN? The chapter commences with an overview of the previous chapters of the thesis and their relevance to the research question. I then provide a contextual analysis of Alford's Structural Interest Theory, highlighting the significant changes within the general practice environment since its development. I explore the main elements of the HCH initiative and align their significance to the role of the PN and Alford's theory. I consider the position of the PN within Alford's theory and postulate that the PN does not align with any of the interest groups proposed by Alford. A summary of the HCH trial and its influence on the role of the PN is provided, followed by the limitations of the research, and finally, I propose a number of considerations for the future role of the PN.

Chapter 10: Discussion

10.1 Introduction

The purpose of this study has been to determine the impact of the Health Care Homes trial (2018-2021) on the role of the practice nurse (PN). The Health Care Homes (HCH) trial was one of a number of Federal government initiatives designed to provide a more streamlined and coordinated approach to the care of people with chronic and complex conditions within the general practice context. I employed a case study approach to investigate the assumptions underpinning my research. This approach has enabled conclusions to be drawn about the role of the PN from the perspectives of the PNs themselves, general practitioners (GPs), practice managers, (PMs) and patients. In order to do this, I assumed that the shift to bundle payments and the new IT platform had the potential to increase the PN role in care for patients in general practice. I outlined in chapter one that this would be explored drawing on three assumptions. These were:

1. over the last two decades, the Federal government has attempted to reorient general practice through a series of initiatives, none of which have fully achieved their objectives.
2. policy directions have impacted on the professional status, role, and position of PNs, mostly contributing to an expanded and enhanced role.
3. those with 'dominant' interests will ensure that any policy reform that does not align with their views will be resisted or manipulated to meet their interests.

To commence this analysis, I identify how each section has contributed to the ultimate goal of determining the impact of the HCH initiative on the role of the PN.

10.2 Thesis overview

This thesis began with an introductory chapter which provided context for the reader by illustrating some of the more prominent Federal government initiatives undertaken within the general practice setting over the past few decades. I introduced Robert Alford's Structural Interest Theory (1975) as the theoretical underpinning of the study and posed three overall assumptions used to explore the research question: What is the impact of the Federal government's Health Care Homes initiative on the role of the

PN? I then provided a chronological overview of the PN role in Australia from the early 20th century to the current day, highlighting some of the more prominent local, global, and government influences on the role. This provided further context and opportunities for comparison relating to the impact of the HCH initiative of 2018-2021 on the role of the PN.

Chapter two introduced the HCH initiative in Australia. I identified the main objectives of the initiative, focusing on the significant elements purported to enhance the care of people with chronic and complex conditions. These elements included a move from fee-for-service payments in general practice to a bundle payment system and the use of an online shared care planning system. These two components of the HCH trial created greater opportunity for the expansion of the role of the PN. In this chapter, I also introduced initiatives similar to the HCH trial, the Quality Enhanced general practice Services Trial (QUEST) and the EQuIP-GP trials, both funded by the Royal Australian College of General Practitioners (RACGP) and designed to trial alternative outcome-based funding systems in general practice. The significance of the Medicare freeze on general practice payment systems was also described in the chapter, along with the impact of the COVID-19 pandemic.

Chapter three provided a more focused analysis of Robert Alford’s Structural Interest Theory as it pertained to the HCH trial and attempts at health reform. I then linked this to the primary health care system within Australia, focusing on the general practice context, the people working within it, and the influence of professional governing bodies representing them.

Chapter four provided the reader with the process and findings of a systematic literature review undertaken to explore the role of PNs when assisting people to manage their chronic conditions in New Zealand, Canada, and the United Kingdom. The findings from this literature review assisted in identifying similarities and exploring comparisons between PNs working with populations of similar demographics in other high-income countries. This was an important perspective given the occurrence of policy sharing between countries and its influence on the PN role.

Chapter five provided a comprehensive account of the research methodology and methods used for this study. I justified the use of case studies as the methodology to answer the research question. I rationalised the importance of the chosen methods used in this study to collect data and detailed some of the challenges in gaining access to data in the general practice context. I discussed how the rigour and credibility of the findings have been substantiated along with the ethical considerations and limitations of the study.

Chapters six, seven, and eight presented the findings from the interviews undertaken with general practice staff and patients in the four general practices chosen as case studies for the research. These findings illustrated the influence on the role of the PN as a consequence of the HCH trial from a whole-of-practice perspective, positioning the PN at the centre of the exploration. Observations and insights gleaned from the interviews demonstrated the impact of the trial and its associated elements on the role of the PN. This data was used to triangulate the findings in the final discussion chapter as they related to the interests of those involved and the impact this had on the PN role.

Chapter nine aligned the HCH initiative with Carol Bacchi's framework for policy interrogation, providing an alternate examination of the forces that have an impact on policy reform. Bacchi's framework consists of a series of questions designed to analyse how the 'problem' is represented. I addressed each of these questions, aligning them to the HCH trial and Alford's Structural Interest Theory to explore policy perspectives, processes, and agendas that have an impact on the role of the PN. The impact of the changes brought about by COVID-19, especially in relation to telehealth, were presented as they relate to the role of the PN and the interests of other general practice staff and patients.

The final chapter, chapter ten, is the culmination of the research findings and focuses on addressing the research question and answering the question as to whether or not a shift to bundle payments and the introduction of an IT shared care plan impacted on the role of the PN. In summary, this chapter demonstrated that despite the potential for the enhancement of the role of the practice nurse during the Health Care Homes trial, the role remained essentially unchanged. Attempts at reform such as the instigation of an online shared care plan, and a move away from a fee-for-service payment model to a bundle payment system did not impact the way that the practice nurses worked. The private business model of general practice and the power of general practitioners transcended any attempts at reform. Forty-seven years from the development of Alfords Structural Interest Theory, the general principles within it have demonstrated that self-interests impede health reform.

10.3: Health Care Homes and the bundle payment system

The fee-for-service payment model has been embedded in general practice in Australia for more than a century. With the growing burden of chronic disease, the Federal government has encouraged general practice to take a more interdisciplinary approach to assist people to manage their conditions. This has proved challenging within the scope of episodic care, and organisations such as the Australian Medical Association and The Royal Australian College of General Practitioners have been lobbying for an 'enhancement' of Medicare and alternate funding opportunities for many years (Australian Medical Association, 2010a; Lyons, 2018). In contrast, the AMA also has a history of safeguarding the fee-for-service system for GPs and opposing key health reforms (Russell, 2015).

General practices participating in the HCH trial were provided with an alternative to the fee-for service system, a 'bundle payment' to be used for the care of patients with chronic and complex condition/s, with the payments being indexed according to the complexity of each patient's care needs. This provided flexibility in how participating practices were able to use the bundle payments. The four practices used for this study all developed their own financial business models by developing in-house 'item numbers' used to track how the funds were used. This was a way to make comparisons between what they could have earned by using the MBS billing system and the money actually spent from the bundle. During the set-up phase of the trial, practices were supported by the Primary Health Network (Wentworth Healthcare-PHN Nepean Blue Mountains) HCH facilitators who provided some examples of potential in-house billing. As mentioned by the PHC HCH facilitator, HCH was more about cohort management rather than single patient payment. Their vision was that HCH was a team approach, and therefore, by adopting team-integrated care for a person with more complex needs, the 'touchpoints' would reduce as there would be more coordination of their care. This reasoning meant that greater profit could be gained from the tier-3 patient cohort (those with more complex needs), whose HCH funding was the greatest. This not only had the potential to affect the number of patients signed to the trial within each tier, but from a financial viewpoint, there was no incentive to see the patient more frequently.

Three of the practice managers (PM) from the cases I researched claimed that the $561 provided for each tier-1 patient was not enough money, given that the patients were all on care plans, were generally older, and required frequent visits to the GP. In contrast, one PM explained that most of their patients were young parents and people around 50 years of age, who fell into the tier-2 category. This PM claimed that around 20 per cent of their patient population needed more money allocated to them than the HCH tier stipulated, and he was able to 'take money from some patients' and allocate it to others. Another PM felt that the funds were adequate as they were able to use them to provide the care that the patients required. They went on to say that if enough patients were enrolled into the trial, they were able to 'pool the money' and make it work, acknowledging that the funding allocated to each patient tier may not have been correctly allocated.

Paying the general practitioner

The PMs from all four general practices were responsible for managing the HCH bundle payments and also paying staff. The bundle payment allowed flexibility in how these funds could be used and, as 'corporate rationalisers' conscious of cost control and profit, all four PMs designed a payment model for their participating HCH GPs that would ensure they would not be out-of-pocket. Not all GPs in the practices agreed to participate in the HCH trial. Payment for the non-participating GPs remained the same, whereas in all practices, the PM provided an additional monetary incentive for their participation. For example, one PM explained that the participating GPs' payment included what they would have received from Medicare plus a gap fee, so as the PM explained, this "protected their income". Another PM ensured that the participating GPs were given a 'responsibility fee' in addition to their usual payment; in his words, it was "like a recognition for the additional work they did". Interestingly, there was no attempt made to financially compensate the PN for extra work undertaken during the trial, suggesting that practice managers were operating in the interests of the professional monopolists (in this case, GPs) who held the power. With the onset of COVID-19, and attempts to mitigate its spread, general practices offered telephone consultations. Initially bulk billed, non-participating GPs found that their income was negatively affected, whereas GPs participating in the HCH initiative did not suffer the same financial loss given that their income was ‘protected’ with the additional incentive payments. One PM claimed that this prompted some non- participating GPs to ask to join the initiative; however, it was too late.

10.4 Visions for how the bundle payments were to be used

The Federal government’s vision was that bundle payments were to be used to deliver better coordinated, comprehensive care for people with chronic conditions, enhance the sharing of health data through online shared care planning, and improve overall productivity (Department of Health, 2020d; Dawda, 2022). The PHN HCH facilitators who visited general practices to promote the benefits of the trial, promoted a health care model that would enable the GP and the client to work together and reduce the touch points between the patient and the practice without reducing the GPs’ income. They believed that HCH would allow the GP to take an oversight role in managing a team of people who would provide integrated care to the patient. Their vision was to place the patient at the centre of care and work with them to facilitate their wishes and empower them in their health journey.

From a financial standpoint, the HCH facilitators promoted many aspects of the HCH model such as using funds from the bundle payment for some routine GP tasks that were traditionally unbillable, such as writing scripts and taking blood. Despite its promotion by the HCH facilitators, the use of telehealth within the HCH model was viewed unfavourably by some GPs who claimed they were not prepared to write a script without the patient being in front of them. This changed with the advent of the COVID-19 pandemic.

A vision of one PHN HCH facilitator was that the bundle payments could be used for group education sessions to assist people with chronic conditions. They proposed that the PNs could liaise with specialist educators; for example, a diabetes educator or physiotherapist to run these sessions. The PN role was envisaged to include more telephone triage and general phone conversations with patients that would in turn free up the GP to see more fee-for-service patients and increase their throughput in this way.

Clearly, the role and primary interest of the PHN HCH facilitators was to promote the benefits of the HCH trial to general practices to enhance the possibility of its success.

Given that these facilitators previously held roles as health professionals with direct patient care, it can be assumed they also had an interest in facilitating optimum health outcomes for patients.

My research has found that the Practice Managers (PM) from each of the four general practices showed an optimism about how the funds could be used. Open to new ideas, the new funding model was viewed as providing new opportunities. This optimism translated into visions of 'fixing' the current funding situation and improving patient care by providing all of the services that the patient required. One PM explained that he "always thought there would come a day when there was a funding model similar to HCH" and that it was important for them to be part of the trial, and thus, be a leader if the funding model was to continue into the future.

The GPs interviewed for this research were all hopeful that HCH would improve patient care. One hoped that HCH would contribute to improved communication between all heath care providers. Another hoped that the additional funding would provide more services for patients, and would therefore improve outcomes. One GP mentioned they felt that HCH would allow them to extend the role that their PNs' already played in assisting people to manage their chronic conditions.

All the patients interviewed for this thesis demonstrated an overall lack of understanding about what the HCH trial could offer them. One patient mentioned that the GP asked her if she would like to have a care plan, and she said yes because she understood thatshe could then receive 'free' visits to a podiatrist and physiotherapist. One patient was told by the GP that if she needed to contact him, she could do it "through the girls", and the patient felt this was a good idea.

From the perspective of the PNs interviewed for this study, one from the Brown general practice stated that as she was previously conducting care plans for patients with chronic disease, she was asked if she would be the HCH nurse and she agreed. She went on to say that the other nurse who assisted with chronic disease management just was not interested and did not want to be involved. Another PN from the Anderson general practice was told by the GP that HCH would help her to 'develop' the patients and provide the best possible care for them, and this PN understood that this would be the case.

The registered nurses working as PNs at the Smith practice were not involved with the HCH trial, and I was unable to interview them. I was told they did not want to be involved in the trial. The Smith general practice did employ medical assistants (MAs) to work with patients during the trial, and one MA stated that she was looking forward to spending more one-on-one time with patients. She hoped the HCH initiative would benefit the patients because they did not have to wait to see the GP and could see them the same day they called the practice with a query. The MA felt that HCH would provide a more holistic approach to care for patients.

10.8: How the bundle payments were used – were visions realised?

According to Duckett (2016b, p. 1), "primary care services are not working anywhere as near as they should because the way we pay for and organise them through Medicare goes against what we know works". The HCH initiative and the trial of bundle payments to assist people to manage their chronic conditions purported to address this.

Bundle payments provided general practices with a great deal of flexibility in how these funds could be used, yet all general practices within this study developed in-house 'item numbers' to track patient encounters and the amount of funding allocated to them. This involved the organisation of payment models for staff during the trial, where predominant changes saw the addition of an extra "HCH payment" to participating GPs.

Funds from the bundle payments were also used to employ additional PNs. For example, the Webster general practice employed an additional nurse with the HCH funding, stating that this nurse could be "used for other things as well … one in the treatment room and one in chronic disease management". The desire to increase the nursing complement within this practice suggests an awareness of the value of the PN and implies that a lack of funding within the previous model prevented them from employing additional nurses as they might have liked. There is also a suggestion that an additional PN was needed to sufficiently perform the additional tasks required for the trial. There was no dedicated HCH PN at this practice, which supports the flexibility of how the bundle payments could be used. Another practice saw the added benefit of using the HCH funds to employ an additional nurse so that she could see patients before they met with the GP, which according to the PM, meant that the GP was able to see more patients because the PN had already updated the patients' clinical data before they saw the GP, saving the GP time.

As the managers of funding and being conscious of the need to maximise profits, PMs found ways to minimise the financial output associated with HCH. Following the unsuccessful engagement of a PN with the HCH trial, the PM from the Smith general practice designated a MA to coordinate it. The PM stated that the PNs "did the care plans" and the MA "coordinated the whole thing". Despite this, the MA stated that she "could do much better in the care plans if [she was an RN]" because she "just didn't have the registered nurse background to be able to fill in all the things". According to True et. al (2022, p.S1), many HCH practices introduced new roles such as MAs, to provide "enhanced monitoring, care management, review and recall, health education and coaching, and pastoral care".as a way to strengthen team-based care. While it is acknowledged that a saving can be made when the MA is paid less than the PN, this illustrates a potential undermining of the PN role and their scope of practice when a non-nurse is performing tasks more appropriate to the scope of the PN. The quality of patient care relating to the comprehensive clinical nature of the care plans also comes into question.

According to Henderson et al. (2016), prior to the HCH initiative, just over 69 per cent of GPs reported providing care that was non-billable, such as arranging tests, referrals, prescriptions, and general patient education. They claimed that this equated to between 10 and 23 thousand dollars of lost revenue each year (Henderson et al., 2016).

My research has shown that one of the greatest benefits of HCH for the GP and the practice as a whole was the ability to bill for work that was previously unbillable. This was a recurring theme between all case studies and, as mentioned by one GP, the HCH trial enabled the practice to bill for such tasks as writing prescriptions that would have previously been unbillable. He claimed that previously there was pressure to "bring the patient in" for reviewing tests or writing prescriptions; however, this was not required during HCH. A patient enrolled with HCH was able to ring the dedicated HCH nurse who would relay the patient's request to the GP and the practice was billed for that work. The GP explained: "… the doctor gets paid, the patient is not inconvenienced, and the service is improved".

A GP from another practice claimed that the HCH trial afforded greater flexibility for patients to have an appointment with only the PN. Funding for the role of the PN has traditionally been linked to specific initiatives such as the PNIP and MBS care planning items. Additional activities undertaken by the PN such as health promotion or motivational interviewing could not be captured within the traditional billing system. For example, in the past, the GP may have performed wound care but had no mechanism for billing it, but with HCH, they were able to bill the practice for the nurse's time performing wound care.

Using HCH funds to bill for all aspects of the PN role may encourage future discussions towards greater remuneration for the PN role. One PN supported these benefits by acknowledging that before HCH, she might have spent 30 minutes educating a patient, but with HCH, this time could now be billed to the practice. Although this represents a financial gain for the practice, it did not contribute to an increase in the PN's wage. Another PN agreed that there were benefits that allowed the PNs to be paid for their time, although she acknowledged there were no rules about how the funding was organised.

One of the GPs claimed that he never really knew what the bundle payments could be used for. He initially thought the funds would provide more services for patients with associated improved outcomes; however, he felt there was no change from the previous care plan where the patient was able to see five health professionals. He claimed that "if there were any extra funds available, I didn't see them … perhaps they went to management". This GP supported the fee-for-service payment system which he claimed actually motivated GPs to see patients, although he acknowledged that fee-for-service does not work for the waged worker. His feeling was that in general, patients do not really have an appreciation that it is fair to pay for health care, and that payment models such as the bundle system offered through HCH encouraged this way of thinking.

One practice used the HCH bundle payments for patients to attend group exercise sessions with an exercise physiologist. Patients were charged a nominal fee and the PM acknowledged that the practice did not make money from this. This model of care is something that many general practices have provided and continue to provide irrespective of their funding models.

One general practice used the HCH funds to purchase designated HCH telephones so that patients could ring and speak to the HCH nurse if they felt the need (during business hours). This practice also purchased key ring tabs with the HCH telephone number with the acronym ‘VIP’ engraved on them. These were given to HCH patients, not only to ensure that the HCH telephone number was handy to them. but also, to remind them that as an HCH patient, they were ‘very important people’. According to the PM, GP, and PN at this practice, this was something that the patients “really loved”. This meant that patients could ring this number and speak with the MA any time during business hours. The MA would facilitate the patient’s request which meant that this reduced some of the workload of the reception staff, the patients felt as though they were being treated as ‘VIPs’, and the practice was able to bill for this work whereas in the past, there was no mechanism to do so. Another practice set up a specific HCH email for patients to use, although from a cohort of approximately 100 HCH patients, the PN felt that only about 5 patients chose to use it.

Impact on the role of the practice nurse

The use of the bundle payment to provide participating HCH GPs with an additional ‘responsibility fee’ was not replicated for the PN. Despite practices using funds from the bundle payment to employ additional PNs and bill for some of the PN work that had previously been unbillable, there was no monetary benefit for the PN. While the PNs did see this as advantageous for the practice, none of them felt it was unfair. Whether they were aware of this is unclear.

This illustrates the interests of the PM as a corporate rationalist in maintaining their allegiance to their employer, while also demonstrating their business acumen in relation to the trial funds. This also demonstrates the dominant power of the GPs as professional monopolists given the PM’s desire to ensure they were not financially disadvantaged as a result of the trial.

It is assumed that the PNs were not involved in decisions about how the HCH funds would be used, and despite an increase in their workload through setting up the online care plans and assisting in patient enrolment, there was no additional remuneration for them, albeit additional PNs were employed to assist with the added workload associated with the trial. The research does show that by employing additional nurses and using the HCH funds to bill for some of their work, practices valued their contribution. The general practices also have an interest in maximising profit for any tasks that have traditionally been unbillable, whether they are tasks performed by the GP or the PN.

As a waged worker, the change to bundle payments made no change to the financial remuneration for the PN.

By employing an MA to coordinate the HCH trial, there was some sense of the influence this could have on undermining the role of the PN. Although common overseas and relatively new in Australia, the MA is trained to perform delegated duties (Anderson et al., 2019). According to the RACGP, the MA undertakes “their clinical duties in the context of a consultation conducted by a medical practitioner, or under the supervision of another healthcare professional as delegated by the medical practitioner” (Royal Australian College of General Practitioners, n.d., p. 1). According to the (Nursing and Midwifery Board of Australia, 2018, p. np), “a registered nurse must accept responsibility for supervision of the activity of a Medical Practice Assistant and ensure an appropriate supervisory framework is in place”.

Although increasingly seen to support the health and wellbeing of people within the primary health care sector, MAs are unregulated and, as such, their employment and quality of working standards differ across Australia (Australian Primary Health Care Nurses Association, 2021). In addition, MAs have no mandatory minimum level of education or training required for a role within primary health care and there are many discrepancies between roles, responsibilities, and scopes of practice (Australian Primary Health Care Nurses Association, 2021). According to the Australian Primary Health Care Nurses Association (2021), nurses have raised concerns about their role in regulating the various levels of competency of these workers in the primary health care setting.

As previously mentioned, I was unable to interview the PNs at the practice where the MA worked; however, the Chief Operations Manager at this practice explained that the PNs were not interested in being involved with HCH.

10.6: Health Care Homes and the online shared care plan – visions

In an attempt to enhance interdisciplinary care for people with chronic and complex conditions, the HCH initiative saw the implementation of an online care plan. One of the proposed benefits of this plan was that it identified local health providers best suited to assist the person's care needs and provided a platform for them to input data about the person's care and care needs. The belief was that this would enhance care coordination and the integration of care between all providers (True, et. al 2022). The PHNs supported general practices by providing and installing the information technology platform on which this plan was housed.

One GP's vision for the plan was that it would enhance communication between all health providers. Another GP felt that having all of the patients on the same software platform would mean the system was less disjointed, because all records would be on the same database. One PN felt that one of the advantages of the online care plan related to her accessing the patient's care plan; for example, if the patient forgot to bring a hard-copy of their care plan to the practice, the PN could access the online version. Another PN demonstrated more of a patient focus and was hopeful that the care plan would empower patients and assist in more of a shared platform between the patient, herself, and other providers.

10.7: The online shared care plan – were the visions realised?

My research has demonstrated an overall appreciation of the benefits this plan could offer. The PMs, GPs, and PNs were all in favour of the potential the plan might offer; however, issues with a lack of engagement and the additional work required to operationalise the plan proved prohibitive to its success.

Within all general practices used for this study, the PN and MA were the predominant users of the care plan. Occasionally, a GP might enter some data or check the plan, but it was the PN and MA who were the dominant users. One GP and a PN claimed that the online care plan had made interdisciplinary care a little more organised by having the same care providers on the same platform, thereby reducing the number of records kept in different places. The GP felt that moving the care plan to an electronic system might encourage those health providers who were reliant on paper-based systems to embrace the change. The MA was also supportive of having a system that allowed all the patient's care team to be able to access the care plan, stating that it reduced the number of additional forms and notes required.

All the GPs, PMs, and PNs interviewed expressed their concern about the large volume of work associated with the online care plan. As one PM explained, there was much work involved in moving current patients with care plans to the new online system. This was supported by the PNs who worked to move patients enrolled in the HCH trial across from the previous care planning system to the new one. As one PN explained: “there were patients who already had a care plan; we then, without the patient present, created a care plan structure in the new system and moved them across”. All the PNs interviewed felt that moving patients from one care plan to another was cumbersome and time-consuming.

Some participating GPs only saw a few HCH patients, and as the PN explained, this meant they did not engage with the system because they were not familiar with it, asking the PN to enter any relevant details on their behalf.

There were also difficulties with running two separate systems. One GP expressed his frustration at having to write in two different systems, ultimately duplicating his work. His reasoning for using the two systems was that if the practice was audited by Medicare, there needed to be proof that he had seen that patient. He felt that he was constantly “flicking between two screens” and was thankful that the PNs were able to assist him, claiming that he was “completely reliant on the nurses”.

Inherent in trials, there was uncertainly related to whether the trial would continue, and for one PM, this meant moving all HCH patients to the new online care planning system while others remained on their previous system. Another practice moved all patients with a care plan to the new online system, and once the trial ended, there was additional work moving all patients back to the previous system.

There was poor engagement with the online care plan from the patients and interdisciplinary team; a challenge supported by True et al, (2022). As one PN explained, the online care planning system was not really explained to them, and therefore, they were unfamiliar with its use, and ultimately, it was easier for them to revert to the previous way of doing things. Another PN explained that allied health just did not know how to use the system, and said that she did not see any specialist using it. After a week with no engagement, this PN would phone the health professional asking them to make their contribution to the plan; however, they were unaware of how to. One PM agreed that not enough awareness was undertaken to inform the allied health professionals about how to engage with the care plan, with some refusing to use it.

There was also poor engagement by the patients, with many of the HCH patients aged in their eighties being challenged by some of the technology involved. In one instance, a patient received an email about the plan and rang the nurse because they were unaware of what it actually meant or involved.

One patient recognised that the allied health professionals had trouble accessing the online care plan for information about his care. He went on to say they needed to ring the practice to gain the information they needed. Another patient had a similar experience when two of his care providers told him they were unable to access the electronic plan to access the GP referrals required for them to see the patient. In this instance, the patient then provided the allied health providers with a hard copy of the referrals the GP had previously given him. One patient was completely unaware that an online care plan existed: “I don’t know what it is all about to be honest, I trust them”, another “didn’t need” to access it. One younger patient attempted to access the plan but became “stuck” and then needed to contact someone to assist her. This was deemed cumbersome, so she did not call for assistance. There were a couple of patients who did engage with the care plan and were able to input their observations, while others were not interested in engaging as they felt that it added another aspect to their care. One GP stated that he was unaware that patients could even engage with the plan.

According to the PNs interviewed, the process of care planning was essentially unchanged, and as a consequence, there was no improvement in interdisciplinary care. Although it was more labour-intensive, the PNs were still doing things “the old way”, and one PN stated that she would use the software without the patient being present and print it out for them. There was a lack of awareness from the patients about the plan, its intent, and how it could be used, and consequently, this PN could not see any benefit to the patient at all. One GP supported this position, stating that “the care planning is pretty similar to what it was before”.

While the intent of the online shared care plan may have had merit, poor implementation, and a lack of awareness from interdisciplinary providers, patients, and some GPs contributed to its failure. Other contributing factors were the amount of work associated with its implementation and the frustrations of operating a system lacking in interface capabilities between the practices' existing software and that used for the plan.

Impact on the role of the practice nurse

The majority of engagement with the online care plan was from the PN. There were general comments related to the volume of work needed by the PN to transfer the previous care plans across to the online system. Apart from this, most PNs felt there was no change in relation to their role in the care planning process. Some PNs did find they were entering data on behalf of the GP who was not familiar with the system. Due to a lack of engagement and poor education for all involved, the online plan failed to enhance interdisciplinary care, and the role of the nurse in care planning for people with chronic and complex conditions was essentially unchanged.

10.8: Alford's 1975 Structural Interest Theory and its relevance to Health Care Homes

At the core of Alford's theory is the assertion that successful health reform is impeded by the interests of three organised groups: corporate rationalisers, professional monopolisers and the repressed group of patients and their advocates. In his analysis, the professional monopolisers usually maintain their power and resist reform. Given this, the Federal government-initiated (corporate rationalisers) health care reforms such as the HCH initiative are likely to be met with resistance from general practitioners (professional monopolisers) due to uncertainty and the process of restructuring that inevitably occurs (Dadich & Hosseinzadeh, 2013). In the case of HCH, the two most significant changes brought about by the HCH trial were the funding model shift from the MBS fee-for-service model to bundle payments, and the move to an online system for care planning that would have enhanced multidisciplinary care. As illustrated above, neither of these initiatives were successfully implemented to their full potential, with the result that the role of the PN was not enhanced.

10.9: Professional monopolists

According to Alford, doctors, their boards and associations, and medical schools comprise the dominant structural interest group he calls professional monopolists (Alford, 1975). As outlined in this study, the Australian Medical Association (2016a), initially did not support the trial, indicating that the modelling was of concern as it was underfunded. This was reiterated by GPs themselves with them seeing is as a cost-cutting exercise (Thomas et. al, 2019, p. 868). Further to this, the RACGP funded two separate trials at the same time using a similar funding model, but with additional MBS funding, arguing that both the bundle payment and the MBS reimbursement were essential to cover costs of the additional work. Interestingly, published research on these trials shows similar disappointing outcomes to the HCH evaluation (Reed, et al, 2022, Peterson, et al, 2019, Health Policy Analysis, 2022). What the case studies illustrated was that the practice managers developed a fee-for-service item against the HCH tier payments and in some instances, provided additional monetary amounts to ensure the participating GPs were not financially disadvantaged. The bundle payments were not used to provide additional services for patients in any organised manner as the PHNs had hoped might occur. Patients could access their doctor or the PN more readily, but there was no attempt to initiate multidisciplinary models of care that might improve health outcomes for those patients with chronic conditions.

There was a similar resistance to the shared care plan, which was a key characteristic of the HCH trial, and according to McInnes et. al, (2017a), an aspect of care poorly understood by both GPs and PNs that is more often manifest as a mutual understanding and respect for task delegation rather than true integrated care. As the case studies illustrate, few patients were aware or accessed their care plan, medical specialists did not access them, the GPs did not keep them up to date, leaving this to the PNs, and allied health professionals were either not aware of the existence of the plans or could not access the relevant IT platforms. The shared care plans operated as a burdensome technology that the PNs had to manage through up-dating and transferring back and forth between the various platforms operating in the practice. And as one PN noted, much of the care provided under the rubric of HCHs was already available to these patients under the fee-for-service model.

Writing in support of the RACGP, Kruys (2016) who was vice-president of the RACGP at the time, stated that the college along with other professional groups were not consulted in relation to HCH. He went on to say that when implementing the initiative, professional organisations such as the RACGP were not fully represented and that, while HCH funding was minimal, additional funding should be sought from the state government and private health funds to ensure its success (Kruys, 2016). In summary the professional monopolisers did not engage fully in the reform.

10.10: Corporate rationalisers

Identifying the corporate rationalists is more complex in this study than that originally proposed by Alford (1975). They include the Federal government department of health, the PHNs, the Australian General Practice Accreditation Limited and in the case of corporate owners of General Practice, the major shareholders, or owners. As Alford notes, the corporate rationalists are continually looking for ways to improve efficiency and maximise financial return on their investment. This is particularly so where funding is provided through government or in the case of corporate practices where resources are pooled to maximise profit and streamline functionality.

The HCH trial was first mooted in 2016 following the recommendations of the Primary Health Care Advisory group that aimed to improve care for Australians with chronic and complex health conditions (Jackson & Hambleton, 2017). The Health Care Homes trial was instigated to address these recommendations and was purported to be a different way for patients to interact with their general practice through improved system management, a review of payment systems, and a more patient-centred and integrated care focus. As noted in chapter two, the Federal government funded the trial, allocating 21 million dollars over the 3 years of its operation.

The Primary Health Networks (PHNs) as corporate rationalisers worked with the government to assist in the roll-out of, and education for, the HCH initiative. They had a particular vision of how the trial might operate, including what additional services might be provided for patients. They were assisted in this marketing of the trial by the AGPAL, the formal organisation responsible for accrediting general practices (Australian Government, 2020b). Despite this, as the case studies illustrate, as does the official evaluation of the trial, they were unable to change the way general practitioners operate and the trial ceased in 2021 (Health Policy Analysis, 2022). This outcome is consistent with other attempts at reform embarked upon by the Federal government both here in Australia and elsewhere. As outlined in the literature review, the opportunity for PNs to engage more fully in providing care for patients with chronic illness waxes and wanes as governments provide incentives for general practice. It could be argued that the professional role of PNs in Australia, Canada, the United Kingdom, and New Zealand is highly dependent on reform initiatives, which unfortunately are inconsistent and, in many cases, not sustained (Askerund, 2016).

10.11: The community: the repressed interest group

Alford described the community as patients or groups acting in the best interest of patients and coined the term ‘repressed interests’ (Checkland et al., 2009b). Patients have repressed interests because “they will not be served unless extraordinary political energies are mobilised”, usually understood as coalitions between at least two of the interest groups (Alford, 1975). The HCH initiative claimed to place the patient at the centre of care, empowering them to take control over their health; however, it is not always clear to patients what their interests actually are (Williamson, 2008). To assist patients to be empowered and less repressed, patient autonomy is key through the attainment of knowledge, choice, and shared decision-making (Williamson, 2005).

As reported by Wells and Jackson (2016), some patient advocacy groups had high expectations of the HCH trial due to an understanding that it would provide a less cumbersome health care journey where they could receive all of their chronic disease care at one general practice either face-to-face, or via telephone or email. Under the HCH model, team-based care meant that the patient as well as allied health professionals had access to the online care plan that supported their chronic disease management (McKittrick & McKenzie, 2018). In addition, according to the Department of Health (2020c), patients signed to the HCH trial were able to choose the leader of their care team which would usually be a GP. However, the reality was that most patients were not aware that they had been signed up to the trial, or its purpose. They could not or did not access their shared care plan or realise they could select a primary carer.

It is difficult to see how patients could have operated as a powerful interest group in ensuring the success of the trial. They are mostly elderly, with little knowledge of current Federal government health reforms, and are not represented by powerful lobby groups. They invariably have a relationship with their local doctor and possibly the PN and are unlikely to make demands on the practice given their vulnerability. While only a small number of patients were interviewed for this study, they were hand-picked by the PM and a presumption is made that they would present the trial in a good light. However, as the case studies indicate their interests were in accessing their doctor in a timely manner or being able to ring the practice and speak to their primary carer or to receive a repeat prescription over the phone. Some valued their ready access to the PN, but this in no way changed the work of the nurses or enhanced the care the patient received, or the nurse provided. Alford (1975) suggested that coalitions between the repressed structural group of patients and one or other of the other two groups could result in significant health reform. Had patients aligned themselves with the corporate rationalists much of the trial agenda might have been achieved, but this would have required considerable work on the part of the Federal Government.

The interests of interdisciplinary health professionals were absent from Alford's theory. Due to the ageing population and associated growth in chronic illness over recent years, interprofessional collaboration has become more widespread in general practice in an effort to reduce costs and improve patient outcomes (Rawlinson et al., 2021). According to van Dongen et al. (2016), it is imperative that primary care has an efficient and effective model of interdisciplinary care to address the needs of those with chronic conditions. According to Kodner (2009, in Goodwin (2014, p. 2), "a fully integrated model of care is characterised by integrated teams working in an organisation with a single set of governance and accountability rules and common budgets and incentives". The fee-for-service funding model, while an effective reimbursement scheme, has been deemed unsuitable to address the needs of people with complex and chronic conditions (Harris & Zwar, 2014; McInnes et al., 2017b).

10.12: The practice nurse, Alford's Structural Interest Theory, and Health Care Homes

This thesis demonstrates that the HCH trial had little impact on the health outcomes of patients or the role of the PN. According to McKittrick and McKenzie (2018), a fundamental barrier to the PN developing a more enhanced role within the HCH model is the socio-political and historical effects of medical dominance (McKittrick & McKenzie, 2018). In this case this dominance is in the form of poor policy and economics that continue to undermine nursing (Radcliffe, 2017). Practice Nurses are positioned outside of the three major structural groups of interest (and are possibly an additional repressed group). Enhancements in their role has only come about through increased funding allocated by the Federal government (a corporate rationaliser) to GP (professional monopolisers) for their employment. Some individual nurses were able to maximise the benefits of the trial for patients, but at an organisational level they had little sway. The two major nursing organisations; the ANMF and the APNA continue to advocate for PNs, but with minimal success. The ANMF has been unable to ensure wage equity for PNs across the country partly because of the restrictions on pattern bargaining, but also because of the private business nature of GP. While APNA supported the trial they were not part of its design or evaluation. The Australian Primary Health Care Nurses Association's (APNA) 2017 position statement on Health Care Homes claimed to strongly support the initiative and saw opportunities for maximising the nurse's role in care coordination and nurse-led services (Australian Primary Health Care Nurses Association, 2017). The statement went on to say that: "Not only are nurses suited to the care coordination role, but research has also shown that expanding the role of the nurse to lead services can prevent costly hospitalisation while providing safe, efficient and high quality care" (Australian Primary Health Care Nurses Association, 2017, p. 4). As an employee within a private business, the PN is paid by the practice owner (often a GP) and works within an environment where there few opportunities for advancement. As a final comment, the links between Alford's (1975) argument that health reform invariably fails given the conflict between the various structural interests, and Bacchi's argument that the 'problem' is often ill conceived by the corporate rationalists is worth consideration. Much of the failure of the HCH trial, and by default a loss of opportunity for PNs to enhance their role within a multidisciplinary care framework can be put down to the gap between how the problem was defined and the solution put forward by the corporate rationalists. The definition of the problem as outlined in Chapter nine, noted that general practitioners lacked time to provide adequate care for patients with chronic illness partly because of the fee-for-service reimbursement model which is time based and time required for multidisciplinary consultations, or knowledge of how shared care might operate. Drawing on Bacchi's questions, it is clear that the corporate rationalisers assumed that changing from a fee-for-service model to bundle payments and introducing an electronic care plan would provide a tidy response to these issues. It may well be that the trial failed because of the resistance of the professional monopolisers, but it is also possible that the failure was in part due to the trial solutions not aligning with the definition of the problem. If one of the issues was time poor GPs and PNs, then HCH did little to free up the PNs clinical time, extend their engagement in patient care or encourage GPs to engage in shared multidisciplinary care.

Changes in organisational support

Since the publication of Alford's findings in 1975, the structure of general practice has also changed. The emergence of the role of the practice manager has added a new layer to the make-up of general practice support. The development of organisations such as Divisions of General Practice, Medicare Locals, and Primary Health Networks (seen as corporate rationalisers), has also been a way to support the work of general practice. The impact of informatics on data record-keeping, analysis, and business modelling has also been a significant advancement and support for the work of general practice. The increase in numbers of PNs and associated funding opportunities over the years has offered another avenue of support.

The corporatisation of general practice

Another significant change in the organisational structure of general practice over the years has seen a decline in the number of practices owned by GPs and an associated move to corporatisation. Before the 1990s, general practice in Australia was predominantly made up of small private businesses, partnerships, or associateships (Erney-Albrecht & Bywood, 2016). As a response to rising costs and the many complexities of running a business, corporatisation of general practice is based on reduced economies of scale through more efficient management processes and the sharing of resources, with the principle aim of providing a profit to its owners and/or shareholders (Erney-Albrecht & Bywood, 2016; Tsirtsakis, 2021). Despite these potential benefits, corporate practices have also been seen as disruptive to continuity of care when the patient may not always have access to their usual GP. Other issues arise when there is potential for tension between the health professional’s responsibility towards the organisation and to their patient when the organisation must strive to decrease costs (Erney-Albrecht & Bywood, 2016). With increases in the overall costs of running a business, a decrease in the number of available GPs, and effects from the 2013-2019 Medicare freeze, more GPs are now fighting against bulk billing (Davey & Convery, 2022).

10.13: Limitations

This thesis has used case study methodology to place the PN at the centre of the real-world context of general practice during the HCH trial. Valuable insights have been gleaned from interviews with PMs, GPs, PNs, and patients. One limitation has been the inability to interview PNs at the Smith general practice. At this practice, the MA was elected to oversee the HCH trial. While an interview with the MA offered an alternative insight into how the trial operated at this practice, this resulted in a reduction in the number of PNs interviewed for this research.

Patients interviewed from participating practices were selected by the PMs of each practice, indicating the possibility that they were chosen because of the favourable light in which they perceived the trial. In addition to this, some patients interviewed for this thesis showed minimal understanding of the trial, and in some instances, were unaware they were part of a trial. It can be assumed that practices participating in this research did so based on their perceived success of the trial which may have influenced their responses.

The study was limited to participating general practices within South Australia, and while evaluations of the trial were representative of an Australia-wide approach, this thesis was limited to private South Australian practices only.

10.14: Recommendations for the future

The HCH trial provided an opportunity for the expansion and enhancement of the PN role. This research has demonstrated that despite a genuine willingness to improve interdisciplinary care through the instigation of an online shared care platform, a move from fee-for-service payments to bundle payments, and the associated flexibility to redirect funds, the role of the PN was essentially unchanged.

If the PN role is to develop and expand into the future, the PN must be supported in their quest to address the challenges of the future. These challenges include the changing landscape of disease burden, in particular the growth of chronic and complex conditions as well as the challenges associated with a work environment focused on value-based, high-quality care.

Recommendations - policy

The implementation of HCH across practices was variable. The trial highlighted the importance of a whole of practice approach when instigating change as well as the importance of providing enough time to train people in the use of the Risk Stratification Tool (RST) and shared online care plan (True et. al 2022). Considerations for the future highlight the importance of significant time to prepare staff for the challenges associated with change as well as an ongoing commitment from all staff involved. The voice of the nurse within policy decision-making remains relatively unheard (Mendes, et. al, 2020) and if the PN role is to progress into the future, an increase in professional autonomy, supported by nursing governing bodies such as the Australian Nursing and Midwifery Board (ANMB) is recommended with more nurse leaders as representatives on boards and committees associated with policy decision-making at all levels.

Recommendations – education

Future considerations should be directed at the development of a formal career structure for the PN. For many, a lack of career structure and associated opportunities for increased pay, provides little incentive to undertake additional education. If the role of the PN is to advance, ongoing education tailored to role expansion and enhancement is paramount. Education specific to the needs of people and groups within the primary health care sector that includes opportunities to lean with other members of the general practice team has the potential to enhance the integration of care and a person-centred approach.

Recommendations - research

Future research should be directed at enhancing, generating, and utilising knowledge to benefit people and populations through contributions to policy development and the enhancement and expansion of the PN role (Hajizadeh, 2021). This cannot be achieved without further educational and organisational support for PNs and GPs, appropriate remuneration for the PN and most importantly, equality between all members of the patients care team.

Voluntary patient registration

In Australia, attempts to introduce patient enrolment to a general practice and GP have been ongoing since the early 1990s; however, there has been continual opposition by some peak medical organisations such as the Australian Medical Association which has often resulted in the government proposing a series of trials or pilot programs (Duckett & Willcox, 2015). The HCH model was clearly another attempt to move away from the traditional fee-for-service model and involved Medicare-eligible patients with two or more chronic conditions being enrolled to the HCH (general practice). Annual bundle payments were provided to the practice for each enrolled patient, and each bundle amount was commensurate with the complexity of the patients' conditions and associated care, as determined by a Risk Stratification Tool (Dawda 2022). This type of patient enrolment constitutes a formal agreement between a patient and a GP or general practice. According to Oliver-Baxter (2014), patient enrolment can be either formal or voluntary. In the case of HCH, patients were 'invited' to enrol with the proposed benefits of the initiative provided to them as seen by the following excerpt from the Federal government Department of Health patient information sheet:

> *You are being invited to enrol in the Health Care Homes program because you have been assessed as potentially eligible and likely to benefit from the Health Care Homes primary care delivery model. As a Health Care Homes patient, you will have your own care team. The care team will develop a care plan for you and help to coordinate your care, both inside and outside the Health Care Home. The benefits of the program include:*
>
> - *having a greater say in your care*
> - *having a care team take the hassle out of coordinating your care, and*
> - *easier access to your care team to get advice on your care* (Australian Government, 2018b).

The patient enrolment scheme is not new. In Canada, patients are invited to enrol with a Family Health Team (FHT) designed to improve and expand access to a group of health professionals. Enrolment is voluntary and there are a variety of FHTs across Canada, each focusing on specialised groups with specific health needs such as palliative care, Aboriginal health, and those living rurally (Ontario Ministry of Health, 2021). In the UK, the National Health Service (The NHS Health Education England) health policy has had a strong focus on case management for the care of those with long-term health conditions. Their model requires patients to register with a general practice which then offers a range of services (North & Peckham, 2001). Their Long Term Condition model uses a three tier triangle approach known as the Kaiser Permanente triangle to identify suitable patients in need according to three levels of complexity and match them with appropriate packages of care (Carrier & Newbury, 2016). This model is akin to the three-tiered Risk Stratification Tool used in Health Care Homes to:

> *… systematically categoris[e] patients based on their health status and other factors … and allow for care management, in which practices manage patients based on their assigned risk level to make better use of limited resources, anticipate needs, and more proactively manage their patient population* (Dera, 2019, p. 21).

In 2010, the Australian Medical Association successfully lobbied against people with diabetes enrolling with GPs because they opposed the move away from fee-for service, and at the time stated:

> *… it removes patient choice, limits access to services and compromises the independence of doctors' clinical decision making (financial considerations versus clinical need), creates perverse incentives that diminishes access to, and the quality of care, and adds to the red tape burden on GPs* (Australian Medical Association, 2010b).

In order to support MBS telehealth and continuity of care into the future, the Australian Government Department of Health proposes that voluntary patient registration (VPR) should occur, where people can choose to register with their usual general practice and nominate their usual GP (Department of Health, 2021a). This represents a new way of framing the problem, and addressing the issue of a lack of continuity of care. This new proposal restricts telehealth to only those who sign up (Daniel, 2021). Daniel (2021) goes on to say that patients who register would receive integrated person-centred care from a team of health professionals. Hailed as a system that benefits patients, health system funders, and those who provide holistic care within the general practice setting, the future establishment of VPR, while not new in Australia, remains devoid of any decision about specific funding models (Wright & Versteeg, 2021).

Dawda et al (2022) recommend expanding partnerships by supporting the development of care teams involving nurses and supporting them to have a greater presence and expanded role within these teams (Dawda, 2022).

The experience of the Quality Enhanced general practice Services Trial (QuEST) has demonstrated that the role of the PN can be enriched when mutual respect and understanding between the PN and the GP exists. In this instance, the PN was proactive in developing care teams within the practice, ensuring that each PN was assigned to a care group. This group was responsible for the overall care of several patients. This model was shown to be beneficial in establishing the PN as a valuable

member of the persons care team. Patients understood that if their GP was unavailable, the PN could assist them. This model assists in promoting a team approach to care, mitigating the potential to suppress the PN role as task orientated, and has the potential to enhance and expand the PN role.

The general practice environment poses many challenges to the future expansion of the PN role. Empowering the PN through education, research and a voice in policy decision-making may prove to be the necessary foundations for the development of an enhanced and expanded role into the future.

10.15: Summary

My research has demonstrated that the role of the PN during the HCH trial was essentially unchanged. Forty-seven years on from the development of Alford's Structural Interest Theory, approaches to care within general practice have included the introduction of a greater number of nurses and allied health professionals, the corporatisation of practices, and advances in technology. Despite this, Alford's theory remains relevant. In 1975, Alford identified three groups with varying interests: the professional monopolists, corporate rationalists, and the community. His theory was devoid of any consideration about allied health professionals or the nurse.

This thesis has explored the impact of policy change upon the PN role. Evidence has shown that a move away from fee-for-service to a bundle payment model has had no impact upon the PN role. During the HCH trial, financial remuneration was offered to participating GPs, but not PNs. The business model will triumph because the business is not prepared to suffer financial loss, suggesting that regardless of government reform, the private business nature of general practice and the power of GPs transcends any attempt at policy reform.

While PNs noted an appreciation that their time could be billed to the practice using the HCH bundle payment, their wage did not change. The fluidity of the bundle payment meant that some practices employed additional PNs indicating their appreciation for the role; however, while this additional PN was sometimes used for non-HCH tasks, this made no difference to the role. In fact, the employment of a Medical Assistant to engage with the HCH trial by some practices served to challenge the professional role and status of the PN.

PNs reported a greater sense of job satisfaction and ability to work to their scope when standing orders were employed. When the PN working within the Davies practice developed teams of GPs and PNs, she acknowledged feeling a part of the patients' care team rather than someone who the GP would delegate tasks to. During the HCH trial, not all GPs within a practice participated in the initiative which meant that HCH patients would not always see the HCH GP, especially when they were unavailable or absent.

One of the greatest disruptions to the HCH trial was the advent of COVID-19. Telehealth was one of the elements of the HCH trial for people with chronic and complex conditions, and was introduced to all patients during the pandemic as one way to mitigate the spread of the virus. PNs reported undertaking care planning via telephone, which was delayed in some cases.

Impediments to integrated care during the trial were a result of a lack of time to educate all involved, especially allied health professionals who were reluctant to engage with the online shared care plan due to a lack of education and awareness about its use. Poor engagement from patients with the online care plan was also deemed to be due to a lack of education and awareness about how it was to function, coupled with a lack of technological prowess, especially for older people. Most PNs reported no change in how they conducted care planning, albeit the care plan was placed on an online shared platform.

Despite the potential for an enhanced PN role, especially in relation to funding and the shared care plan, the role was essentially unchanged during the HCH initiative. Any enhancement of the role was due to initiatives shown by the PNs themselves as well as the willingness of the GP to relinquish tasks to the PN.

Irrespective of which of the three groups determined by Alford one falls into, it will always be self-interest that prevails, even if it means jumping from one category to align with the beliefs and interests of those in another.

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Appendices

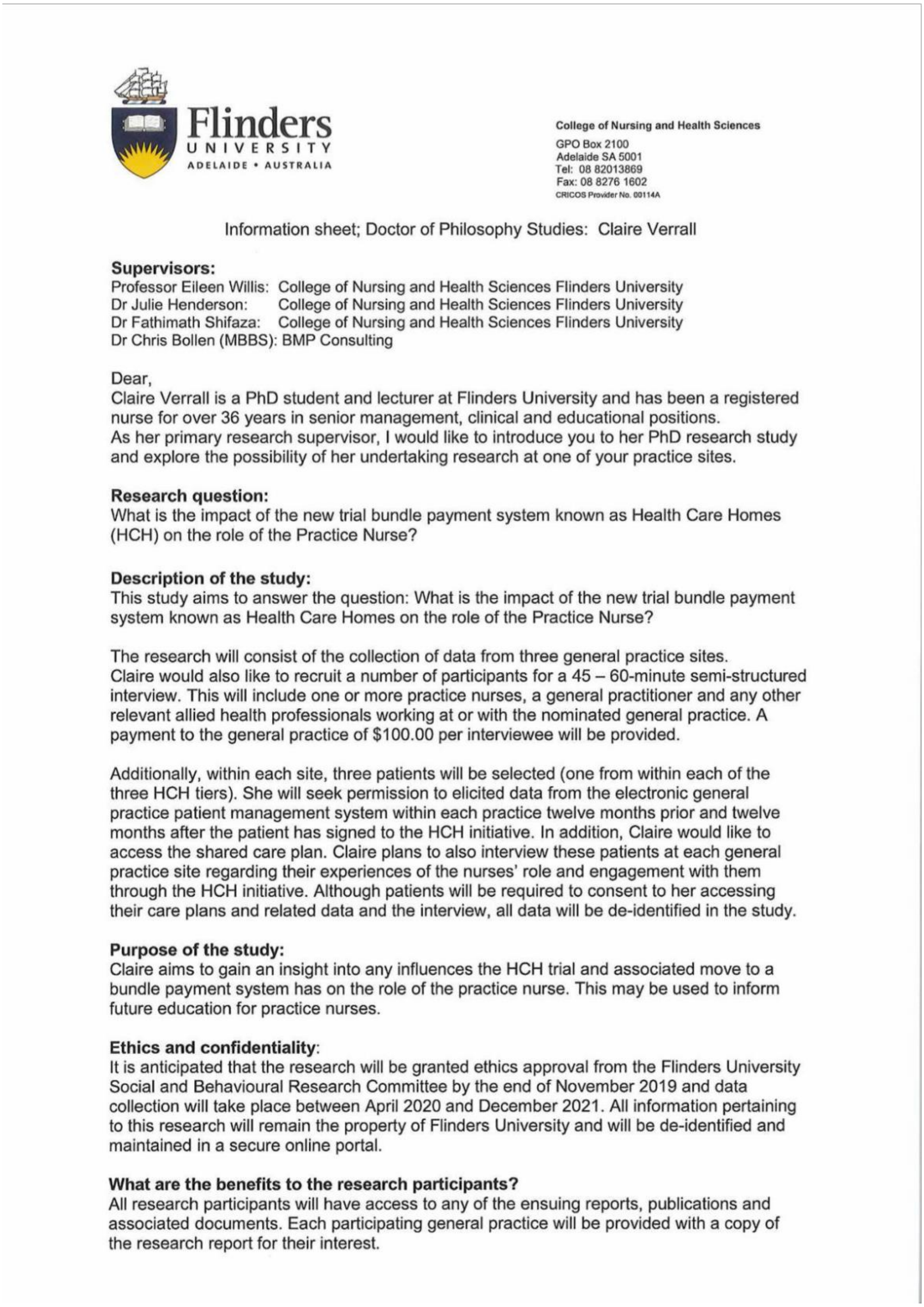
Appendix A: The Critical Skills Programme Checklist (CASP), adapted from Critical Appraisal Skills Program checklist 2021.

Authors and publication	Year and country	Did the review address a clearly focused question?	Did the authors look for the right type of papers?	Were all the important relevant studies included?	Did the reviewers do enough to address quality of the included studies?	Was it reasonable to combine the results of the studies?	What are the overall results of the review?	How precise are the results?	Can the results be applied to the local population?	Were all important outcomes considered?	Are the benefits worth the harms and costs?
						√ The SLR presents a thematic response to the research question			√ All results have relevance to the Australian context		√ Benefits from qualitative data informs future practice
Lukewich ,J, Edge,D., VanDenKerkhof, E., Williamson, T., Tranmer, J.,	2014 Canada	√	√	√	√	√	CDM is not uniform, role descriptions require clarification	Captured detailed information of a range of nurse characteristics	√	√	√
Poitras, M., Chouinard, M., Fortin, M., Girard, A., Crossman, S., Gallagher, F.	2018 Canada	√	√	√	√	√	PNs have a large scope of practice with many variables	In-depth interpretation of nursing activities	√	√	√

Lukewich, J., Edge, D., VanDenKerkhof, E., Williamson, T., Tranmer, J	2018 Canada	√	√	√	√	√	Relationships between CDM teams and services should be examined	Included 34 practices and 26 staff. Focussed on Family Health Teams	√	√	√
Daly, B., Kenealy, T., Arroll, B., Sheridan, N., Scragg, R.	2013 New Zealand	√	√	√	√	√	The “get checked” program provided opportunities to extend the role of the PN	86% response rate – nurses responded to questions about the program	√	√	√
Doolan-Noble, F., Gauld, R., Waters, D.	2015 New Zealand	√	√	√	√	√	Poor level of PN engagement with care planning for CDM	PN perceptions were gauged	√	√	√
Askerud, A., Conder, J. 2016	2016 New Zealand	√	√	√	√	√	Appropriate funding is necessary for successful CDM	General perceptions of a team-based approach	√	√	√
Macdonald, W., Rogers, A., Blakeman, T., Bower, P.	2007 United Kingdom	√	√	√	√	√	PNs lacked the knowledge and resources for Effective long term CDM	Two researchers analysed all data from interviews	√	√	√
McDonald, R., Rogers,	2008 United	√	√	√	√	√	PNs and patients	The same research	√	√	√

A., Macdonald, W.	Kingdom						have a mutual dependence	er conducted all interviews			
Kennedy, A., Rogers, A., Bowen, Lee, V., Blakeman, T., Gardner, C., Morris, R., Protheroe, J., Chew-Graham, C.	2014 United Kingdom	√	√	√	√	√	Minimal support for PNs when performing CDM	Face-to-face interviews	√	√	√

Appendix B: Information sheet



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Information sheet; Doctor of Philosophy Studies: Claire Verrall

Supervisors:
Professor Eileen Willis: College of Nursing and Health Sciences Flinders University
Dr Julie Henderson: College of Nursing and Health Sciences Flinders University
Dr Fathimath Shifaza: College of Nursing and Health Sciences Flinders University
Dr Chris Bollen (MBBS): BMP Consulting

Dear,
Claire Verrall is a PhD student and lecturer at Flinders University and has been a registered nurse for over 36 years in senior management, clinical and educational positions.
As her primary research supervisor, I would like to introduce you to her PhD research study and explore the possibility of her undertaking research at one of your practice sites.

Research question:
What is the impact of the new trial bundle payment system known as Health Care Homes (HCH) on the role of the Practice Nurse?

Description of the study:
This study aims to answer the question: What is the impact of the new trial bundle payment system known as Health Care Homes on the role of the Practice Nurse?

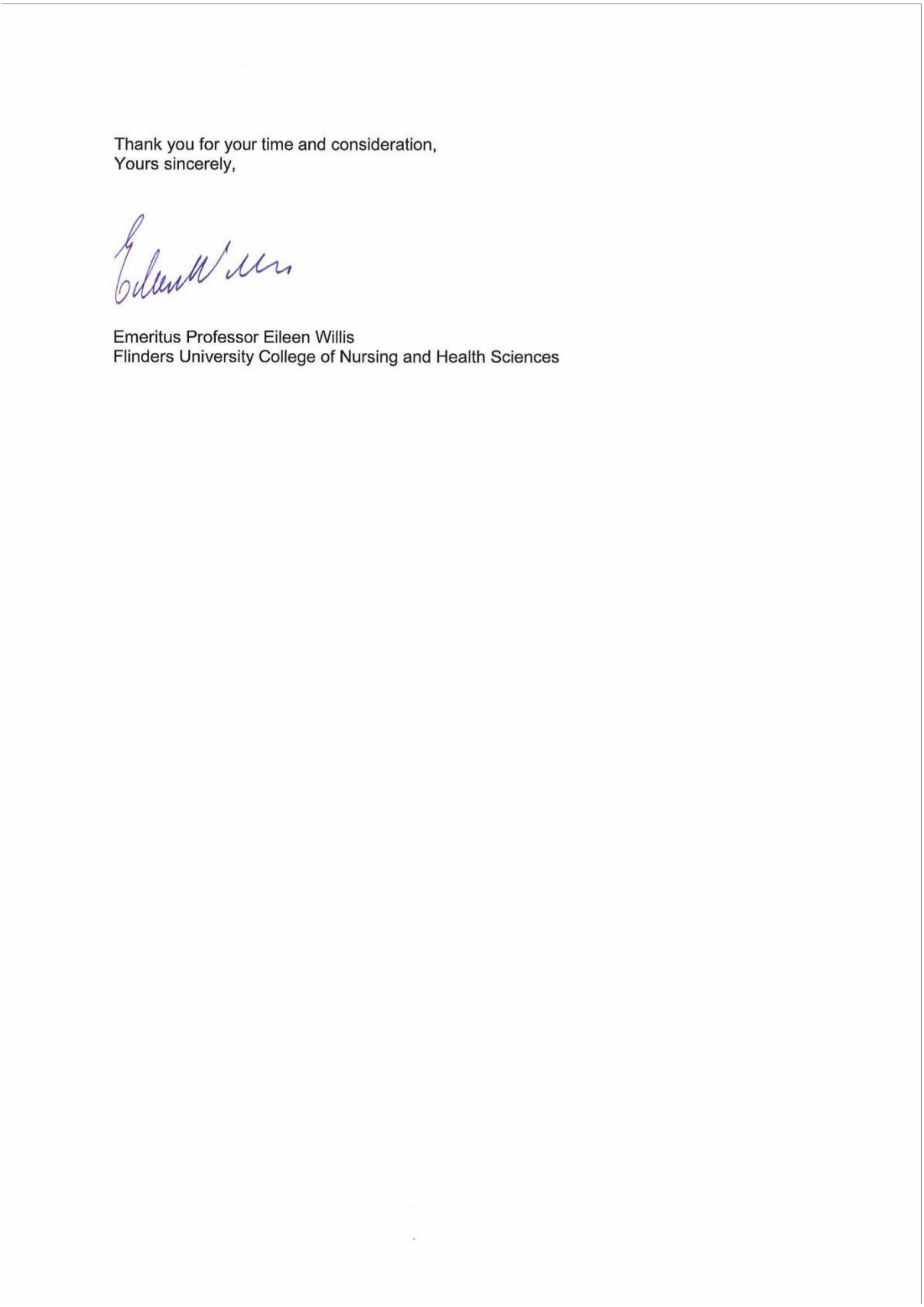
The research will consist of the collection of data from three general practice sites.
Claire would also like to recruit a number of participants for a 45 – 60-minute semi-structured interview. This will include one or more practice nurses, a general practitioner and any other relevant allied health professionals working at or with the nominated general practice. A payment to the general practice of $100.00 per interviewee will be provided.

Additionally, within each site, three patients will be selected (one from within each of the three HCH tiers). She will seek permission to elicited data from the electronic general practice patient management system within each practice twelve months prior and twelve months after the patient has signed to the HCH initiative. In addition, Claire would like to access the shared care plan. Claire plans to also interview these patients at each general practice site regarding their experiences of the nurses' role and engagement with them through the HCH initiative. Although patients will be required to consent to her accessing their care plans and related data and the interview, all data will be de-identified in the study.

Purpose of the study:
Claire aims to gain an insight into any influences the HCH trial and associated move to a bundle payment system has on the role of the practice nurse. This may be used to inform future education for practice nurses.

Ethics and confidentiality:
It is anticipated that the research will be granted ethics approval from the Flinders University Social and Behavioural Research Committee by the end of November 2019 and data collection will take place between April 2020 and December 2021. All information pertaining to this research will remain the property of Flinders University and will be de-identified and maintained in a secure online portal.

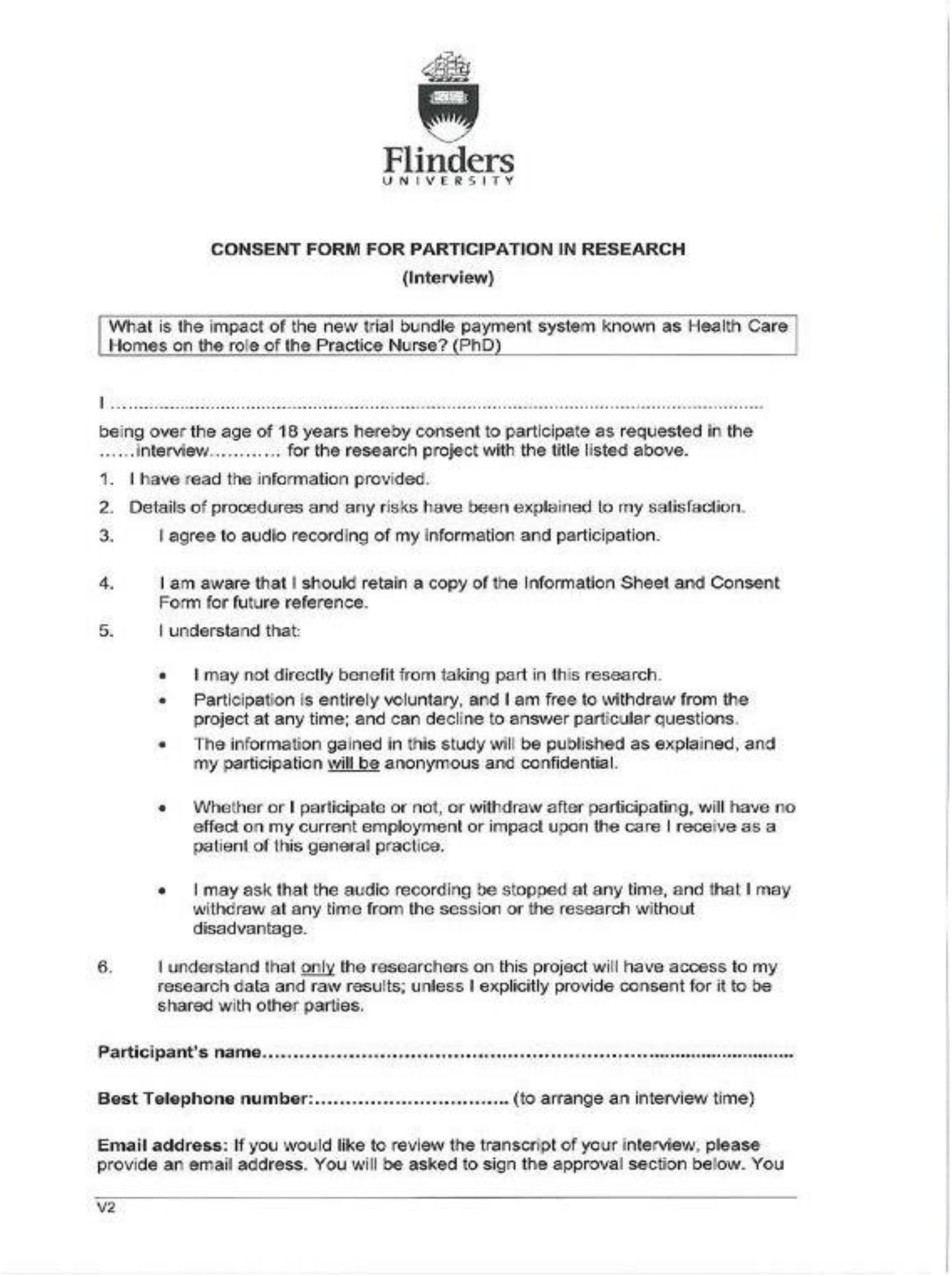
What are the benefits to the research participants?
All research participants will have access to any of the ensuing reports, publications and associated documents. Each participating general practice will be provided with a copy of the research report for their interest.



Thank you for your time and consideration,
Yours sincerely,

Emeritus Professor Eileen Willis
Flinders University College of Nursing and Health Sciences

Appendix C. Interview consent form



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CONSENT FORM FOR PARTICIPATION IN RESEARCH
(Interview)

What is the impact of the new trial bundle payment system known as Health Care Homes on the role of the Practice Nurse? (PhD)

I ……………………………………………………………………………………………

being over the age of 18 years hereby consent to participate as requested in the ……interview……….. for the research project with the title listed above.

1. I have read the information provided.
2. Details of procedures and any risks have been explained to my satisfaction.
3. I agree to audio recording of my information and participation.
4. I am aware that I should retain a copy of the Information Sheet and Consent Form for future reference.
5. I understand that:
    - I may not directly benefit from taking part in this research.
    - Participation is entirely voluntary, and I am free to withdraw from the project at any time; and can decline to answer particular questions.
    - The information gained in this study will be published as explained, and my participation will be anonymous and confidential.
    - Whether or I participate or not, or withdraw after participating, will have no effect on my current employment or impact upon the care I receive as a patient of this general practice.
    - I may ask that the audio recording be stopped at any time, and that I may withdraw at any time from the session or the research without disadvantage.
6. I understand that only the researchers on this project will have access to my research data and raw results; unless I explicitly provide consent for it to be shared with other parties.

Participant's name……………………………………………………………………………

Best Telephone number:………………………….. (to arrange an interview time)

Email address: If you would like to review the transcript of your interview, please provide an email address. You will be asked to sign the approval section below. You

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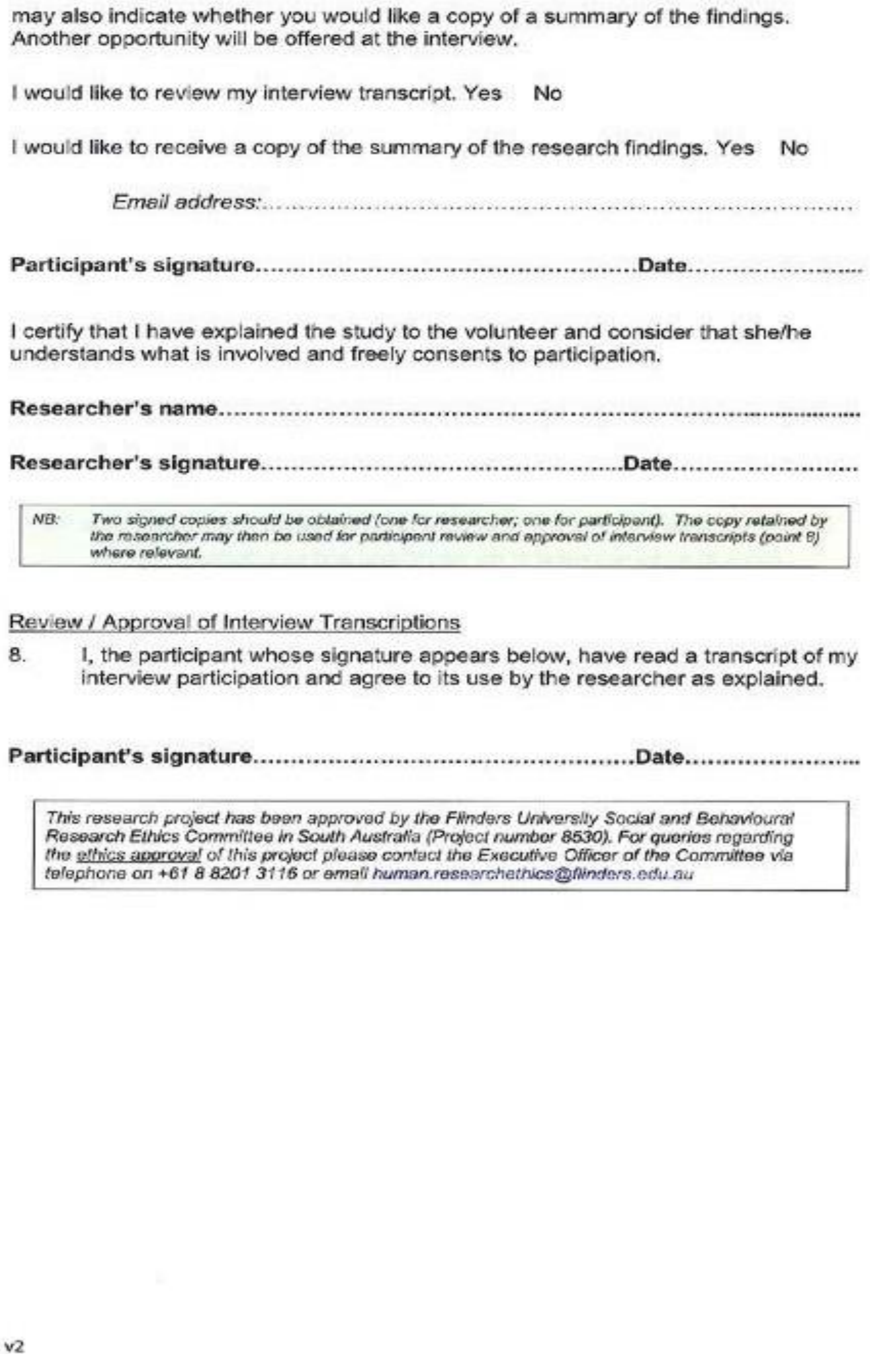

may also indicate whether you would like a copy of a summary of the findings. Another opportunity will be offered at the interview.

I would like to review my interview transcript. Yes No

I would like to receive a copy of the summary of the research findings. Yes No

Email address:...

Participant's signature...**Date**.......................

I certify that I have explained the study to the volunteer and consider that she/he understands what is involved and freely consents to participation.

Researcher's name...

Researcher's signature..**Date**.........................

NB: Two signed copies should be obtained (one for researcher; one for participant). The copy retained by the researcher may then be used for participant review and approval of interview transcripts (point 8) where relevant.

Review / Approval of Interview Transcriptions

8. I, the participant whose signature appears below, have read a transcript of my interview participation and agree to its use by the researcher as explained.

Participant's signature...**Date**.......................

This research project has been approved by the Flinders University Social and Behavioural Research Ethics Committee in South Australia (Project number 8530). For queries regarding the ethics approval of this project please contact the Executive Officer of the Committee via telephone on +61 8 8201 3116 or email human.researchethics@flinders.edu.au

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Appendix D – Predetermined interview questions - practice nurse, general practitioner, practice manager and patient

Practice Nurse

Can you tell me about your nursing history?

How long have you worked at this practice?

What interested you in this role?

What was your understanding of the role when you began working here?

What training did you have for this role?

When you commenced in this role, what were your main tasks?

Has your role changed since you have been working here?

Do you feel that you were adequately equipped to perform this role?

If not, what education do you believe was lacking?

How many nurses work at this practice?

How does your role relate or fit in with the roles of the other nurses at this practice?

For example, do you all share tasks/responsibilities?

Is there any type of nursing hierarchy?

Can you tell me how Health Care Homes was implemented in this practice?

> Did you undergo any training for Health Care Homes?
>
> Did you have any involvement in the set up or any discussions about the trial?

Has your role changed because the Health Care Homes trial?

> In what way has it changed?
>
> Can you describe a typical day?

Can you tell me what differences if any has Health Care Homes made to your working relationship with:

> General practitioners?
>
> Patients?
>
> Reception staff?
>
> Allied health professionals?

How is Health Care Homes organised in this practice? For example, do you have regular meetings, is there a leader?

How would you describe any changes to your role? For example, do you feel that your role has been enhanced? Has it made any difference to your job satisfaction?

Do you feel that Health Care Homes has been beneficial for patient care?

Have there been any new activities or patient initiatives as a result of Health Care Homes?

Do you run or facilitate any group sessions that you would not have done before?

What would you say are the strengths of Health Care Homes?

What would you say have been the challenges or issues?

Do you feel that Health Care Homes has provided you with any more autonomy?

Can you describe your role in relation to the Health Care Homes team?

What influence has COVID had on the Health Care Homes trial and your role?

Are there any other comments that you would like to make?

General Practitioner

Can you tell me a bit about this practice and the general practitioners that work here?

What interested you to sign up for the Health Care Homes trial?

What were you hoping that the Health Care Homes initiative would provide?

Was there anything that you were concerned about?

What did you find were some of the challenges of the trial?

Can you tell me how Health Care Homes was implemented in this practice?

    Did you undergo any training for Health Care Homes?

Has your role changed because the Health Care Homes trial?

    In what way has it changed?

Do you feel that your working relationship with the nurse altered as a consequence of the trial?

Do you feel that Health Care Homes has been beneficial for patient care?

Do you feel that the online shared care plan has enhanced interdisciplinary care within this practice?

Have there been any new activities or patient initiatives as a result of Health Care Homes?

What would you say are the benefits of Health Care Homes?

Do you feel that there has been a benefit to patient care?

Do you feel that Health Care Homes has changed the way that the practice nurse works?

Can you describe your role in relation to the Health Care Homes team?

What influence has COVID had on the Health Care Homes trial and your role?

Are there any other comments that you would like to make?

Practice Manager

Can you tell me a bit about this practice?

How many staff and what are their roles?

What is your role at this practice? What training and education have you undertaken for this role?

What interested this practice to sign up for the Health Care Homes trial?

What were you hoping that the Health Care Homes initiative would provide?

Was there anything that you were concerned about?

What did you find were some of the challenges of the trial?

Can you tell me how Health Care Homes was implemented in this practice?

Did you undergo any training for Health Care Homes?

Has your role changed because the Health Care Homes trial?

In what way has it changed?

Do you feel that your working relationship with the nurse altered as a consequence of the trial?

Do you feel that Health Care Homes has been beneficial for patient care?

Can you tell me a bit about how the bundle payments were organised in this practice?

Do you see any benefits from the change in funding systems?

Do you feel that the online shared care plan has enhanced interdisciplinary care within this practice?

Have there been any new activities or patient initiatives as a result of Health Care Homes?

What would you say are the benefits of Health Care Homes?

Do you feel that there has been a benefit to patient care?

Do you feel that Health Care Homes has changed the way that the practice nurse works with you and other members of the practice team?

What influence has COVID had on the Health Care Homes trial and your role?

Are there any other comments that you would like to make?

Patient

Can you tell me what you know about the Health Care Homes trial?

Do you think that your care has changed at all during this trial?

Do you think that there is a difference in the way that you have engaged with the nurse during the trial?

Do you feel that you have received better care?

If so, can you provide some examples?

Are you aware of the online care plan associated with Health Care Homes?

Do you think that there has been a difference in your care because of this care plan? For example, in relation to the other health care professionals assisting you such as a podiatrist or physiotherapist?

Are you aware that you can enter things into the care plan yourself such as blood pressure readings for example?

Do you feel that your care changed during COVID?

Is there anything else that you would like to say about the trial?