Allied Health Leadership:

Critical for Successful Primary Health Care Reform

By

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Statements and Declarations

Declaration of Originality

This thesis contains no material which has been accepted for a degree or diploma by the University or any other institution, except by way of background information and duly acknowledged in the thesis, and to the best of my knowledge and belief no material previously published or written by another person except where due acknowledgment is made in the text of the thesis, nor does the thesis contain any material that infringes copyright.

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The research associated with this thesis abides by the international and Australian codes on human and animal experimentation, the guidelines of the Australian Government's Office of the Gene Technology Regulator and the rulings of the Safety, Ethics and Institutional Biosafety Committees of the University.

29/7/2019

Deborah E. Zwolsman

Dated

Acknowledgements

This thesis is the result of many years of work and has been part of my life in Tasmania since I arrived here in 2009. I was the daughter of migrant parents who arrived from the Netherlands in the 1950's after World War II. Both of my parents' education was disrupted because of the war and so I am the only person in my immediate family that was fortunate enough to attend university. It is because of my parents' strong belief in education that I was initially given the opportunity to study. Over the years I have maintained my thirst for knowledge and an interest in the world that has been handed down to me from my Mother, whose love of knowledge never seems to diminish.

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Glossary

Allied Health Professional	The term 'Allied Health Professional' refers to those groups registered with Australian Health Professional Regulatory Authority, or via their own professional organisation, who apply their expertise to prevent disease transmission, diagnose, treat and rehabilitate people of all ages and all specialties and deliver direct patient care, rehabilitation, treatment, diagnostics and health improvement interventions to restore and maintain health and wellbeing.
Biopower	Biopower is a technology of power which organises human subjects as a population (Foucault, 1978). The techniques of biopower are to "incite, reinforce, control, monitor, optimise and organise" (Foucault, 1978, p.136).
Discourse	Foucault (1972) terms 'discourse' the interplay between language and knowledge and to the material verbal traces left by history.
Disciplinary power	This is a mechanism of power that regulates the behaviour of individuals through training, examination, timetables, the organisation of space, people activities, surveillance and study (Foucault, 1977).
Integration	Health service integration aims to provide sustainable integrated services that better meets the needs of the end user. Integration refers to horizontal and vertical systems across micro, meso and macro levels.
Leadership	Leadership is a process of social influence that can enlist the aid and support of people in the accomplishment of a shared goal.
Marginalisation	Marginalisation is defined as the treatment of a person or group as insignificant or peripheral.
Medical personnel	The term 'Doctor 'in common community use refers to a medical practitioner and the terms are used interchangeably. A medical practitioner is registered under health practitioner national law in Australia. The protected titles include medical practitioner and medical specialist who may be referred to as general practitioners or specialists. In this thesis the term 'Doctor' is used as a catchall to refer to medical practitioners whether they be general practitioners or specialists.
Othering	Othering, as a process of differentiation, works to influence self- and professional-identity by reinforcing the dominant-subordinate relationship (Roberts & Schiavenato, 2017).
Power	Foucault conceives power in multiple ways (see sovereign, disciplinary, social and biopower descriptions in this glossary) but uses the term in a general way to refer to processes that identify and invest the body (1977) to influence how people think and act.
Primary Care	These terms primary care, primary health care and comprehensive primary health care denote three levels of care on a spectrum. Primary care describes primary medical care/ general practice-led care.

Primary Health Care	Primary health care is a broader term that considers a wider range of treatments and interventions, including those provided by Allied Health Professionals.
Comprehensive Primary Care	Comprehensive primary health care, predicated on the Declaration of Alma Ata's (1978) strategy to respond more equitably, appropriately and effectively to the health needs of a population, also addresses underlying social, economic, and political causes of poor health (also known as the social determinants of health).
Selective Primary Care	An interim strategy proposed by Walsh and Warren (1979) after the Declaration of Alma Ata (1978) to implement primary health care that sought to fight selected diseases based on a cost-effective medical intervention strategy. They proposed targeting diseases that had a high prevalence, high mortality and morbidity, and a feasibility of control (including efficacy and cost).
Sovereign Power	Sovereign power is a term used by Foucault (1977) to denote a form of power that controls and limits the behaviour of the population.
Technologies	Within the context of theories of power, the notion of technology is used in two ways to denote how language influences the ways people think and act. First, 'technologies of power' (Foucault 1975, 1991), and secondly through 'technologies of the self' (Foucault, 1977).
Technologies of power	Foucault's (1977) analysis of power is grounded in his concept of "technologies of power". Technologies of power are an externalised means of control and is related to his concepts of power/knowledge and discipline.
Technologies of self	Technologies of the self are internalised mechanisms of power. Foucault (1988, p.16) describes technologies of the self as that which "*permit individuals to effect by their own means or with help of others a certain number of operations on their own bodies and souls, thoughts, conduct, and way of being, so as to transform themselves in order to attain a certain state of happiness, purity, wisdom, perfection, or immortality*".

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Abstract

Study Aim

This study examined the ways in which primary health care was represented by Medicare Locals and how these representations impacted on how Allied Health Professionals formed meanings and therefore approached integration, collaboration and multidisciplinary ways of working as leaders in primary health care.

Background

In the early 2000's, the Australian government made a commitment to improve the health and wellbeing of its diverse populations by undertaking major reform in the primary health care sector. Major structural reforms, including the dismantling and reorienting of the Divisions of General Practice to establish 61 Medicare Local organisations, was implemented in 2011. To diversify leadership and foster interprofessional collaboration, Medicare Locals were mandated to appoint Allied Health Professionals to their governing Boards. The establishment of a skill base that included Allied Health Professionals provided a rich basis for a case study on ways primary health care was constructed in the overarching policy documents for Medicare Locals and enacted in leadership practices.

Methods

In this critical, retrospective study a qualitative research design informed by a language-centred approach brought together different theoretical orientations. It used power as the main theoretical lens and drew on Foucault's socio-cultural theories of language, power, discourse and identity. Critical discourse analysis refers to various semiotic methods used for examining the signification and meaning explicit and implicit in written and spoken texts. Use of Fairclough's critical discourse analysis framework made it possible to critically examine how power was exercised through discourse. The framework enabled an in-depth analysis of the Medicare Local documents, and interviews with seven Allied Health Professionals who were in leadership roles on the Boards of Medicare Locals. Allied

Health Professionals' leadership identity was also explored, and these combined insights enabled a deep examination of the cultural dimensions of comprehensive primary health care reform, including integration, collaboration and multidisciplinary ways of working.

Findings

Complex relations of power exist in primary health care. The major themes from analysing the policy framework documents were *the Australian government's prescribed vision and mission for Medicare Locals,* the *interpretation of the guidelines to develop Constitutions* and *health for all*, which included the sub themes *the need for health improvement and discursive tensions in promoting health and primary care.* The medical model, its associated biomedical discourse and a professional discourse that underpins the traditional hierarchy within the health professions persists. Medicare Locals, charged with implementing primary health care reform, and its associated discourses of health, health promotion and community dimensions, were sites of tension for Allied Health Professionals acting as leaders in their Board member roles.

The seven Allied Health Professionals interviewed were profiled. The major themes emerging from the interviews were b*ringing Allied Health Professionals to the table,* e*xperiences of being at the table, and enacting leadership to achieve the vision and mission of Medicare Locals,* and *the tension between directives, rhetoric and reality. Experiences of Being at the Table* included the sub-themes: *Being Silenced, Finding Voice, and Being Heard. Being Silenced*. *Enacting leadership to achieve the prescribed vision and mission* of Medicare Locals included c*ontributions to health planning, leading Primary Health system transformation,* and *the glue in the system.* There was a tension between *the directives, rhetoric and reality experienced,* however some Allied Health Professionals considered their inclusion in Medicare Locals facilitated integration and multidisciplinary collaboration by providing a new vision, and through their multidisciplinary ways of working, saw Allied Health as the *Glue in the System.*

Bringing Allied Health Professionals to the Board table facilitated a new vision for comprehensive primary health care, and integrated, multidisciplinary collaboration. However, processes of othering

marginalised communities as well as the Allied Health Professionals who had to negotiate belonging. Some were at risk of falling into a subservient role of Doctor's Assistant and playing a 'Doctor-Allied Health Professional game' while others found voice and developed a strong Allied Health leadership identity which they used to ensure they were Being Heard in primary health care.

Conclusion

Bringing Allied Health Professionals to the Board table in Primary Health Care is merely the first step in achieving better health through integrated, multidisciplinary collaborative practice. The next step involves *Being at the Table* and ensuring they are *Being Heard* and supported to share their views, understanding and ideas about advancing comprehensive primary health care. Transformative, inclusive and democratic leadership attributes were demonstrated by some of the Allied Health Professionals. These qualities are instrumental for transforming the health professional hierarchies and cultures that have impeded successful primary health care reform and replace them with innovative leadership for coordinating, connecting and managing services and interventions. They are also important for disrupting the othering of communities to situate them at the centre and engage them in health service planning at the local level.

With ongoing support and development, Allied Health Professionals are well-placed to lead comprehensive primary health care, the preferred model for improving Australia's health. Lurching from one policy directive to another in the absence of timely and robust evidence is disruptive and counterproductive. Supportive mechanisms to inspire and foster strategic change management, innovation and leadership are lacking. Discourse, power and identity influence cultural perspectives in primary health care and shape what people can and cannot do. The ongoing evaluation of primary health care renders understanding these dimensions critically important for improving the success of future health reform. Critical transformative research can give voice to the intended beneficiaries of policies and provide a mechanism for driving meaningful change in primary health care practice.

Chapter 1. Introduction

Introduction to the thesis

This is a case study of the legacies of Medicare Locals, a national network of primary health care organisations that resulted from the national health care reform which occurred in Australia under Prime Minister Rudd's Labor Federal Government between 2011 and 2015. As a psychologist, and therefore Allied Health Professional, my role as an Australian Government Public Servant involved working on the selection process for the Medicare Locals. Immersion in early policy documentation and discussion led to the realisation that the primary health care reform agenda heralded new opportunities for public health that espoused values of community-focused, holistic, integrated, and multidisciplinary health care. The vision and mission of Medicare Locals seemed to align with the knowledge and value systems of Allied Health and therefore afforded these disciplines with new opportunities for leadership contributions in health care, which was the catalyst for this case study.

This chapter is divided into two sections. The first section situates the study by outlining the social determinants of health and health of Australians and specifically, the dual issues of an aging society and burgeoning chronic disease that underpinned the drive for change. Chronic disease refers to conditions that are long lasting and that have persistent effects, such as arthritis, asthma, cardiovascular disease and diabetes (Australian Institute of Health & Welfare, 2018a). The notions of health, primary health care and health system reform are explored in the Australian context before describing the transition from Divisions of General Practice to Medicare Locals. Primary care and primary health care are differentiated, and primary health care discussed as both a philosophy and a set of principles. The section ends by defining Allied Health and Allied Health leadership. The second section justifies the study and outlines the structure of the thesis.

Medicare Locals were tasked to work with local Hospital Networks, primary health care providers and communities to ensure people received 'the right care, in the right place, at the right time' (Australian Government, 2013, p.4). This study focused on the ability of Medicare Locals to progress the Australian

government's vision to improve public health by transforming the health system structure. The study used retrospective organisational document analysis and interviews with Allied Health Professionals who had been Board members, to generate insights about how primary health care reform was implemented and operated under the umbrella of Medicare Locals

There have been major shifts in health policy and reform in Australia over the past four decades, often in concert with political change. Prior to Medicare Locals, the Australian health care system consisted of public and private hospitals, not for profit organisations, community health services, Divisions of General Practice, and financial mechanisms designed to provide universal access to health insurance and services, such as Medicare and the Pharmaceutical Benefits Scheme. Prior to 2011, 53% of the population took out private health insurance to facilitate choice and access and buffer the limitations of public health care (Australian Bureau of Statistics, 2016). Figure 1 provides an overview of the incumbent governments and the policy shifts that resulted under their leadership. The incumbent government and Prime Minister/s are indicated on the diagram along with the major primary health care policy shifts that each government was responsible for during their term of leadership.

Figure 1 Landmark shifts in Australia's health policy and reform

Despite the multiple changes that have shaped the Australian health care landscape, health reforms have persistently privileged the medical model and authority. The medicalised language prevalent in the early settlement period has prevailed as the legitimate authoritative voice and continued to influence how health, health systems and health services have evolved (Fletcher, 2000). Language is important because it defines the boundaries of what can and cannot be known, and what roles people can and cannot play in health care. The interplay between language and knowledge, which Foucault (1972) terms 'discourse', has important ramifications for primary health care reform. The discourse concept is explored more fully later in the methodology chapter.

At the time of writing in 2019, health and wellbeing are regarded as central to social capital, progress, and productivity (Productivity Commission, 2013). However, societal needs are very different from those that were prevalent when our health care system was established. The burden of disease has shifted from episodic acute care to managing chronic illness and the language of disease, illness and treatment, to a new vernacular of health and well-being, health promotion, and disease prevention: the tenets underpinning the primary health care reform agenda.

Concern for Australia's public health was reflected in the 2009 report from the National Health and Hospitals Reform Commission (NHHRC) which concluded that "*service coordination and population health planning priorities should be enhanced at the local level through the establishment of Primary Health Care Organisations*" (Australian Government, 2009b, p.15). Australia's First National Primary Health Care Strategy (Australian Government, 2009a, p.1) outlined the vision for "*building a 21st century primary health care system*". This strategy explicitly articulated the importance of "*facilitating Allied Health care and other support for people living with chronic conditions*" (p.13). In doing so, the strategy effected changes in the structures of health services and the functionality of language and discourse in use.

Medicare Locals were established as the first step in moving beyond the Divisions of General Practice model which operated at the time. The Divisions of General Practice, led by General Practitioners

(GPs), were regionally-based government funded associations. These corporate entities undertook "*a wide range of activities focused on improving the health of the Australian community, including health promotion, early intervention and prevention strategies, health service development, chronic disease management, medical education and workforce support*" (Australian General Practice Network, 2009, p.21). See later in the chapter for further discussion. Further to these activities, the Medicare Locals were tasked to achieve service integration, and collaborative and multidisciplinary ways of working; factors which had implications for the power and hierarchy that existed in the Australian health care system. This study draws on several theories and orientations of power that are introduced in this chapter and addressed more fully in Chapter Three.

For the first time in Australian history, Allied Health Professionals were intentionally appointed as Board members as a catalyst for multidisciplinary interaction and leadership in primary health care. When this study commenced, issues of power, professional hierarchies, and knowledge and discourse that underlie the spirit of primary health care, had rarely been investigated. This gap in research was concerning as evidence-based knowledge and understanding are instrumental in shaping more efficient models of team-based primary health care. The aim of this study was to examine the ways in which primary health care was represented by Medicare Locals, and how these representations impacted on the way Allied Health Professionals formed meanings and therefore approached integration, collaboration and multidisciplinary ways of working.

Operational guidelines and constitutions were used to establish and operationalise Medicare Local organisations. These documents centralised public health within discourse-related problems and by doing so, unintentionally ascribed implicit meanings to primary health care. The innocence of how problems and solutions are framed within documents affects what can be thought and how decisions are made (Goffman, 1978). These documents represented important written texts because they were instances of language unconstrained by research protocols. They were regarded as 'technologies of

power' (Foucault, 1977) that produced and distributed discourses that Medicare Local staff would have drawn on to inform their day-to-day activities.

The inclusion of Allied Health Professionals on Medicare Local Boards engaged them in interdisciplinary conversations and discussions about primary health care. These Board meetings, and other related conversations were therefore regarded as the context within which primary health care social interaction took place. Within all social interactions, discourse operates as a social practice (Fairclough, 2001) that involves "*habitualised ways, tied to particular times and places, in which people apply resources (material or symbolic) to act together in the world"* (Chouliaraki & Fairclough, 1999, p.21). Allied Health Professionals' experiences of being Board members were likely to have been shaped by the conversations that took place within Medicare Locals. Recollections about, and reflections on these interactions, constituted the social and professional interaction sites where different meanings about primary health care, professional cultures and attitudes would come together, as the new multidisciplinary teams enacted their roles to progress Medicare Local objectives.

Potentially, the conversations that occurred within Medicare Locals could reveal the latent power between various health professionals. All conversations involve "*patterns of language that produce, distribute and consume discourse*" (Fairclough, 1995, p.75). Since discourse can govern how topics such as primary health care and integrative collaborative practice can be spoken about and put into social practice (Foucault, 1984), they can influence how people conduct themselves. Arguably, analysis of these relations of power and ideological practice would shed light on the Allied Health Professional's social world and sense of self through the functionality of language. For the purposes of this study, Allied Health Professional's recollections of Medicare Local experiences were regarded as 'technologies of the self' (Foucault, 1988), whereby the social interactions were likely to have regulated their conduct.

Foregrounding the relations between knowledge, discourse, power and sense of self, informed the need to examine what could or could not be said about primary health care, and the roles that Allied Health Professionals could or could not play as Board members. The study employed a qualitative and interpretative research design using a case study approach oriented within the critical tradition to examine how Medicare Locals operationalised the primary health care policy directive. Data were collected from two sources: a) publicly available Operating Guidelines and Medicare Local Constitutions underpinning the establishment of Medicare Locals and b) interviews from seven Allied Health Professionals who worked as Board members in these organisations. Critical discourse analysis (Fairclough, 2001, 2015), and theories of knowledge-power, discourse, and governance (Fairclough, 2001; Foucault, 1977, 1980; van Dijk, 1993, 1995, 1998), provided a framework for examining the ways power relations and hierarchies between GPs and Allied Health Professionals were created and maintained.

Ultimately, the 61 Medicare Locals were disbanded in 2015 by the incoming Liberal Coalition Government and replaced with 31 Primary Health Networks. A retrospective analysis of how Medicare Locals operated provides informative insights for implementing future reforms. Policy makers should be cognisant of the parallel needs for policy to be embedded in evidence and for building developmental, implementation and evaluative capacity (Hewat, 2009). Study findings are likely to matter due to the reforms that are continuing to unfurl in primary health care. The next section shows how primary health care is temporally situated, and culturally and historically informed, and places the study within this broader context.

Section 1. Situating the Study: Looking back to look forward

Given any social interaction is habitually and historically mediated (Germov, 2009; Giddens, 1993; Goffman, 1978), it was important to look back on the influences that shaped the socio-historical context in which primary health care reform was implemented. Social determinants theory posits that public health and inequality are determined by various interconnected social factors (Dean et al.,

2013). The first sub-section that follows examines social determinants of health and the health of Australians. At the time of this study, chronic disease was becoming prevalent (Productivity Commission, 2013), the population was ageing (Australian Bureau of Statistics, 2015) and inequities in health status existed between different groups (Australian Institute of Health & Welfare, 2013).

The second sub-section presents an overview of the historical evolution of Australia's health care system to demonstrate how its structure had become unsustainable for responding to chronic and complex disease. Discussion extends to how the Australian government, under the overall influence of global concerns with health, activated primary health care reform through a network of Divisions of General Practice. The third sub-section presents the transition from Divisions of General Practice to Medicare Locals. The problem underpinning this study was the failure of the Divisions of General Practice to realise the government's objective to create a more sustainable primary health care system. Nor had these Divisions developed a more informed population to make better lifestyle choices. Effective health and primary health care reform have outcomes that are long term in nature. To reduce chronic disease and create a sustainable health system required a shift from primary care to primary health care, where citizens have more control over their care and access to the right services for their needs. The fourth sub-section differentiates primary health care from primary care. As the Allied Health workforce was identified to play a critical role in primary health care reform, the final subsections define Allied Health and describe the concept of Allied Health leadership.

Social determinants and the health of Australians

There are a range of behavioural lifestyle, environmental and socioeconomic factors that are known to influence health (Australian Institute of Health & Welfare, 2018a). These social determinants of health are:

> *…the circumstances in which people grow, live, work, and age, and the systems put in place to deal with illness. The conditions in which people live and die are, in turn, shaped by political, social, and economic forces* (WHO, 2008c, p.9).

In this section, the social determinants are applied to contextualise the health profile of Australians. One way that countries assess and gauge the health of the population is by comparing health statistics and trends with other similar countries and the Organisation for Economic Cooperation and Development (OECD). The OECD provides a range of policies and resources for this purpose. Compared with other member countries of the OECD, Australia has one of the lowest rates of smoking among people 15 years and over, a level of alcohol consumption like the OECD average, and a rate of obesity among people aged 15 years and over that exceeds the OECD average (Australian Institute of Health & Welfare, 2018a). The average life expectancy of Australians is one of the longest in the world. The Commonwealth government's Intergenerational Report: Australia in 2055 (Treasury, 2015) predicted that in 2054-55, life expectancy at birth will be 95.1 years for men and 96.6 for women. In 2016, the life expectancy at birth was 80.4 years for men and 84.6 years for women (Australian Institute of Health & Welfare, 2018a).

Australia's population is growing and is culturally and linguistically diverse. A significant proportion of population growth can be attributed to migration, with the result that almost half of the population (45%) has either been born overseas or had one or both parents born overseas (19%) (Australian Bureau of Statistics, 2017). The Australian government plans to maintain such growth and has a target to reach 36 million people by 2051 (Treasury, 2010). According to the ABS, Australia reached 24 million people in 2016 (Australian Bureau of Statistics, 2016) and 25 million in 2018 (Australian Bureau of Statistics, 2018).

Whilst migrant populations are often healthier than non-Indigenous Australians when they arrive, this can change after they have lived here for more than 10 years (Jatrana et al., 2017). Also, for some people, English proficiency can affect access to health services, their understanding of health information, and therefore their health (Australian Government, 2009b). This may also affect access to employment, which has broader socio-economic implications that effect health (Australian

Government, 2009b). Cultural and linguistic determinants of health are nowhere more prominent than in the health of Indigenous Australians.

Indigenous Australians experience more health inequality and disadvantage than their non-Indigenous counterparts regarding the social determinants of health, primarily due to greater geographic distribution, health and lifestyle risk factors and difficulty accessing appropriate health services locally (Australian Institute of Health & Welfare, 2015). The Closing the Gap in a Generation: Health Equities Through Action on the Social Determinants of Health (WHO, 2008a) pointed to various environmental influences on health behaviours and outcomes. These influences have led to, on average, Indigenous Australians having higher rates of risky lifestyle factors that compromise health such as tobacco smoking, alcohol consumption and limited physical activity (Australian Institute of Health & Welfare, 2018a; Thomas et al., 2008). Notably, the most recent data on the gap in life expectancy between Indigenous and non-Indigenous Australians is 10.6 years for males and 9.5 years for women (2010-12 data) (Australian Institute of Health & Welfare, 2018a).

Around 29% of Australia's population live in rural and remote areas (Australian Bureau of Statistics, 2017). People living in rural and remote areas are more likely to have poorer health outcomes than those living in urban areas due to the higher ratio of adults engaging in lifestyles associated with poorer health and the greater prevalence of chronic disease (Australian Institute of Health & Welfare, 2018a). Mortality rates increase as remoteness increases, and the rate in very remote areas is 1.4 times higher than people living in major cities (Australian Institute of Health & Welfare, 2018a).

Other social determinants such as socio-economic position; perinatal and early childhood disadvantage; social exclusion; unemployment; homelessness; and lack of public green spaces in the built environment, also contribute to poorer health outcomes (Australian Institute of Health & Welfare, 2018a). Over the last one hundred years health has improved but patterns of disease have changed considerably. By 2018, chronic disease was estimated to account for more than 80% of Australia's health burden (Australian Institute of Health & Welfare, 2018b). These factors are

associated with an increase in chronic diseases, conditions often associated with lifestyle and comorbidities.

At the time of this study, it was estimated that if Australia took action on the social determinants, 0.5 million Australians would be spared chronic illness, annual hospital costs could be cut by $2.3 billion and Pharmaceutical Benefit Scheme prescriptions cut by $5.3 million (Brown et al., 2012). Accordingly, health services needed to be reoriented from acute episodic care to services that focus on illness prevention, health maintenance and chronic disease management. However, taking action on social determinants of health is not simple. To effect these changes, primary care services had to rethink what they were doing, how they were doing it and, importantly, who needed to do it – hence the need for health care reform. Well-planned and coordinated improvements in primary health care for various populations requires a continuum of care only achievable through fundamental changes in Australia's health care system.

Health, primary health care and health system reform in Australia

On the arrival of the First Fleet to Sydney Cove, Port Jackson, in 1788, Captain Arthur Phillip established hospitals modelled on the British health care system. The main concerns for the new colony during the early settlement period, were the control and prevention of infectious diseases and the maintenance of sanitation (Smith, 2011). The public hospital system was staffed by Doctors to provide basic medical care (Lewis, 2014). These early initiatives in health care were the result of sovereign power held by the British government. Foucault (1977, 1984) explains that sovereign power is held by elite groups who have the authority to govern and is expressed in recognisable ways. The British medical officials were highly visible and recognised as legitimate authority figures in health and health care. This resulted in a unique form of biopower, a term Foucault (1978) uses to describe how the thinking of an entire population can be influenced by authority figures.

Early health care in Australia, shaped by the cultural heritage of the British model, was characterised by the desire to control disease, and the poor, who were seen to cause it (Baum, 2015). Health care

was heavily influenced by biomedical knowledge. Biomedical knowledge operated from a 'clockwork' definition of medicine, in which the body was viewed through its various component parts (Foucault, 1973). The biomedical model emphasised the symptoms, signs and medically diagnosed pathological abnormalities of disease (Baum, 2015). It was a system of knowledge that assisted clinicians to diagnose diseases by focusing on the physical processes of pathology, biochemistry and physiology (Monajemi, 2014). Medicalised knowledge constituted a form of disciplinary power, which Foucault (1977, 1984) explains as a shared knowledge that is historically and culturally shaped for a specific purpose and often accepted as normal. As Doctors were the recognised authority for executing the British government's sovereign objective of responding to episodic illness crises, their authority was rarely questioned. It is this process of normalisation that makes the exercise of power less visible because the actions of the authorised group are widely accepted as rational (Foucault, 1977, 1984). In this sense, disciplinary power influences and normalises the way people think and act (Foucault 1977, 1984).

A highly selective approach was adopted to deal with the most severe public health problems such as measles, malaria, whooping cough and diarrheal disease. The selective approach allowed diseases with the highest prevalence, morbidity, and risk, to be prioritised for cheap and effective mass control (Rifkin & Walt, 1986). It was therefore useful for eradicating a great deal of disease and for many years this emphasis on disease control, and the control of the 'undeserving poor' persisted (Rifkin & Walt, 1986).

During the 1940s, outbreaks of disease, such as cholera and typhoid were linked with poor sanitation. While their treatment demanded medical attention that gave even more legitimacy to medical authority and the underpinning biomedical knowledge system, they also worked as a catalyst to better educate people before they got sick enough to need a hospital. These issues were not limited to Australia. Health emerged as a global concern and in 1948 the World Health Organisation (WHO) was constituted in Geneva to act as an overarching and coordinating authority on international health to

ensure appropriate, practical and productive cooperation, and promote research. As the recognised global authority on health, the WHO attained significant sovereign power (Foucault, 1978) that enabled them to lead health reform worldwide. In a radical departure from previous definitions of health, the WHO linked health to well-being; "*physical, mental, and social well-being, and not merely the absence of disease and infirmity*" (WHO, 1958, p.1).

During the 1950's, the Australian government attempted to increase people's access to health care and in 1953, under a Menzies Liberal Coalition Government, the Earl Page Scheme was introduced. The Scheme, based on the British National Health Service, introduced a constitutional amendment that enabled the Commonwealth government to legislate on 'pharmaceutical, sickness, hospital benefits, medical and dental services' (Section 51 (23A)). This amendment was significant as it paved the way for the Commonwealth government to influence policy and control the distribution of health funding (DeVoe, 2001; Duckett, 2004) and thereby further increased their sovereign power (Foucault, 1978).

The Earl Page Scheme was Australia's first national health scheme developed with the medical profession to subsidise voluntary private insurance for medical and hospital fees, and fee-for-service remuneration for medical services (Donato, 2009). The Scheme was heavily criticised for its complexity, inadequate coverage of large amounts of the population, and contributions that were above what the average family could afford (Sax, 1984; Shamsullah, 2011). Excluding approximately one third of the population, the Scheme was quite inadequate for providing the population with access to health care (Shamsullah, 2011). Following the 1968 Commission of Inquiry (the Nimmo Inquiry), modifications were made to the Scheme, which allowed the Commonwealth government to legislate on health matters and control health services. The unintended consequence of splitting funding between the state and commonwealth government triggered discord (Shamsullah, 2011).

In response to the inequitable access to health care deriving from the Earl Page Scheme, the incoming Labor Whitlam Government introduced Medibank as a national health service which centralised

funding and control, like the British National Health Service. Medibank allowed for universal access to public hospital and medical services (Palmer & Short, 2014). The introduction of the Medibank Bill to Parliament in 1973 generated staunch opposition. The Australian Medical Association and the General Practitioners' Society opposed the plan for health funds, private hospital groups, and successfully obstructed the legislation (Scotton, 2000). Doctors, by then a powerful and elite group, were resisting the proposed changes in health by voicing collective opposition, which can be understood as an exertion of social power (Foucault, 1972). Doctors expressed their concern that the Labor proposals would lead to 'socialist nationalised medical care' (Sax, 1984, p.109). However, as Scotton (1978) noted, the most likely reason that the AMA opposed the Bill was due to the government's stance on medical fees, that would see Doctors having to adhere to a schedule of fees prescribed by government. Through this social power, the Bill was blocked numerous times in the Senate before finally being passed into legislation in 1974.

By 1975, primary health care had emerged as a concept at the global level. A set of seven principles had been submitted to the Executive Board of the WHO to assist countries to improve their health services (Litsios, 2015). The principles emphasised the need to shape health care around:

- the life patterns of communities;
- involving communities in addressing issues;
- maximising resources whilst working within budget;
- integrating approaches to prevention, cure and promotion for the community and the individual;
- interventions to be undertaken at the local level by trained workers;
- services to be designed around local need; and
- for all primary health care services to be integrated with services in other sectors involved in community development (Litsios, 2015).

The idea of promoting 'Health For All' the citizens of the world was disseminated at the thirtieth WHO World Health Assembly in 1977, with the aspirational aim of everyone attaining a productive level of health by the year 2000. Health promotion – as a means to achieving Health For All – was a process that empowered people to improve their health and have greater control over it (O'Connor-Fleming & Parker, 2001). The first international declaration stating the importance of primary health care and the role and responsibilities of world governments to global health, was produced at an International Conference held at Alma-Ata in 1978 (Hurley et al., 2010). The Declaration expresses *"the need for urgent action by all governments, all health and development workers, and the world community to protect and promote the health of all the people of the world"* (WHO, 1978, p.2).

As a concept, primary health care was introducing a new language of health and wellbeing that mirrored the 1970s social justice movement swelling in Australia. During this period, there were waves of dissent as different groups began to lobby for peace, women's liberation, gay rights and Aboriginal justice. These issues were framed within arguments about power and oppression being embedded in social structures and the broader culture (Mendes, 2006). The target was conservatism rather than capitalism. Conservatism, as a political and social philosophy, is concerned with societal tradition, human imperfection, hierarchy, and authority (Cheek, 2008). It places emphasis on social stability and continuity and perceives resistance as deviance and radicalism (Cheek, 2008). Through a conservative lens, the Australian government focused on the health and welfare of its citizens. The newly elected Prime Minister Whitlam was concerned with viewing health within a wider purview - as more of a community affair, than an individual one, and saw beyond just hospital services to include Community Health Programs that emerged to complement the new Medibank (Baum, 2015). Although the biomedical discourse had been highly effective for managing the prevalence of communicable diseases and pathologic illness, it was less suited to a social model of health (Germov, 2009).

According to the first General Director of the WHO (1948-1953), one common idiom for understanding health was "*a sane mind in a sound body*" (Larson, 1996, p.181). However, the dichotomous

relationship of mind/body assumed in the biomedical model paid no regard to the effect mental health had on an individual's physical health. Limitations of the 'absence of disease' model of health were the impetus for the WHO to redefine health as the "*complete state of physical, mental and social well-being*" (WHO, 1978, p.1). Adoption of the new social determinants approach, that shifted the concern beyond an individual to public health, was slow. In part this may have been because the public health discourse underpinning the WHO (1978) definition of health was attracting criticism (Larson, 1996). Nevertheless, the definition of health became the international standard underpinning a more comprehensive view of primary health care (Larson, 1996). The Fraser Coalition Government in Australia, espousing a return to strong conservatism, finally responded to dissent and medical lobbying by disbanding Medibank in 1981. As a result, Australia implemented a selective approach to health care that fell short of considering the broader environmental and socioeconomic issues influencing public health (Rifkin & Walt, 1986).

Although progress in primary health care reform was slow, the Community Health Service model was significant as it promoted integrative and responsive community development approaches such as support groups, health promotion, consumer-led groups, and assertive outreach models. Under this program, Community Health Centres were funded on a cost sharing basis with the states. The Victorian government refused the offer, so funding was provided directly to community groups who continued to independently run the centres even after the Victorian government later agreed to cost-sharing arrangements (Baum, 2015). While primary health care reform had commenced, its impact was heavily scrutinised and resisted (Walsh & Warren, 1979).

An influential paper by Walsh and Warren (1979) argued that implementing the primary health care approach proposed by the WHO (1978) would require vast resources. Most governments considered it too costly and idealistic to be implemented (Baum et al., 2016; Willis, Reynolds, & Keleher, 2012). Walsh and Warren (1979) argued the best way to improve health was to selectively target scarce resources to control diseases that accounted for the highest morbidity and mortality. Selective

primary health care reflected neo-liberal ideology in that it emphasised efficiency, effectiveness and cost-containment, results-based financing, user fees, competitive tendering processes, private contracting, and stressed the individual's responsibility for their own good health (Baum et al., 2016). Originally an interim idea, selective primary health care was adopted as a permanent solution to improving public health (Baum et al., 2016).

By the 1980s, it became apparent that Australian hospitals were not keeping up with demand and some groups were experiencing difficulties accessing health services. Another change in government meant new measures were once again undertaken to improve the equity of access to health services for all Australians. The Hawke/Keating Labor governments epitomised a new political regime that reinforced the implementation of neoliberalism (Davidson, 2013). During this period, the government floated the Australian dollar; privatised public infrastructure; introduced fringe benefits tax and a capital gains tax; and adopted competitive policy frameworks (Davidson, 2013; Humphreys, 2015).

From a health policy perspective, the Hawke Government resurrected the defunct Medibank and refined it as Medicare. Doctors again exerted their social power (Foucault, 1984) to oppose the new policy direction and fought against controls that had been introduced to limit the private sector activities of surgeons in public hospitals. There were mass resignations and industrial action taken in New South Wales hospitals, where the dispute seemed to concentrate. Donato (2009) notes that it was only by the Hawke government utilising a consensus approach that the issues were eventually resolved. The Hawke government also introduced other health reform initiatives such as: a Pharmaceutical Allowance, Australia's first national mental health policy, and the transition of nursing education to universities.

Structural reforms were implemented to improve social and economic equity. These included a more targeted welfare system, asset tests for the pension, arbitrated superannuation, and family allowance supplement for poor families (Kelly, 2000). Whilst these initiatives had somewhat improved equity of access to health services for all Australians, it was the 1984 establishment of Medicare that marked a

significant change to the health care landscape. Medicare remains Australia's universal health scheme and is operated and funded by the Australian Commonwealth Department of Health by a mix of general revenue and the Medicare levy. The move to this model gave rise to health financing based on a tax-funded revenue system and provided the benefits of universal access to hospital and medical services. The introduction of Medicare highlighted the Australian government's commitment to improving health outcomes: however, optimising health outcomes also required a carefully planned primary health care strategy.

At the global level, the concept of primary health care was evolving. An action plan outlining the strategy for achieving health promotion was developed at the First International Conference on Health Promotion held in Ottawa in 1986. The Ottawa Charter defines health promotion as:

> *the process of enabling individuals and communities to increase control over the determinants of health and thereby improve their health. It has come to represent a unifying concept for those who recognise the basic need for change in both the ways and conditions of living in order to promote health. Health promotion represents a mediating strategy between people and their environments, combing personal choice with social responsibility for health to create a healthier future* (WHO, 1986, p.1).

The Ottawa Charter (WHO, 1986) specifies five action areas for health promotion:

(i) building healthy public policy;

(ii) creating supportive environments;

(iii) strengthening community action;

(iv) developing personal skills; and

(v) re-orientating health care services toward prevention of illness and promotion of health.

Health promotion focuses once more on communities that are empowered and involved in their own and their community's health needs. This was to be achieved through community-based advocacy, a

commitment to health advancement at the local level via community participation in decision-making, and a commitment to achieving a new social order in power relationships (O'Connor-Fleming & Parker, 2001). Foucault (1980) argues that power is not a substance and therefore has to be understood in terms of relations. Accordingly, he usually refers to 'power relations' rather than power (Lemke, 2012).

During the 1980s and 1990s, the principal providers of primary care were local GPs who generally worked in small practices segregated from each other, other health professionals and the broader health care system. The professionalisation of general practice demanded Doctors engage in collaborative professional development activities resulting in the formation of informal networks of GP's. The professionalisation of general practice also dictated high levels of accountability and efficiency. These imperatives aligned with the drive for increased efficiency and quality in health care (Swerissen & Duckett, 2002).

To honour its commitment to quality, the Australian government initiated major reforms in 1989. Multiple initiatives were directed at defining the role of the GP and their contribution to improving health outcomes (Weller & Dunbar, 2005). These reforms changed the landscape of primary health care and consolidated the Doctors' hierarchical position in the system. As the first points of contact in primary care, they were at the forefront of guiding patients through the health care system. In 1991, the General Practice Strategy was launched. It included workforce distribution initiatives, a recognition of postgraduate medical training, voluntary accreditation for general practices, and remuneration strategies to improve quality of care.

In line with the General Practice Reform Strategy (Australian Government, 1992), ten demonstration Divisions of General Practice were established in 1992. Consequently, there was a proliferation in general practice in Australia and $17 million of the 1992 Federal Budget was allocated to further develop the Divisions of General Practice network. The investment in general practice exemplifies the narrow way the government was attempting to improve health. It was continuing to adopt the medicalised approach rather than embracing the WHO recommendation that health and wellbeing

could be improved through the utilisation of a multidisciplinary, integrated primary health care workforce.

In 1991, the National Centre for Epidemiology and Population Health, at the Australian National University, conducted a General Practice Financing Think Tank. The discussion highlighted that the current health system was not encouraging health promotion, disease prevention, or promoting continuity of care, and was not conducive to collaboration with other health professionals (Douglas, 1991). These concerns were voiced by the Australian Medical Association, the Royal Australian College of General Practitioners and reiterated in the Department of Health report: The Future of General Practice: A Strategy for the Nineties and Beyond (Australian Government, 1992).

By 1992-93, the Federal Budget dedicated $65.5 million, and a further estimated $280 million over the next four years for a multi-faceted GP Reform Strategy. The GP Reform Strategy included the following key elements:

- Divisions of General Practice and Project Grants Program funding to provide infrastructure and project funding for the development of local networks or Divisions, so that GPs could work cooperatively on activities and projects to meet local health needs;
- A Rural Incentives Program to provide incentives for the recruitment and retention of GPs in rural areas. These consisted of relocation grants; training grants; remote area grants; continuing medical education/locum grants; and undergraduate grants;
- A Better Practice Program for GPs to supplement their income by providing further services;
- A development program to support quality of care initiatives; and
- The General Practice Evaluation Program.

The disciplinary power (Foucault, 1977) held by Doctors as an elite group enabled them to wield unprecedented authority and attract an abundance of resources (Australian Government, 1992). These developments encouraged extensive discussion about the future of general practice. By 1993,

the Divisions of General Practice had grown to 100 organisations covering 80% of Australia (Russell, 2013) and by 1995, had increased to 116. By the late 1990's, the continued fragmentation of the primary care sector led to discord which resulted in a review of the Divisions of General Practice Program. The General Practice Strategy Review Group commissioned by the Australian government released the report: *General Practice: Changing the Future Through Partnerships* (Department of Health and Family Services, 1998). Though the report recommended a vision for the future of general practice to unify and expand the profession, it overlooked primary health care. The Australian Division of General Practice formed as a peak body, which further legitimised Doctors' position in the health care hierarchy.

To shift away from the short-term funding arrangements that were in place, the 1990s saw the Commonwealth government release three-year block grants as an outcomes-based funding contract. The block grants enabled the government to request that Divisions of General Practice meet certain targets of defined health outcomes in several priority performance areas (Russell, 2013). In doing so, the government was able to shift the focus back from general practice to a broader view of health. At this point the language of the health system, health services and health care began to change.

The primary health care approach was lauded for improving global health (WHO, 1995). However, in Australia the selective approach adopted had not addressed health as more than an absence of disease (Magnussen et al., 2004). The biomedical model was still influencing health care. To address its health issues, Australia needed health systems and services to be better coordinated and integrated; and to achieve these, required health system reform. It was anticipated that an effective primary health care system would meet the needs of consumers, be responsive to emerging needs, and function effectively within the wider health system (Australian Government, 2009a).

In 2003, the Phillips Review reported that the Divisions of General Practice range of activities were too wide and had no set objectives. The Report (Phillips et al., 2003) made calls for the government to improve the Divisions of General Practice governance and accountability arrangements. Introduction

of a new National Quality and Performance System set performance indicators, covering nine priority areas, for Divisions of General Practice to meet as part of their contractual arrangements. These included: governance; prevention and early intervention; access to health care; support for integration and multidisciplinary care; better management of chronic disease; general practice support; quality support; consumer focus; and workforce support. In 2004, the Commonwealth Minister for Health and Ageing, the Honourable Tony Abbott responded to the Phillips Review and noted:

> *The Government believes that the development of the Division network has been one of the most important health innovations of the last decade. The Divisions, by and large, have done a very good job. Total Australian Government funding across the network in 2003-04 is $132 million, or about $9,400 per FTE GP. This demonstrates the Government's commitment to strengthening and securing the role of the general practitioner in the broad health system. However, taxpayers require the Government to be able to demonstrate a strong return on investment* (Department of Health and Ageing, 2004, p.5).

These comments foreshadowed increasing concerns that the Divisions of General Practice were not delivering on targets set by the Commonwealth government programs via the 2004-2005 funding contracts. The government shifted to a more publicly accountable process for investing in programs that encouraged integration and multidisciplinary care; focused on prevention and early interventions; and better managed chronic conditions. A raft of discrete programs were implemented immediately. These were the: workforce support for Rural General Practitioners Program; More Allied Health Services Program (MAHS); Access to Allied Psychological Services (ATAPS); Aged Care GP Panels initiative; Australian Primary Care Collaboratives Program; broadband for health; Nursing in General Practice Program; National Primary Mental Health Care Network; Better Outcomes in Mental Health Care Program; National Alcohol and Mental Health Comorbidity Project; MindMatters Plus GP

initiative; Enhanced Divisions Quality use of Medicines Program; General Practice Immunisation Initiative (GPII); and the Rural Palliative Care Program. Despite this prolific programmatic activity, the performance of Divisions of General Practice in improving community health was not a prominent activity (Kalucy, 2004). The University of Melbourne's Institute of Applied Economic and Social Research released the evaluation of the Divisions of General Practice (Scott & Coote, 2007), which became a catalyst for reforming the primary care system.

In 2006, the Blame Game Report was tabled in the Commonwealth Parliament by the House of Representatives Standing Committee on Health and Ageing (House of Representatives: Standing Committee on Health and Ageing, 2006). The Report (2006) indicated that the separation of responsibilities in Australia's health care had given rise to a culture of blame between the Commonwealth government and the states and territories centring on who was at fault for the failings of the health system. The blame-game was counterproductive to improving health outcomes and addressing the bias towards treating 'illness' rather than promoting 'well-ness'. The Australian government was able to leverage its sovereign power (Foucault 1977) to legitimise the public health discourse. It was clear the Australian, state and territory governments needed to develop and adopt a coordinated national primary health care agenda.

Between 2008 and 2011, various reports called for new health policy development (Table 1). The assumption that health policy is developed to fix public health concerns overlooks the cultural and political dimensions of public policies and leaves unexamined the way public health problems are understood by different groups. As explained earlier, all forms of written texts 'produce and distribute' discourse (Foucault, 1972). As 'technologies of power' (Foucault, 1977), texts exercise power through the production of *what* can be known and *how* it can be known. When people 'consume' (Foucault, 1988) discourse they draw on habitualised ways of knowing how to interpret the texts and make their own meanings. Differences in interpretation can lead to conflict and tensions within and among groups, or as Foucault (1972) argues, power-struggles are an intrinsic reality of all human relations.

Table 1. Summary of Australian government health reports 2008-2011, strategies and discussion papers

Date	Name of Government Document
2008	Beyond the Blame Game
2008	A Healthier Future for all Australians: Interim Report
2009	A Healthier Future for all Australians: Final Report
2009	Australia's First National Primary Health Care Strategy
2009	Primary Health Care Reform in Australia – Report to Support Australia's First National Primary Health Care Strategy
2010	A National Health and Hospitals Network for Australia's Future (The Blue Book)
2010	A National Health and Hospitals Network: Further Investments in Australia's Health (The Green Book)
2010	A National Health and Hospitals Network: Delivering Better Health and Better Hospitals (The Red Book)
2010	A National Health and Hospitals Network: Delivering the Reforms (The Gold Book)
2010	Medicare Locals Discussion Paper on Governance and Function
2011	National Health Reform: Progress and Delivery (The Purple Book)
2011	Medicare Locals Guidelines for the Establishment and Initial Operation of Medicare Locals and Information for Applicants Wishing to Apply for Funding to Establish a Medicare Local

Because of the separation of responsibilities, the Commonwealth government undertook several reviews of the Australian health system. Moving beyond the blame-game to advance the public health agenda, the National Health and Hospitals Commission (Australian Government, 2008) identified three main goals to reform the health system:

- Tackle major access and equity issues that affect health outcomes;
- Redesign the health system so it is better positioned to respond to emerging challenges; and
- Create an agile and self-improving health system for long-term sustainability.

The Australian government clearly articulated the priorities for public health in its report: *A Healthier Future for All Australians: Final Report* (Australian Government, 2009b). The impact of health workforce shortages and concurrent ageing of the workforce were identified as pressure points in the health system. The Final Report (2009b) recommended the establishment of dedicated

multidisciplinary primary health care organisations. Primary health care in Australia was becoming more important than ever before.

Australia's First National Primary Health Care Strategy was published in 2009 (Australian Government, 2009a). The Strategy retained the public health discourse and articulated how the primary health care system was to reform (Australian Government, 2009a). Subsequently, the Discussion Paper: Towards A National Health Care Strategy (Australian Government, 2009d) invited stakeholder feedback. Responses from the Australian Government Department of Health and Ageing, an external reference group of primary health care experts, and discussions with state and territory health departments were used to refine the strategy. The *Primary Health Care Reform in Australia – Report to Support Australia's First National Primary Health Care Strategy* (Australian Government, 2009c) set out the primary health care context and articulated the funding arrangements for supporting general practice and primary health care to achieve the following objectives:

- Establish Medicare Locals to work with the full spectrum of GP, Allied Health and community health care providers to provide better services, improve access to care and drive integration between services;
- Ensure that communities have access to GP advice and services after hours, with the capacity to put people in contact with GP services in their community when needed;
- Transform the way Australians with long-term illness are treated with investment in coordinated care for people living with diabetes;
- Deliver more GP Super Clinics and upgrades to general practices, primary care and community health services, and Aboriginal Medical Services to improve access to integrated general practice and primary health care; and
- Invest in the expansion and enhancement of the role of Nurses in general practice, to improve patients' access to primary health care and take pressure off GP's.

The 61 Medicare Local organisations that evolved from or replaced the Divisions of General Practice were charged with coordinating services and prioritising population health planning at a local level.

These newly formed organisations required a suitable governance structure that reflected the diversity of clinicians and services. The new configuration sought to provide a more comprehensive approach to primary health care to ensure the right care, in the right place and at the right time (Australian Government, 2010c).

In the periods 2010-11 to 2014-15, total health expenditure had reached 9.31% and 9.97% respectively of the Gross Domestic Product. However, funding was mainly being directed to hospital and acute services, which increased from 40.1% in 2010-11 to 40.9% in 2014-15 (Australian Institute of Health & Welfare, 2018a). Table 2 provides a more detailed breakdown of the proportions of recurrent health expenditure by area of expenditure 2010-11 to 2014-15.

Table 2. Proportions (%) of recurrent health expenditure, by area 2010-11 to 2014-15

Area of Expenditure		2010-11	2011-12	2012-13	2013-14	2014-15
Hospitals		40.1	40.2	40.1	40.4	40.9
	Public hospital/public hospital services	31.4	31.6	31.4	31.4	31.6
	Private hospitals	8.7	8.6	8.7	9.0	9.4
Primary health care		38.2	38.0	38.3	37.6	37.2
	Unreferred medical services	7.4	7.2	7.3	7.3	7.3
	Dental services	6.3	6.3	6.3	6.1	6.3
	Other health practitioners	3.5	3.6	3.8	3.7	3.7
	Community health and other	5.1	5.3	5.4	5.4	5.4
	Public health	1.6	1.7	1.5	1.5	1.5
	Benefit-paid pharmaceuticals	7.9	7.6	7.2	6.9	6.4
	All other medications	6.3	6.3	6.7	6.7	6.6
Referred medical services		10.7	10.7	11.0	11.1	11.1
Other Services		7.6	7.6	7.1	7.2	7.4
	Patient transport services	2.2	2.2	2.2	2.2	2.3
	Aids & appliances	2.9	2.8	2.8	2.7	2.8
	Administration	2.4	2.6	2.1	2.3	2.4
Research		3.5	3.5	3.6	3.7	3.3

Source: Health Expenditure Australia 2016-17, Health & Welfare Expenditure Series No. 64. AIHW 2018 (Australian Institute of Health & Welfare, 2018b).

With Australia's population growing and living longer, the cost of health services was rising at twice the rate of the Gross Domestic Product (Productivity Commission, 2013). The ageing population, sedentary lifestyles and escalating chronic disease burden were placing significant pressure and

demand on the health system (Productivity Commission, 2013). Projections were suggesting Commonwealth health expenditure per person would more than double over the next 40 years (Australian Bureau of Statistics, 2017). In 2014-15, 85% of Australians saw at least one GP in the previous 12 months, 47% saw a dentist, and 28% saw an Allied Health Professional such as a pharmacist (8.1%), physiotherapist (8.0%) or an optician or optometrist (6.5%) (ABS, 2017). These figures exclude subsidised services such as those of the Department of Veterans Affairs (DVA), or other compensated publicly funded programs. The AIHW (2018a) reports that in 2015-16, 6.1 million GP and specialist services, 3.6 million Allied Health services and 721,000 dental services were processed by the DVA. The long-lasting over-reliance on medical services was rendering the health system unsustainable and medicine alone would be unable to meet the emerging health needs of Australian citizens.

Greater emphasis was placed on shifting health care from a focus on treatment to prevention, providing alternatives to general practice, and reducing community dependence on hospital-based care (Palmer & Short, 2014; Wutzke et al., 2016). The public health discourse was consistently reproduced in a suite of reports (Table 1) that provided progressively more nuanced detail on the ways primary health care reforms were to be enacted. These changes were the catalyst for the shift away from the GP-focused Divisions of General Practice to the community focused Medicare Locals (Australian Government, 2009b).

The transition from Divisions of General Practice to Medicare Locals

Widespread concern that the Divisions of General Practice model was not effectively addressing the increasing demands of chronic disease shifted the focus from selective primary health care to a more inclusive Medicare Local model. A concern for public health and the prevention of chronic disease was by now firmly being articulated in the public health discourse embedded within health reform policy, and this required a structural shift away from the general practice model.

By June 2011, there were 109 Divisions of General Practice across Australia, plus two combined State Based Organisations/Divisions in the Australian Capital Territory and the Northern Territory. The established network of Divisions of General Practice represented 7,035-member practices, 20,438 GP members and 9,672 non-GP members (Australian General Practice Network, 2009). Clearly, the Doctors' privileged position had been working to legitimise their monopoly within the public sphere of health and the dominance of biomedical knowledge (Germov, 2009). However, the government's commitment to primary health care meant public health could no longer be sidelined. The intent of creating Medicare Locals to realise primary health care objectives therefore meant some dismantling and re-orienting of the Divisions of General Practice. The Department of Health and Ageing began a transition process to establish a network of 61 Medicare Locals to replace the then existing 111 Divisions of General Practice (Australian Government, 2011b). The change to the organisations was met with resistance from Doctors who had become accustomed to working in positions of legitimate authority and exercising substantial disciplinary and social power (Foucault, 1977).

As government funding ceased for the Divisions of General Practice, most stopped trading and the residual company structures merged with other organisations to become Medicare Locals. Resources and finances were transferred along with the program functions that each Division of General Practice had been performing. At the same time, Local Hospital Networks and Lead Clinician Groups were developed in each state and territory to integrate services and forge links between local communities and health professionals.

As a consequence of moving to an integrated and more inclusive model of primary health care, the membership and governance structures of Medicare Locals changed from the once homogenous medical membership-based Division of General Practice to a multidisciplinary model. The move was similar to the changes undertaken in the United Kingdom during their transition to Primary Care Trusts (Department of Health, 2003). During the period foreshadowing the transition from Divisions of General Practice and Medicare Locals, the government released a discussion paper articulating the

Governance and Functions of Medicare Locals including their structure and function (Australian Government, 2010b). The Discussion Paper specified five objectives: identify the needs of local areas and develop locally focused and responsive services; improve the patient journey through developing integrated and coordinated services; provide support to clinicians and service providers to improve patient care; facilitate the implementation and successful performance of primary health care initiatives and programs; and be efficient and accountable with strong governance and effective management. Further details are provided in Appendix 1.

The Medicare Local Operational Guidelines (Australian Government, 2013a) and the Guidelines for the Establishment and Initial Operation of Medicare Locals and Information for Applicants Wishing to Apply for Funding to Establish Medicare Locals (Australian Government, 2011b) outlined the legal structure and internal governance arrangements of these organisations. The new organisations had multidisciplinary Boards and multidisciplinary membership. Membership could range from a small number of individual primary care practitioners (including GPs, Allied Health and other health professionals), to local health and aged care representatives or community members. Basing membership on local primary care practitioners would give these groups a voice to influence how Medicare Locals were governed and managed. Medicare Locals had a range of roles and responsibilities, including making health care services more accessible, effective and affordable. To meet prescribed objectives, they were accountable to local communities, and were tasked to maintain collaborative relationships with Local Hospital Networks and Lead Clinician Groups. To be accountable to the community the Medicare Locals were required to have transparent and visible processes for engaging with them, which needed to be clearly listed on their web site (Australian Government, 2013a). They were also required to produce annual Healthy Communities Reports for the Government and many formed Community Advisory Committees.

At the end of 2013, a new Liberal Coalition government came into power. In March 2014, the Horvath Review was commissioned by the Health Minister to consider the Medicare Locals' structures,

operations and functions (Horvarth, 2014). While Horvath, Australia's former Chief Medical Officer, concluded primary health care organisations would potentially improve health outcomes, he was highly critical of the Medicare Locals. He made a range of recommendations (Appendix 2) for achieving the original objectives and emphasised the need to improve integration and collaboration (Elnour et al., 2015). However, this Review recommended "*the government should reinforce general practice as the cornerstone of integrated primary health care"* (Horvath, 2014: p.v), and that whilst:

> *the original intent of Medicare Locals was to broaden the net of professional engagement within the primary health care sector, … this appears to have come at the expense of GP goodwill. This goodwill needs to be rebuilt if any future organisation is to be successful. Comprehensive professional engagement is still required; however, it must be recognised that GPs are by their nature the first authoritative point of contact for primary health care, they start the patient on their care pathway and remain critical to their ongoing care* (Horvath, 2014, p.10).

Horvath's (2014) critique reflects the inherent and prevailing tensions between systems of knowledge underpinning primary care and primary health care. As a result of transitioning from Divisions of General Practice to Medicare Locals, the tacit understandings of primary care were adopted uncritically and were conflated with the notion of primary health care. In line with the critical intent of this research, there was a need to differentiate these terms.

Differentiating primary care and primary health care

Because of its historical genesis, the health system emerged as a three-tiered system of primary, secondary and tertiary care (Australian Institute of Health & Welfare, 2016). Primary care was established as the first point of contact within the health care system for an individual with a health concern (Australian Institute of Health & Welfare, 2018a). Secondary care services were generally provided by health professionals who did not have the first contact with the consumer (Australian Institute of Health & Welfare, 2018a). Commonly, the consumer had been referred by another health

professional for ongoing health care, such as a physiotherapist, podiatrist, occupational therapist, or dietician. Tertiary health care, on the other hand, was delivered as highly specialised health treatment, most likely in a hospital, and included surgical and other complex medical procedures (Australian Institute of Health & Welfare, 2016).

The World Health Report (WHO, 2003) specifically questions whether 'primary care' and 'primary health care' are synchronous terms. As language is intricately bound with discourse and power (Foucault, 1977), it was important to interrogate how these terms were operationalised. Sharing common tenets, such as the provision of preventive services and health promotion, there is some overlap of primary care with the philosophical ideals of primary health care (Rogers & Veale, 2000). However, while some health researchers consider primary care and primary health care as distinct disciplines (Keleher, 2001; Powell et al., 2006), others regard them as coexistent (Muldoon et al., 2006). For example, the New South Wales Corrections Health Service regards primary health care and population health as being coterminous and include immunisation, screening, outbreak investigation and other more traditional public health functions (Justice Health, 2007). The incertitude of the terms 'primary care' and 'primary health care' is attributed to ambiguity in original source documents, such as the Alma-Ata Declaration (1978), from which primary health care emerged.

Contemporary primary health care is characterised by "*the importance of a focus on positive well-being over absence of disease with communities and individuals controlling health service planning as opposed to health professionals*" (Ernst & Young, 2014, p.12). Although some claim there is no real definition of primary health care, Wass (2000) makes it clear that there is indeed a definition, but the understanding of what it is – is complex. Primary health care is more than just a type of health service, which is typically how it is described. Rather, primary health care is a philosophy; a strategy for organising health care; a set of activities (Wass, 2000); and a system response to reducing health inequalities (Keleher, 2001).

Before delving into definitions of primary health care, it is important to reflect on how 'health' is socially conceived. The public health and socio-ecological approaches posit the interaction of people, their behaviour and social environment (Baum, 2015). As articulated by the WHO (1948), health is situated within the concept of wholeness. It is a relative state in which an individual functions physically, mentally, socially, and spiritually to express their potentialities (Larson, 1996). These elements are reflected in salutogenesis, a theory of health that accommodates system complexities in which people respond to "*promotive, preventive, curative and rehabilitative ideas and practices*" (Antonovsky, 1996, p.13). Salutogenesis is a concept aligned with the Indigenous holistic worldview of health that focuses on the person, their community and the environment in which they live (National Aboriginal Community Controlled Health Organisation, 2011).

Health services based on a social model of health are likely to focus on the determinants of health and work alongside other services to improve health outcomes. Aboriginal community controlled primary health services exemplify these principles and focus on the person within their context of land, community and culture. The National Aboriginal Community Controlled Health Organisation (NACCHO) Constitution states that for Indigenous people health is:

> *not just the physical well-being of an individual but refers to the social, emotional and cultural well-being of the whole Community in which each individual is able to achieve their full potential as a human being thereby bringing about the total well-being of their Community. It is a whole of life view and includes the cyclical concept of life-death-life.* (National Aboriginal Community Controlled Health Organisation, 2011, pp.5-6).

These conceptions of health espoused by the National Aboriginal Community Controlled Health Organisation underpin the notion of comprehensive primary health care and its focus on equity, acceptability, cultural competence, affordability and universalism, and a commitment to community and health development (WHO, 2008c). Primary health care therefore has a wider purview than commonly put forward in an Australian primary care context. Arguably, inequities in health care will

not be resolved without more attention to how primary health care is defined and operationalised, and what services are resourced (Hurley et al., 2010).

The language of primary care and primary health care are underpinned by different discourses and therefore carry very different meanings (Rogers & Veale, 2000, 2018). The variable use of language is counterproductive (Keleher, 2001) as it masks the discursive differences in philosophy and practice between both terms (White, 2015). Primary health care resonates with public health discourse and was advanced as a systemic response to reducing health inequities and social disadvantage. In contrast, primary care has emerged from the medical model and its associated biomedical discourse and has relied on people becoming unwell before seeking medical attention through first points of contact in the health system.

Primary health care exists on a theoretical spectrum ranging from comprehensive primary health care, primary health care, and selective primary health care, to the medical model of primary care (Keleher, 2001). Each term can be differentiated from the other, though one could argue that primary care could be placed within the wider context of primary health care. The most widely accepted definition of primary care identifies it as a level of service: "*Primary care is first-contact, continuous, comprehensive, and coordinated care provided to populations undifferentiated by gender, disease, or organ system*" (Starfield, 1994, p.457). Roland and Wilkin (1996) extend this definition to include geographical location of primary care and service provider relationships:

> *Primary care provides first-contact, generalist continuing care to the great majority of health problems presented to the NHS [National Health Service in the UK] … Primary care is, in general, located geographically close to patients' homes. It treats people in the context of their communities and is potentially more accountable to its local community.* (Roland & Wilkin, 1996, p.21).

Bryar (2000) claims interpretations of the Alma-Ata definition are valid in their descriptions but tend to focus on 'level of care' rather than the 'approach' of primary health care. The National Primary Health Care Strategic Framework (Australian Government, 2013b, p.6) defines primary health care as:

> *the first (primary) layer of services encountered in health care and requires teams of health professionals working together to provide comprehensive, continuous and person-centred care.*

Whilst this definition encompasses primary health care, the philosophical basis is overlooked. For the purposes of this study, it was important to outline the philosophy underpinning primary health care.

Primary health care as a philosophy

The philosophical basis of primary health care is important as it provides another means to differentiate between primary medical care services and primary health care. The philosophy of primary health care is founded on tenets of health, wellness, universality and based upon several factors:

- Equity in health care;
- Community participation and control over how health services are provided;
- A holistic understanding of health that recognises the multiple factors that underlie it;
- A focus on health promotion and disease prevention;
- Affordable, accessible and acceptable technology; and
- Evidence-based health services (Rogers & Veale, 2000).

The philosophy underpins both a 'level of care' and an 'approach' (Tarimo & Webster, 1994). As a level of care, primary health care organisations are focused on servicing communities therefore activities are often the first point of contact between health workers and individuals. However, in Australia the legacy of the Divisions of General Practice meant medical care services had been associated with the concept of primary care and were not reflecting the philosophical ideals and goals of primary health

care (Tarimo & Webster, 1994). The primary health care approach refers to several philosophical principles and values that provide a conceptual framework for strategies that encompass accessibility, continuity of care, collaboration between providers, and community involvement (Australian Government, 2009c).

Primary health care as a set of principles

The primary health care is characterised by four principles that derive from the philosophical underpinnings:

- Commitment to health equity as part of development oriented to social justice
- Universal access to care and coverage on the basis of need;
- Community participation in defining and implementing health agendas; and
- Intersectoral approaches to health (Tarimo & Webster, 1994; WHO, 1995).

Equity in Australian health care is multifaceted and emphasises the need for health care services that are not only based on health needs but also socio-cultural circumstances (Leeder, 2013). Braverman and Gruskin (2003, p.256) describe equity in health as:

> *an ethical value, inherently normative, grounded in the ethical principle of distributive justice and consonant with human rights principles…and reflects a concern to reduce unequal opportunities to be healthy [which are] associated with membership in less privileged social groups, such as poor people; disenfranchised racial, ethnic or religious groups; women and rural residents…Pursuing equity in health means eliminating health disparities that are associated with underlying social disadvantage or marginalisation.*

Different social, economic, political and cultural conditions are known to create health inequities (Wilkinson & Marmot, 2003) through socioeconomic position, social exclusion, social capital, employment, work, and housing. These conditions all contribute to poorer health outcomes, higher

rates of disability, illness, death and shorter lives (Mackenbach, 2015). The principle of equity underpins the values of a holistic view of health, involvement of empowered communities and inter-sectoral input (Rasanathan et al., 2010).

Universal access to health care and coverage based on need is an important aspect of equity (WHO, 1995). In Australia, different groups experience difficulties accessing health care (Australian Institute of Health & Welfare, 2018a). The Australian Institute of health & Welfare (2018a) reports there are lower rates of medical consultations and higher rates of hospital admissions in regional and remote areas than in major cities. The lack of locally available health services, an insufficiently staffed and suitably qualified workforce, high costs, long distances and inadequate infrastructure all contribute to the ongoing issues in achieving equitable access to health care for those in isolated areas (Bywood et al., 2011). The outcome is many residents living in regional, rural and remote communities experience poorer health outcomes than those living in urban areas (Australian Institute of Health & Welfare, 2018a).

To ensure universal accessibility to all available resources and services, all allocated funds for health must be utilised appropriately. Resources must be secured for health and where possible they should be allocated to those who are most in need (Tarimo & Webster, 1994). In Australia, people with cultural, physical and language barriers are among some of the groups who are most in need of dedicated resource allocation, and support for targeted disease prevention and health promotion strategies. Such groups include Aboriginal and Torres Strait Islanders, those living with a disability or cognitive impairment, or homeless, people from culturally and linguistically diverse backgrounds or refugee and asylum-seekers, lesbian, gay, intersex, and transgender people. Each of these groups consistently fare worse than others in the Australian population on key health indicators (Australian Institute of Health & Welfare, 2018a). Commitment to health equity therefore requires the principle of development oriented to social justice.

The gross inequities in health status are unacceptable. Health is now recognised as a fundamental human right (WHO, 2013) and a commitment to social justice demands more equitable provision of health care and examination of injustices in access to quality health service (Faden & Powers, 2008). Social justice concerns itself not only with how individuals fare, but also how different groups compare with one another in the face of systematic disadvantage being associated with group affiliation (Faden & Powers, 2008). The aims of social justice are advanced by making the health needs of disadvantaged groups a public health priority.

Community participation and control over health service planning and delivery is another foundational principle of primary health care (Bath & Wakerman, 2015; Green, 1986; Perlstadt et al., 1999). It emerged from public demand for more inclusion in local health care programs (Boudioni et al. 2018; Green & Frankish, 1994) and involvement in decisions about the use of local, national and other available resources. Optimising the use of resources is contingent on promoting self-reliance, individually and within the community, and facilitating community engagement in strategic planning, organisation, operation and control of primary health care. It also aligns with increased public transparency in the use of government funded services (Alexander et al., 1995; Wiseman et al., 2003).

It is now widely accepted that local people must be included in identifying their health needs, organising strategies to meet those needs (Zakus & Lysack, 1998) and contributing to their treatment choices and decisions by making their preferences clear (Australian Commission on Safety and Quality in Health Care, 2017; Boyce & Lamont, 1998). Health was recognised as having a social function: community-led initiatives such as 'healthy communities' led to increased 'social capital' (Australian Institute of Health & Welfare, 2016; Eastis, 1998; Lomas, 1998; Veenstra & Lomas, 1999). Other espoused benefits range from improved health outcomes, service access, equity, quality, responsiveness, relevance and acceptability (Draper et al., 2010; Rifkin, 2018; Rifkin & Walt, 1986). Whilst there is a relatively small body of evidence for these claims, it is significant. Bath and Wakerman

(2015) advocate for participatory mechanisms in primary health care to be strengthened through policy reform and funding.

Primary health care as the frontline of Australia's health care system reform, demands a multi- and inter-disciplinary team for delivering services such as health promotion, prevention, screening, early intervention, treatment and management (Mitchell et al., 2008). As Allied Health Professionals are an integral part of the primary health care team, providing specialist services for people of all ages and with various health issues, it is important to be conceptually clear about how the term Allied Health has been operationalised in the study.

Defining Allied Health

There is no universally accepted definition of Allied Health Professions (Australian Health Workforce Advisory Committee, 2006). The notion Allied Health Profession is made up of three component parts: 'allied' meaning 'related to' or 'connected with'; 'health' which refers to the type of care delivered by this workforce and the system in which it is delivered; and 'profession', a term that connotes a group that has a specific level of occupation and confers a high status (Williams, 2009). Various government authorities and departments, health service providers, health funds and tertiary institutions tend to develop their own definitions to differentiate Allied Health Professionals from other health professionals, usually medicine and nursing. Turnbull and colleagues (Turnbull et al., 2009) call for a more inclusive approach to categorise these disparate health groups as allied, scientific and complementary health professions. This definition of Allied Health categorises and describes the nature of "*what they do, who they work with and their career development opportunities*" (Turnbull et al., 2009, p.34). These types of definitions are misleading because of the unqualified use of term 'profession'. Allied Health is a disparate group, having a variety of qualifications, level of autonomy, scope of practice and lack consistent regulatory mechanisms. This variation has led some to argue this group should be considered para- or semi-professions (Williams, 2009). These terms may be relevant to some, but not all, Allied Health groups depending on the criteria applied.

The Australian Council of Professions defines a 'profession' as:

> *a disciplined group of persons who: (i) adhere to high ethical standards; (ii) hold themselves out, and are accepted by the public, as possessing special knowledge and skills in a widely recognised, organised body of learning derived from education and training at a high level; and (iii) are prepared to apply this knowledge and these skills in the interests of others* (Australian Council of Professions, 2018, p.13).

These features are reflected in Allied Health Professions Australia's (2017) advice that an Allied Health Professional is one which has:

- A direct patient care role and may have application to broader public health outcomes;
- A national professional organisation, with a code of ethics/conduct and clearly defined membership requirements;
- University health sciences courses (not medical, dental or nursing) at an Australian Qualifications Framework level 7 or higher (i.e. a bachelor's degree to a doctoral degree) accredited by the relevant national accreditation body;
- Clearly articulated national entry level competency standards and assessment procedures;
- A defined core scope of practice; and
- Robust and enforceable regulatory mechanisms.

Furthermore, the profession must consist of Allied Health Professionals who:

- are autonomous practitioners;
- practise in an evidence-based paradigm, using an internationally recognised body of knowledge to protect, restore and maintain optimal physical, sensory, psychological, cognitive, social and cultural function; and
- May utilise or supervise assistants, technicians and support workers.

The peak body, Allied Health Professions Australia (2017) makes it possible to more clearly identify Allied Health Professionals. They tend to fall within Australia's National Registration and Accreditation

Scheme which was formed in 2010 and implemented under the mantle of the Australian Health Professionals Registration Agency (AHPRA) to oversee the national register for medical, nursing and Allied Health Professionals. Currently, there are fifteen national Boards under the scheme: Aboriginal and Torres Strait Islander health practice; Chinese medicine; chiropractic; dental; medical; medical radiation practice; nursing and midwifery; occupational therapy; optometry; osteopathy; paramedicine; pharmacy; physiotherapy; podiatry; and psychology. The Commonwealth government has stated that it will continue to include more professions under the registration scheme, such as dietetics, in the future and this will enable more Allied Health Professions to become professionalised.

As a collective term, 'allied health' obscures the professional identity and contribution of some professions. As an artefact of this invisibility, some Allied Health groups are defined by their relationship to other health professions rather than being valued as a distinct professional group that has its own meaning. When a group is defined as a united "us", in relation to the attributes of another group, they are constructed through a lens of sameness and difference. These can be understood as processes of 'othering', which Foucault (1972) attributes to the effects of power and knowledge. Hegel posits these understandings of 'self' are constituted through the juxtaposition towards 'the other' (Heartfield, 2005). Historically, 'allied' meant 'allied to medicine' (Williams, 2009), however, Boyce (1995) has argued that to survive reductive economic rationalist thinking, Allied Health professions must work together to maintain their disciplinary presence and visibility, and strengthen their collective voice. The Indigenous Allied Health Australia (Indigenous Allied Health Australia, 2012, p.1) definition of Allied Health partly addresses this requirement, stating Allied Health is:

> *a collective term used to refer to a variety of healthcare disciplines that contribute to a person's physical, sensory, psychological, cognitive, social, emotional and cultural wellbeing, excluding medicine, nursing and Aboriginal and Torres Strait Islander health worker/practitioner roles. Allied Health functions include but are not limited to, services related to the identification, evaluation, management and prevention of disease and disorders; dietary and nutritional services; and rehabilitation services.*

This definition distinguishes health disciplines and attempts to reflect the service dimensions of Allied Health work without assuming all Allied Health groups meet the criteria for being recognised as a professional group. It is one of the more comprehensive definitions of allied health, which is further supplemented with a clear definition of an Allied Health Professional, being a person who:

> *1. Has undertaken a tertiary qualification at bachelor's degree (Australian Qualifications Framework Level 7) level or higher in an Allied Health course; and*
>
> *2. Has attained the necessary knowledge, attributes, attitudes and skills required to be an autonomous practitioner and practices in an evidence-based paradigm using a recognised body of skills and knowledge to contribute to the physical, sensory, psychological, cognitive, social, emotional and cultural wellbeing of people so that each individual is able to achieve their full potential as a human being; and*
>
> *3. Does not practise as a Doctor, Nurse or Aboriginal and Torres Strait Islander Health Worker/Practitioner.*

The organisation of International Chief Health Professions Officers (2012, p.2) provided a similar definition of Allied Health Professionals:

> *a distinct group of health professionals who apply their expertise to prevent disease transmission, diagnose, treat and rehabilitate people of all ages and all specialties. Together with a range of technical and support staff they may deliver direct patient care, rehabilitation, treatment, diagnostics and health improvement interventions to restore and maintain optimal physical, sensory, psychological, cognitive and social functions.*

These definitions describing the nature of Allied Health practice are of value to this study because they provide some insight into Allied Health knowledge and value systems. These were important considerations for this study being primarily concerned with examining the relations of power, expressed through discourse, associated with the integrative and collaborative practice dimensions of

primary health care reform. Unlike medicine with its biomedical knowledge and curative values, and nursing with its bio-psycho-social knowledge and caring values, Allied Health Professionals draw upon salutogenic knowledge (Antonovsky, 1996) that values the experiential nature of individuals within their community and centralises the importance of health, wellbeing and quality of life within this knowledge framework (Mittelmark & Bauer, 2016). In this study, the term 'Allied Health Professional' is therefore used to denote those groups registered with AHPRA, or via their own professional organisation, "*who apply their expertise to prevent disease transmission, diagnose, treat and rehabilitate people of all ages and all specialties and deliver direct patient care, rehabilitation, treatment, diagnostics and health improvement interventions to restore and maintain health and wellbeing*" (International Chief Health Professions Officers Group, 2012, p.2)

At the time Medicare Locals were recruiting Allied Health Professionals as Board members, they constituted 18% of the overall health workforce and consisted of occupations that were professionally registered, such as psychologists, dentists, pharmacists, occupational therapists, and podiatrists, and those not required to do so, such as social workers and dietitians (Australian Institute of Health & Welfare, 2012). The Australian Allied Health workforce data (Table 3) profiles the feminisation of a range of Allied Health professions and their distribution by geographic classification region. The most highly feminised health professions are occupational therapy, psychology, Aboriginal and Torres Strait Islander health practitioners, medical radiation, physiotherapy, and pharmacy. Geographically, most disciplines were densely concentrated in major cities and inner regional areas although pharmacists, physiotherapists. dentists, occupational therapists and psychologists are relatively prominent in outer regional areas. There are multiple classification systems used for designating rurality. The area/regional code used in the current study was based on a classification system developed by the National Health Performance Authority, an independent government agency that monitored and reported on the performance of primary health care organisations and other bodies that provided health care services to the community. The classification system, constructed on remoteness and socioeconomic status, is comparable to the Australian Bureau of Statistic's Australian Standard

Geographical Classification - Remoteness Area (ASGC-RA). It is a geographical classification system used to define locations from their nearest urban centre. Essentially the ASGC-RA is a measure of a location's level of access to goods and services (Australian Institute of Health & Welfare, 2018a).

Few Allied Health Professionals work in remote areas. These were important considerations for recruiting participants.

Table 3: Australian Registered Allied Health Practitioner Workforce Data, by Gender and Geographic Classification Region

	ATSI Health Practitioners	Chinese Medicine	Chiropractic	Oral Health	Medical Radiation	Occupational Therapy	Optometry	Pharmacy	Physiotherapy	Podiatry	Psychology
Male	23.4%	46.2%	62.5%	50.9%	33.5%	9.2%	48.4%	39.6%	34.0%	41.0%	21.4%
Female	76.6%	53.8%	37.5%	49.1%	66.5%	90.8%	51.6%	60.4%	66.0%	59.0%	78.6%
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Major cities	63	3,454	3,472	15,394	10,361	12,273	3,738	18,391	19,621	3,262	20,914
Inner regional	58	408	801	2,755	2,015	2,414	722	3.559	3,189	789	3,110
Outer regiona	148	112	268	1,159	673	1,079	237	1,595	1,222	235	1,035
Remote	90	np	39	131	76	117	26	211	154	29	109
Very Remote	115	np	9	46	26	44	10	85	79	11	47
Total	474	3,983	4,589	19,490	13,156	15,928	4,734	23,842	24,271	4,327	25,219

Source: Australian Institute of Health & Welfare (2016). Australian Health Workforce data sets. Canberra, Australia.

*'np' denotes these counts have been suppressed for confidentiality reasons

Allied Health Professionals work in hospitals, community and private settings. Within the public health system, many Allied Health Professionals work in community-based centres, away from acute care, where there are fewer medical positions. However, consumers of services remain under the supervision of a medical officer, and referral is generally conducted via a Doctor or specialist. In private practice settings, Allied Health Professionals have more autonomy and might see consumers without a medical referral – although this can limit funding opportunities through Medicare. With the introduction of schemes such as the Enhanced Primary Care (EPC) system of 2004, the Access to Allied Psychological Services (ATAPS) Scheme, and further mental health services available through the Better Access to Psychiatrists, Psychologists and GP's under the Medicare Benefits Scheme of 2008, the ability for consumers to obtain rebates is once again moving back towards a dependence on medical referral (Williams, 2009).

Allied Health leadership

Primary health care has a long and complex history in Australia. As the global authority, the WHO has unshackled health from the biomedical model, defined primary health care and articulated its underpinning philosophy and principles. The Australian government used its sovereign power to effect health system reform in Australia using primary health care. Doctors, with their knowledge and value systems underpinned by biomedical discourse, were assumed to be the most appropriate group to lead the health reform. The Divisions of General Practice were established to facilitate health reform, however the biomedical model prevailed and was ineffective for meeting the Australian government's vision for health system reform and improving health outcomes. Nevertheless, Doctors had attained substantive disciplinary power and used their social power to resist various health reform strategies.

The Australian government once again used their sovereign power to reengineer health policies, funding models and established a network of Medicare Locals. Integrative, collaborative practice became the hallmark of health system reform and this required clinical leadership for improving decision making, clinical governance and service delivery. Allied Health Professionals were positioned to play a key leadership role in primary health care reform (Markham, 2015).

Most Australian states have developed strategies for building Allied Health leadership capacity and capability at all levels within the workforce (Boyce & Jackway, 2016; Dawber et al., 2017; Joubert et al., 2016). However, various State reports identify Allied Health is poorly represented in the health leadership strata, is not highly visible as a potential leadership resource and has limited access to organisational leadership development pathways (Boyce & Jackway, 2016; Dawber et al., 2017; Joubert et al., 2016). These reports are concerning given the government expectation that Allied Health Professionals would contribute to primary health care reform through their leadership roles within Medicare Locals. It was an expectation that failed to consider that Allied Health leadership in primary health care was to be implemented within an existing and long-standing professional hierarchy. Doctors were dominant in the hierarchy, and Nurses through career structure and their clearly defined caring knowledge and value systems had made themselves highly visible as health care leaders.

In primary health care, nursing was cultivating its disciplinary power alongside Doctors. The Australian Nursing and Midwifery Federation articulated strong support for the adoption of primary health care as the centre piece of health policy in Australia to improve public health (Adrian, 2009). To better meet the needs of the community Nurses and Midwives called for "*an acknowledgement that appropriately qualified health professionals other than medical practitioners are safe and confident to lead a transdisciplinary primary health care team*" (Adrian, 2009, p.3). Whilst nursing and midwifery was advocating for a range of health disciplines, the voice of Allied Health was less audible. Some Allied Health Professions, such as psychology and pharmacy, had moved through career structure reform and an internal hierarchy emerged, which recognises some professions as holding more disciplinary power (Boreham, Pemberton & Wilson, 1976; Dingwall and Lewis, 1983; Freidson, 2001; 2007). As a collective however, Allied Health leadership as a resource is still ill-defined and the disciplinary power for leading primary health care is largely invisible. This gap was a key concern for this study.

This section has problematised definitions of 'primary care', 'primary health care', and 'allied health' and clarified how they have been operationalised in this study. It was an important task because Foucault (2012), argues whenever terms remain undefined and concepts lack clarity, they obscure the power effects of their associated discourses which can work to reinforce the status quo. For primary health care reform, the status quo of medical-oriented approaches to health care as a sole solution needed to be disrupted to allow for meaningful evolution in public health. Medicare Locals were mandated by the Australian government to appoint Allied Health leaders to their Board. However, the contributions of Allied Health Professionals to primary health care reform had not been examined. This concern was at the centre of the research problem, questions and design of this study.

Section 2. Justifying the study

Australia has moved through a period of intensive health reform in its commitment to improve health and reduce the burden of chronic disease through primary health care. A new public health discourse is clearly articulated and discursively expressed in a range of national health policies, strategies and reports. Major structural reforms, including the dismantling and reorienting of the Divisions of General Practice to establish Medicare Local organisations, were implemented during the 2000's. The mandate for Medicare Locals was to work with local primary health care providers, Local Hospital Networks, and communities to ensure people could receive the right care, in the right place and at the right time (Australian Government, 2013a). These structural reform initiatives were designed to shift the medically oriented health system and services to community-focussed, integrated and collaborative ways of working. The public health discourse symbolises the emergence of new ways of talking about and understanding health, health systems, services and practices - but the full extent of impact on relations of power within this discursive shift were largely unknown.

The focus of primary health care was its emphasis on achieving health through equity and community empowerment (Ernst & Young, 2014). To be accepted and operationalised in health reform this paradigmatic shift required a move away from medical solutions for disease eradication and

management as the sole approach to health care. Allied Health Professionals were included on Medicare Local Boards to diversify primary health care leadership across the health professions.

Problem statement

The health system was buckling under the pressures of an aging population, escalating burden of chronic and complex disease and increasing inequities in access, affordability and use of health services. However, Doctors continued to deliver services based on biomedical knowledge and a curative approach. In response, the Australian government implemented health policy reform to facilitate the social model of health and integrative collaborative practice core primary health care. To address these shortcomings, the Australian government adopted a more targeted reform approach that insisted on coordinated and multidisciplinary integration. Medicare Locals were established to facilitate the shift from primary care to primary health care and included broader representation on their Boards. Until the shift to primary health care, Allied Health Professionals had not had a voice in primary care.

Study aim

The study aim was to examine ways primary health care was represented by Medicare Locals, and how these representations impacted on how Allied Health Professionals formed meanings and therefore approached integration, collaboration and multidisciplinary ways of working as leaders in primary health care.

Study purpose

The purpose of the study was to examine how Medicare Locals operationalised the primary health care policy directive, and the impact on primary health care reform of including Allied Health Professional leaders on Medicare Local Boards and in primary health care teams. That is, to look beyond the ideas of structural reform in primary health care to investigate the deeper and hidden cultural, historical and temporal associations of language, discourse, power and identity located within the practices of Allied Health Professionals elected to Medicare Local Boards, with a view to

establishing whether Medicare Locals were meeting their intended vision and mission of integrated and collaborative primary health care.

Research questions

There are four research questions:

1. How was primary health care constructed within written strategic documents mandating the vision and mission of Medicare Locals?
2. How did Allied Health Professionals who worked in Medicare Locals understand primary health care as it related to their leadership roles?
3. How were Allied Health Professionals within Medicare Locals positioned for achieving integrated and collaborative multidisciplinary approaches in their work as Board members?
4. Were Medicare Locals meeting their intended vision and mission of integrated and collaborative primary health care?

Research design

Drawing primarily upon Foucault (1972, 1977, 1978, 1980, 2009) and Fairclough's (2001, 2015) work, this study engaged in a critical discourse analysis of Medicare Local policy documents, including their Constitutions and their Operational Guidelines and Allied Health Professionals accounts of their leadership experiences as Medicare Local Board members. The objective was to interrogate how these policies constructed primary health care, uncover the deep-seated assumptions that underpinned such constructions, and examine how power was exercised through a production of 'truth' and 'knowledge' (Foucault, 1972) to realise the reform agenda. Recognising discourse as a form of social practice (Foucault, 1972) allowed for examination of the ways primary health care discourses influenced social interaction, decision making and practice, and how it contributed to study participants in taking up different leadership identities.

Given the interest in the way Allied Health Professionals thought and acted as Medicare Local leaders, a qualitative research design was necessary to examine their social world (Denzin & Lincoln, 2008). A purposive sample of Allied Health Professional Medicare Local Board members allowed for rich, thick descriptions of their understandings of primary health care that permitted a contextual understanding of leadership. Discourse reflects and creates dynamics of power, dominance, resistance, and social inequality (van Dijk, 1995). Critical Discourse Analysis begins with a discourse- related problem which, in this study, is primary health care. It provided a useful framework for examining the Medicare Local policy documents and the participant accounts as both reflection and creation of the primary health care landscape in terms of explicit and implicit interests related to power.

This study is critical in orientation because of its focus on: a) health care reform which is socio-politically grounded, b) the relationship between Allied Health Professionals as leaders and members of Medicare Locals and c) individuals and the role of power of social control in society, discourse and identity. This also pointed to the need for reflexivity to elucidate the position from which the researcher was carrying out the analysis (Chouliaraki & Fairclough, 1999). The critical orientation and need for reflexivity aligned with the use of power as the theoretical lens. Power theories were also important because Allied Health leadership in primary health care forms part of the concept of governance. Governance has generally come to refer to "*any mode of coordination of interdependent activities*" (Lemke, 2012, p.34) and signifies a mechanism to control, manage or regulate problems, at a local, national, or even organisational levels. However, Foucault extended this definition to include the "*conduct of conduct*" (Foucault, 1982, p.220) to "*cover the way in which an individual questions his or her own conduct (or problematizes it) so that he or she may be better able to govern it*." (Dean, 2010, p.19). Discourse not only shapes how primary health care can be known; these representations work to legitimise certain attitudes or opinions, and therefore influence how professional identity is shaped and people behave.

Outline of the Thesis

So far, this opening chapter has situated primary health care in its socio-political context and traced its development in Australia in the period leading up to Medicare Locals. The social determinants of health were introduced to orientate discussion of Australian's health in a way that demonstrates health status and outcomes vary within and between different population groups.

Chapter two reviews the published and grey literature related to primary health care reform in Australia between 1990 and 2019 to examine the antecedents, operational practices, outcomes and legacies surrounding the establishment of Medicare Locals. The chapter is structured in four sections and presents the literature chronologically to mirror the historical, cultural, ideological and temporal nature of primary health care reform.

Chapter three describes and explains the methodology applied, situates the study within the qualitative paradigm and grounds it intellectually in the critical tradition. This section explains how these ontological and epistemological orientations were reflected in the study aim, purpose, research questions, and how they informed the selection of theories used in the study. The theoretical lens adopted reflects the power-discourse-governmentality (Foucault, 1978, 1980) nexus, which is outlined and linked to the three-dimensional theoretical framework used to examine each of these theoretical components.

Chapter four outlines the research procedures related to setting up the study, including ethics approval and its related considerations, and sampling and recruitment of participants. It describes the methods used to collect and analyse the data, including procedures related to collecting the documents, developing a guide for interviewing the Allied Health Professionals and outlines how the interviews were structured and conducted. The following section explains three data analysis cycles that combines a coding-categorising-theming sequence (Green et al., 2007) with Fairclough's (2015) three-dimensional methodological framework for critical discourse analysis. The chapter concludes

with an explanation of processes used to mitigate bias and ensure rigour and trustworthiness and how the study procedures were distilled and informed the write up of this thesis

Chapters five and six are the findings chapters. Chapter five addresses the first research question and chapter six the other three. Chapter five is part one of the findings reporting the analysis of the operational framework of Medicare Locals. The findings as reported under the major themes of *the Australian government's vision and mission for Medicare Locals; Interpretation of the Guidelines to develop Constitutions;* and *Health for all,* which includes two subthemes, *the need for health improvement* and *Discursive tensions in promoting health and primary care.* Chapter six is part two of the findings reporting the analysis of how Allied Health Professionals who worked on Medicare Local Boards accounted for and interpreted their roles, social interactions and everyday practices. The first section provides a profile of the Allied Health Professionals interviewed. The other findings are presented in four sections under the major themes: *Bringing Allied Health Professionals to the table*, participants' experiences of *Being at the Table, Enacting leadership to achieve the prescribed vision and mission* of Medicare Locals and *The tensions between the directives, rhetoric and reality* Allied Health Professionals experienced.

Chapter seven reflects on the main findings of the study in terms of its aim, purpose and the research questions. It situates these findings within the literature and identifies their implications for future policy and primary health care practice. In four sections the chapter discusses a) the value of bringing Allied Health Professionals to the Medicare Local Board table b) how they experienced being othered and negotiated a sense of belonging, as well as how communities were marginalised as other c) how health reform could be improved by developing future Allied Health Professional leaders and facilitating evidence-based primary health policy reform, and d) the strengths and limitations of the study.

Chapter eight concludes the thesis. The chapter answers the research questions and brings together the key tenets of the research process to consider the merit of the approach adopted for examining

the case of the health policy reform that gave rise to Medicare Local organisations. The chapter draws attention to the contribution the study makes to understanding the interface between policy, and its implementation both structurally and operationally and the time required to begin to affect a paradigmatic and cultural shift and realise the outcomes intended. The intentional recruitment of Allied Health Professionals to leadership positions at the Medicare Local Board table was shown to provide Allied Health Professionals with a voice in policy decision-making and the impetus to continue working towards integration. The chapter also sheds light on how Medicare Locals were set up and operated, the tensions within and between policy texts and the constraining and enabling influences of discourse. Chapter eight closes by examining the implications of the study for devising, planning, implementing and evaluating primary health care policy and provides future directions and recommendations.

Chapter summary

This chapter has situated the study and the need to look back to look forward. The first section introduced the notion of social determinants of health and their influence on the health of Australians. It traced the lineage of health, primary health care and health system reform and the transition from Divisions of General Practice to Medicare Locals. The section closed by differentiating primary care and primary health care and defining Allied Health and Allied Health leadership. The second section of the chapter justified the study and approach adopted by articulating the research problem, the study aim and purpose, research questions and logic for adopting a qualitative, interpretive, critical research design and outlined the structure of the thesis.

Australians generally have good health and an effective health care system. However, some Australian's experience significant disadvantage and health issues, such as: those living in rural and remote areas; from culturally and linguistically diverse populations; living with a disability; those who are lesbian, gay, bisexual, transgender or intersex; or veterans or prisoners. People living in the most socio-economic disadvantaged groups are also at a higher risk of experiencing a chronic disease

(Australian Institute of Health & Welfare, 2018a). The prevalence and burden of chronic disease are significant and is increasing with the ageing population (Australian Institute of Health & Welfare, 2018a). Increasing rates of chronic disease places growing pressure on health expenditure as well as a reduction in future labour force participation rates and productivity (Australian Institute of Health & Welfare, 2018b; Buchmueller & Johar, 2015; Productivity Commission, 2013). Primary health care reform has focused on ameliorating some of these pressures by encouraging a population health focus, greater use of integrated, collaborative multidisciplinary teams, increased accountability for performance, and improved access to services (Australian Government, 2013b). With an increased focus on addressing the social determinants of health, primary health care reform aimed to improve equity of access for those experiencing social and economic disadvantage (Australian Government, 2009c). One of the key aspects of these reforms was to integrate health care services to improve the effectiveness, efficiency and quality of care provided. Medicare Locals were established to improve consumers experience of primary health care through developing and facilitating integrated and coordinated health care services (Australian Government, 2013a). They were tasked to address population needs; coordinate local and regional primary health care systems; improve access; and facilitate preventive health and health promotion activities.

Medicare Locals symbolised innovation in strategy as Australia moved to transform its health system (Australian Government, 2013a). They therefore provided an ideal case study for critically, retrospectively investigating ways Medicare Local's delivered primary health care and how Allied Health Professionals as Medicare Local Board members formed meanings and approached their leadership roles. In these written and spoken texts there is a relationship between language, discourse, power and identity. Despite the subsequent shift in 2015 from Medicare Locals to Primary Health Networks, there are likely to be ongoing challenges and tensions about public health performance and governance. This chapter reconceptualises primary health care and proposes a new theoretical lens and analytic framework to address the gaps in how health reform was studied an evaluated.

The key points in this chapter are that:

- Australia has a rich history of health reform which have led to significant improvements to the health system.
- The burden of disease, increasing rates of chronic disease, and an ageing population have placed growing pressure on existing health services and providers.
- Consumers have been left with gaps in health care that disadvantage some groups more than others.
- Medicare Locals were established to improve interdisciplinary collaboration and integration of health care services, using a population health and health promotion focus that engages communities.
- Primary health care reform was implemented amidst a complex interplay between language, discourse, power and governance. These cultural dimensions of reform were largely hidden and unknown.

Critically examining the literature provides insights into how language gives rise to discourse and power in primary health care. The next chapter reviews published, and grey literature related to primary health care reform in Australia between 1990 and 2019 to examine the antecedents of this reform, the direction taken by Medicare Locals and how they operated, and the aftermath, following their disbanding.

Chapter 2. Literature Review

Introduction

This chapter reviews published, and grey literature related to primary health care reform in Australia between 1990 and 2019, the direction taken by Medicare Locals and how they operated. The methods used for this review align with the critical stance taken in this study and its epistemological position that recognises the historical, cultural and temporal nature of primary health care reform. In this study, knowledge about primary health care is considered a product of both structural health reform *and* a cultural artefact embroiled in complex relations of power and discourse that are not readily visible in policy. Situating the study historically, culturally and temporally influenced the review procedure in two ways.

First, knowledge about primary health care could not be seen as separate to the historical contexts of its production. Analysis of the dynamic evolution in knowledge about primary health care was achieved by temporally tracing the evolutionary changes in Australia's primary health care reform. The knowledge systems, already in operation when Medicare Locals were established, were shaping the socio-political context in which the primary health care organisations were to operate. Accordingly, a targeted search was undertaken of Australian literature between 1990-2009 reporting early activities evidencing the transition from primary care toward primary health care.

Secondly, knowledge about primary health care could not be seen as separate to the cultural contexts of its production. Accordingly, to situate this study in the body of scientific, expert, bureaucratic and social science knowledge, the literature review was not confined to empirical research studies, but instead incorporated published opinion, editorial and discussion papers and grey literature.

The chapter is structured in four sections. Section one establishes the context of the literature review by outlining its aims and scope, and the processes used for searching databases for published and grey literature using defined inclusion and exclusion criteria.

Section two outlines knowledge related to primary care after the establishment of the Divisions of General Practice and prior to the establishment of the Medicare Locals, that is, the published and grey literature between 1990 and 2009. By synthesising the main bodies of knowledge, this section examines what was known at the time and how this knowledge had been generated through research and discourse. The purpose of this section was to describe the antecedents driving the reform agenda and knowledge systems underpinning primary health care reform.

Section three examines the literature published in the period between 2010-2015 that discusses primary health care reform activities and programs and the emergence of the Medicare Locals. The effectiveness of primary health care as a public health improvement strategy was difficult to ascertain given the overarching and long-term goal was to improve the health and wellbeing of communities. This literature did, however, provide an understanding of what the community's service expectations and challenges were for the new Medicare Locals.

Section four builds upon the literature reviewed in section three and retains its focus on the 2010-2015 period to examine how the reform agenda and health service reorientation activities influenced integrative collaborative practice and the new ways health professionals were required to work with each other. It traces the paradigm shift from professional silos to integrated collaborative practice. This section ends with the review of the Medicare Locals that resulted in them being disbanded and the subsequent establishment of 31 Primary Health Networks which commenced operations in July 2015.

Section five situates the primary health care literature published in the period between 2015-May 2019 in the aftermath of the Medicare Locals and focuses on how the legacies of health reform continue today. This final section examines how the complex relations of power, expressed through discourse, underpinned and constrained the social context in which Medicare Locals operated and led them to be being replaced with a biomedical rather than social model of health that reasserted biopower.

Section 1. Literature review process

Aims and scope of the review

The aim of this literature review was to examine the antecedents, operational practices and legacies of primary health care reform following the establishment of Medicare Locals, which occurred in Australia between 2010-2015. Accordingly, it was important to establish how the structural reform approach adopted, influenced and impacted on the knowledge systems governing the ways health professions thought and acted. This review therefore sought to:

- identify the knowledge system and power relations underpinning primary care in the decades preceding the health policy reform implemented under the Rudd Labor government;
- identify how Allied Health Professionals' knowledge and value systems might align with, and contribute to, primary health care;
- examine whether paradigm shifts occurred in the transition from primary care to primary health care; and
- explore the legacies of this primary health reform for future directions of primary health care.

The aim, scope and procedures of the review have been informed by the critical stance and epistemological position that recognises the historical, cultural and temporal nature of primary health care.

Justifying the Australian focus

The study was primarily interested in the concept and practice of primary health care reform in the Australian context therefore the literature review was contained to the Australian context. While the review was initially informed by international literature this collection of publications rarely described associations between national health policy reform and national approaches to primary health care implementation. The differences in political governance, health care governance and systems therefore made transferability of findings, results and recommendations to the Australian context challenging.

The search terms used were primary care organisations, primary health organisations/organizations, primary health organisations/organizations, Medicare Locals, primary care trusts, primary care network, transmural care, family health groups, health maintenance organisation/organization, primary care facility, health centre, health reform, primary health, and primary healthcare. Each of these terms had been used to describe primary health care organisations around the world. Literature was sourced from New Zealand (Crampton, 2005), the United Kingdom (Mickam et al, 2010; Regmi et al, 2010), Canada (Seror, 2002), and the Netherlands (Hansen et al, 2011; Kringos et al, 2010a; Kringos et al, 2010b). It should be noted, however, that overall the international literature search identified relatively few publications from other countries that pertained to initiatives such as the establishment of Medicare Locals. This may be because the English-only search missed a body of literature written in languages other than English.

The international literature did describe a range of primary health care systems (Kringos et al, 2010) organisations (Hansen et al, 2011; Seror, 2002), services (Mickan et al, 2010; Regmi et al, 2010) and attributes (Crampton, 2005). The type of health service, organisational attribute researched, nature of intervention used and kind of organisation performance affected is summarised in Appendix 3.

Databases searched

Two databases of peer reviewed literature were searched - PUBMED and CINAHL. These were chosen because they are dedicated to health and Allied Health and include a wide range of primary health care and Allied Health literature. This meant that the search strategy was likely to reveal a spread of literature from the medical, nursing and Allied Health literature, without the need to target Doctors, Nurses and Allied Health Professionals. A total of three separate searches were conducted across the two data bases, which are described more fully later in this section. Reference lists of identified papers were cross-referenced to identify further studies that did not emerge during the database searches.

Grey literature

Grey literature was understood as information produced by government, academia, business and industry in electronic and print form that is not controlled by commercial publishing (Tyndall et al., 2012). Google searches were undertaken to access the Australian grey literature, using the terms Medicare Local, Primary Health Care Organisation, and health reform. The web searches sought to locate reports authored by the Commonwealth Government Department of Health and Discussion Papers written by the Commonwealth government or stakeholder organisations, such as the Australian Medicare Local Alliance, Australian Medical Association, Australian Nursing and Midwifery Federation and other Allied Health and medical member groups, or consumer organisations. More details regarding this search can be found in Table 4. Reports and papers published during the period 1990-May 2019 were included, which reflects the time leading up to the establishment of the Medicare Locals in Australia as well as their period of operation. It also reflects the time since the Medicare Locals were disbanded and replaced by Primary Health Networks.

Table 4. Results of the review of the grey literature

Name of document	Country/Author/Date	Source of literature	Purpose of document
Beyond the Blame Game	Australia (National Health and Hospitals Reform Commission, 2008)	Department of Health & Ageing website	Government commissioned report on the Australian health system.
A Healthier Future For All Australians: Interim Report	Australia (Australian Government, 2008)	Department of Health & Ageing website	Interim report of the National Health and Hospitals Reform Commission.
A Healthier Future For All Australians: Final Report	Australia (Australian Government, 2009b)	Department of Health & Ageing website	Final report of National Health and Hospitals Reform Commission.
Australia's First National Primary Health Care Strategy	Australia (Australian Government, 2009a)	Department of Health & Ageing website	Primary health care strategy for Australia.
Primary Health Care Reform In Australia – Report To Support Australia's First National Primary Health Care Strategy	Australia (Australian Government, 2009c)	Department of Health & Ageing website	Primary health care strategy for Australia.
Connecting Care: A Blueprint For Improving The Health And Wellbeing Of The Australian Population – The Role And Function Of Primary Health Care Organisations.	Australia (Australian General Practice Network, 2009)	AGPN website	A response to the government's reports on primary health care. Proposes what the role and function of Primary Health Care Organisations may be.
A National Health And Hospitals Network For Australia's Future (The Blue Book)	Australia (Australian Government, 2010c)	Department of Health & Ageing website	Outline of the Government's response to the health reforms.
A National Health And Hospitals Network: Further Investments In Australia's Health (The Green Book)	Australia (Australian Government, 2010f)	Department of Health & Ageing website	
A National Health And Hospitals Network: Delivering Better Health And Better Hospitals (The Red Book)	Australia (Australian Government, 2010d)	Department of Health & Ageing website	
A National Health And Hospitals Network: Delivering The Reforms (The Gold Book)	Australia (Australian Government, 2010e)	Department of Health & Ageing website	Implementation plan for the health reforms.

Name of document	Country/Author/Date	Source of literature	Purpose of document
Media Release: Next steps Taken To Establish Medicare Locals	Australia (Australian Government, 2010a)	Department of Health & Ageing website	Media release from the Hon Nicola Roxon, the Minister for Health.
Medicare Locals Discussion Paper On Governance And Function	Australia (Australian Government, 2010b)	Department of Health & Ageing website	Discussion paper on governance of Medicare Locals.
Health Reform in NSW	Australia (NSW Ministry of Health, 2010)	NSW Ministry of Health website	A Discussion paper on implementing the Federal government's "A National Health & Hospitals Network for Australia's Future" in NSW.
National Health Reform: Progress And Delivery (The Purple Book)	Australia (Australian Government, 2011d)	Department of Health & Ageing website	Progress report of the implementation of the health reforms.
Medicare Locals Guidelines For The Establishment And Initial Operation Of Medicare Locals And Information For Applicants Wishing To Apply For Funding To Establish A Medicare Local	Australia (Australian Government, 2011b)	Department of Health & Ageing website	Guidelines
Lead Clinicians Groups: Enhancing Clinical Engagement In Australia's Health System	Australia (Australian Government, 2011a)	Department of Health & Ageing website	Discussion paper
National Health Reform: Lead Clinician Groups	Australia (Australian Government, 2011c)	Department of Health & Ageing website	Position paper
National Lead Clinician Groups: General Information	Australia (Australian Government, 2011e)	Department of Health & Ageing website	Information paper
Improving Integration Of Care: A Discussion Paper For Medicare Locals.	Australia (Australian Medicare Local Alliance, 2012)	AMLA website	Discussion paper
Medicare Locals Guidelines For After-hours Primary Care Responsibilities Until 30 June 2013	Australia (Australian Government, 2012)	Department of Health & Ageing website	After hours guidelines for Medicare Locals
Report 1: Integrated Care: What policies support and influence integration in health care in Australia?	Australia (Oliver-Baxter et al., 2013a)	PHC RIS website	Report 1 in the series: Towards integrated [primary health care integration within

Name of document	Country/Author/Date	Source of literature	Purpose of document
			primary health care and between primary health care and other sectors.
Report 2: Integrated Care: what policies support and influence integration in health care across New Zealand, England, Canada and the United States?	Australia (Bywood, 2013)	PHC RIS website	Report 2 in the series: Towards integrated [primary health care integration within primary health care and between primary health care and other sectors.
Report 3: Integrated Care: what strategies and other arrangements support and influence integration at the meso/organisational level?	Australia (Oliver-Baxter et al., 2013b)	PHC RIS website	Report 3 in the series: Towards integrated [primary health care integration within primary health care and between primary health care and other sectors.
Report 4: Medicare Locals: A model for primary health care integration? Achieving integration: A study exploring Medicare Locals' implementation of integrated primary health care policy.	Australia (Brown et al., 2013)	PHC RIS website	Report 4 in the series: Towards integrated [primary health care integration within primary health care and between primary health care and other sectors.
Report 5: Integrated Care: What can be done at the micro level to influence integration in primary health care?	Australia (Oliver-Baxter et al., 2013)	PHC RIS website	Report 5 in the series: Towards integrated [primary health care integration within primary health care and between primary health care and other sectors.

Inclusion and exclusion criteria

Australian papers and reports included in the review were those describing the Divisions of General Practice, the transition from primary care to primary health care, disease prevention or health promotion activities, Medicare Local activities, views on primary health care reform, primary health care policy, integrated collaborative practice and primary health research.

Papers and reports excluded from the review were those reporting primary care activities without reference to primary health care, health informatic or related system needs, economic or financial dimensions of system reform, cross professional role substitution, disease management activities, supervision requirements, educational dimensions, or activities unrelated to primary health care. International papers and reports were not included. Papers that met the inclusion criteria but could not be attributed to an author were also excluded.

Search strategy and outcomes

Searches were conducted based on possible combinations of search terms pertinent to each area of the study using the Boolean operators 'AND' and 'OR' and 'NOT'. Initially, a search was undertaken between 1990 to 2009 to gain an understanding of the socio-political context in the field prior to Medicare Local organisations being established. A subsequent search was undertaken to identify publications between 2010 and 2015, during the period in which Medicare Locals were in operation. The final search 2015-May 2019 sought to locate papers related to the disbanding of Medicare Local organisations, the shift to Primary Health Networks, and how the new primary health care focus may have changed.

The search strategy yielded 9,400 articles. After applying a sorting process to identify and extract papers relevant to the scope and aims of the literature review and remove duplications, there were 378 articles. The manual cross-referencing process identified a further 53 articles. The search sequence, terms, time-period, and results are identified in Table 5.

Table 5. Results of the database search strategy

Sequence	Time Limiters	Key Words and Booleans	Number of Articles		
Search 1	1990-2009	Primary Care [MESH Term] AND Australia [All Text] AND Health Promotion [All Text] OR Reform [All Text] OR Care Trials [All Text] OR Enhanced [All Text] AND Divisions of General Practice in PUBMED, CINAHL	PUBMED: n=4989 After sorting n= 163 Duplicate removal: n=8 Total Included n=155	CINAHL: n=2773 After sorting n= 76 Duplicate removal n=12 Total Included n=64	Cross Referenced: n=33
Search 2	2010-2015	Primary Health Care [MESH Term] AND Australia [All Text] AND Reform OR Medicare Local [All Text] AND Allied Health NOT Payments in PUBMED, CINAHL	PUBMED: n=518 After sorting n= 59 Duplicate removal: n=0 Total Included n=59	CINAHL: n=518 After sorting n= 62 Duplicate removal: n=14 Total Included n=48	Cross Referenced: n=20
Search 3	2015-May 2019	Primary Health Care [MESH Term] AND Australia [All Text] AND Reform OR Medicare Local [Title]	PUBMED: n=575 After sorting n= 45 Duplicate removal: n=0 Total Included n=45	CINAHL: n=27 After sorting n= 9 Duplicate removal: n=2 Total Included n=7	Cross Referenced: n=0

Section 2. The knowledge systems underpinning primary health care reform from 1990-2009

This section examines the knowledge systems underpinning primary health care in the decades preceding the health policy reform implemented under the Rudd Labor government. That is, how primary health care was reported in the published literature prior to Medicare Locals being established. During the period 1990 to 2009 there were some examples of primary health care activities, however, they were selective in nature and being implemented amidst discussions about the impact health reform might have on the preferred biomedical approach to primary care. Amidst research and evaluation of early health promotion and disease prevention activities, health and medical researchers were publishing reflective papers about their experiences and views of reform in relation to practice, policy and research.

In the early 1990s, there was uncritical acceptance that the General Practitioner (GP) was the medical authority in health care. Hutton (2005) reported 82% of the population in 1991 had seen a GP at least once a year. However, at a national General Practice Financing Think Tank held in Canberra, there were discussions about the difficulties general practice was experiencing, including GPs feeling unhappy and isolated, and the belief the financing system was challenging quality medical practice (Douglas, 1991). The GPs argued for a stronger voice in health planning, more involvement at the local level, clearer links between GPs and other health professionals and better financial remuneration for GPs involved in preventative care, health promotion and teaching (Douglas, 1991). In December 1991, the General Practice Consultative Council, comprising representatives of The Australian Medical Association, The Royal Australian College of General Practitioners, and the Commonwealth government, proposed the establishment of local Divisions of General Practice under the control of GPs (Hutton, 2005).

Initially funded by the Australian government in 1992 as a pilot program, the Division network grew to 120 regionally-based Divisions of General Practice around Australia, State Based Organisations, and

the national body of the Australian Divisions of General Practice. Hutton (2005), citing the now unavailable *Divisions of General Practice: Future Directions Government Response to the Report of the Role of Divisions of General Practice* (April 2004) reported that 95% of GPs were members of a Division of General Practice, which collectively, were supported with government funding of more than $130 million per annum (Kalucy, 2004). Their key mandate was to build capacity to improve health outcomes and support shared care in Australia for those with chronic diseases (Harris & Powell Davies, 1999). They approached capacity building through governance, the development of a leadership structure, membership engagement, and improving links between GPs, other primary health providers and hospitals (Hutton, 2005). The Divisions, comprising mainly GPs on their governing Boards, used a 'hub and spoke' partnership model with general practice as the central hub and the spokes represented by other health care providers (McDonald et al., 2009). This is evidence of the Divisions of General Practice using a recognised structural model to connect to other health services.

By the late 1990's there was a strong push for innovation and change in professional and practice integration. The governance and formalised partnership arrangements in place within the Divisions of General Practice were reviewed in terms of the level of collaboration they achieved (Phillips et al., 2003). A smaller study of the Divisions of General Practice found they did generate formal models of consumer and community involvement in general practice, but noted it was unclear how effective these models had been in changing the nature of general practice (Allwell & Dawson, 2002). The larger and formal *Review of the Role of Divisions of General Practice* (Kalucy, 2004) affirmed the network had made a valuable contribution to improving the coordination and delivery of health services to the community and health outcomes. The key emphasis, however, was on the way:

> *Divisions of General Practice had made it possible for **general practitioners** to work together, health services to work with **general practice**, **general practice** to become more integrated into the health system at a local level, and Government to achieve outcomes*

> *that are difficult to obtain through individual **general practices** operating in isolation* (Kalucy, 2004, p.3 emphasis added).

Other reports suggested the Divisions were reliant on persuasion and the commitment of their members to develop a common purpose and aim (Rogers & Veale, 2000). The Coordinated Care Trials and the Chronic Disease Self-Management Programs were identified as two examples of program initiatives that actively involved 'at least some' Divisions of General Practice (Allwell & Dawson, 2002).

The National Coordinated Care Trials (NCCTs) were developed in response to a Council of Australian Governments endorsed reform agenda in 1995 that sought to meet Australia's health care needs while managing health expenditures more effectively (Battersby et al., 2007; Esterman & Ben-Tovim, 2002; Mills & Harvey, 2003; Perkins et al., 2001; Shannon, 2002; Walls et al., 2008). That is, neoliberalist ideology was one of the contextual factors influencing the implementation of primary health care practice. The trials were initially implemented across Australia in nine different sites to see whether different models of coordinated care could improve the health of people presenting with chronic and complex needs, within existing resources (Perkins et al., 2001).

Feedback on the effectiveness of the trials was mixed. Weeranmanthri et al. (2002) provided a detailed account of the processes, endeavours and benefits derived from the use of NCCTs for Indigenous populations. Most commentators reporting on the NCCTs identified issues related to the disincentives to cooperation that already existed within the system (Perkins et al., 2001); and the complexities in creating new systems and models of care underpinned by the philosophy of primary health care (Battersby et al., 2001). Other reviews argued the NCCTs were ambitious and the second round might provide more answers (Esterman & Ben-Tovim, 2002).

Calls were made for obtaining a consensus and not just an evidence base for guideline development for establishing standards of best practice health care (Pilla, 2002). Those engaged in the NCCTs made predictions about the effectiveness of prevention and recognised there was a role for epidemiological

modelling and health needs analysis (Macfie, 2006; Walls et al., 2008). The definition and concept of coordinated care remained undefined until Ehrlich and colleagues (Ehrlich et al., 2009) completed a critical review. The common understanding of coordinated care that had been assumed during the 1990s and 2000s was neither clearly defined nor well understood (Ehrlich et al., 2009). Consequently, there were reports the NCCTs were impacted by challenges faced by the various health professionals working together (Battersby et al., 2001; Shannon, 2002). Reports emerged that patients' experiences of the NCCT's were that multidisciplinary team care was implied rather than a reality (Foster et al., 2009), that patients wanted access to GPs for acute rather than anticipatory care (Shortus et al., 2005). Patients' preference for Doctors is evidence of communities' innate acceptance of medical authority and this legacy of biopower manifests as community reliance on Doctors. Community reliance on Doctors was another one of the contextual factors influencing primary health care practice being implemented at the local level (Gunn et al., 2008; Lockhart, 2002).

The medical authority was reflected in the now obsolete general practice-led Medicare EPC Program introduced in 1999 as an initiative to improve the prevention and management of chronic disease (Newbury, 2000). The EPC items were designed to facilitate multidisciplinary care (Foster et al., 2008; Menz, 2009), promote better management of chronic disease and improve health outcomes for people with chronic illness (Newbury, 2000). Despite the multidisciplinary ideals, GPs were the locus of care in the EPC program (Blakeman et al., 2001; Blakeman et al., 2001a; Blakeman et al., 2001b; Harris & Blakeman, 2001; O'Halloran et al., 2006). The use of a GP led approach challenged the neoliberal expectation that the EPC Program would enhance health care quality and efficiency through integrated multidisciplinary multi-professional input. The success of EPC initiatives was reliant on service delivery that supported tailored, needs-based and continuous quality interactions with the care team (Harris & Blakeman, 2001), and cooperation among care providers (Foster et al., 2008; Grimmer-Somers et al., 2008; Haines et al., 2010; Pierce, 2009).

While specific activities of the EPC program literature reflected the aspirational ideals of improved health service access (Lew, 2001; Lewis et al., 2003; Wilkinson et al., 2002) and integrative collaborative practice (Wilson et al., 2004), they tended to obscure the experiential nature of change (Foster et al., 2008). In doing so, the confrontation between structural level initiatives and the individuals most affected by them was not visible (Lockhart, 2002). For example, Haines et al. (2010) reported while EPC did increase access to Allied Health services for people with chronic disease, the duplication of efforts by Allied Health Professionals manifested when patients move between private and public health care sectors. Similarly, while GP's were reporting the effectiveness of EPC for multidisciplinary collaboration, speech pathologists were expressing concern about inconsistent GP referrals to Allied Health services under the program (Skeat et al., 2009). That is, while primary health care was being advanced as a conceptual model that included beliefs and processes that could shape how health care was structured (Thomas-Maclean et al., 2008), there was a dissonance between how GP's and Allied Health Professionals were perceiving the effectiveness of the initiative.

The hidden and entrenched ways of thinking and working in health care were influencing how primary health care initiatives could adopt collaborative multidisciplinary ways of working (Wilson et al., 2004). All forms of change invoke intended and unintended consequences (Germov, 2009; Giddens, 1993). Lockhart (2002, p.31) argued '*the boundary between what happens and what 'should' happen are blurred when ideological rhetoric becomes an unproblematic means by which change in the local context is described*'. These oversights were problematic for the implementation of primary health care because the prevailing medical-led, biomedically informed primary care approach was predominately advancing a chronic disease model (Armstrong, 2005; Foster et al., 2008; Gunn et al., 2006; Lewis et al., 2003; Menz, 2009; Pierce, 2009) rather than health promotion and disease prevention.

Although utilising a chronic disease approach, the model adopted by Aboriginal Community Controlled Health Organisations aligned better with the philosophy and principles of comprehensive primary

health care (Si et al., 2008). Evaluations reported this approach was effective in the prevention and management of chronic illness (Si et al., 2008). Nevertheless, it was a resource intensive model, and this led to calls for increased human and financial resources and an improvement in management practice (Si et al., 2008). Funding arrangements were influencing health service performance expectations and the public health discourse was now beginning to infiltrate communities. As the public became more informed the need to manage chronic disease more effectively served as a catalyst driving reform (Wagner et al., 1999).

As more chronic disease models were adopted, calls emerged for further research to determine whether the EPC and chronic disease management programs were enhancing clinical outcomes compared to standard practice (Menz, 2009). It transpired that EPC and chronic disease management initiatives were not embracing the full potential of multidisciplinary collaboration (Blakeman et al., 2001). Whilst evaluative EPC reports showed health assessments and care planning items were used by GPs for the management of patients presenting with a chronic disease, such as diabetes (Blakeman et al., 2001; Blakeman et al., 2001a; Blakeman et al., 2001b; Blakeman et al., 2002; Grimmer-Somers et al., 2008; Harris & Blakeman, 2001), the multidisciplinary case conference was rarely utilised (Mitchell et al., 2002; Skeat et al., 2009; Wilkinson et al., 2002). Accordingly, the recognised value and aspirations of interprofessional collaboration in primary health care were not being fully realised through the EPC delivery systems. In part, this was most likely because under the EPC scheme, contrary to GPs, Allied Health Professionals were not remunerated to attend case conferences (Lewis et al., 2003). At this point in time, interprofessional teamwork and collaboration in health were in the early days of development.

By the late 1990s, there was evidence that health promotion (Bensberg & Kennedy, 2002; Herrman, 2001; Murray & Jolley, 1999) and disease prevention had some correlation with improved health outcomes (Eakin et al., 2004; Eakin et al., 2008; Kolt et al., 2009; McKay et al., 2001; Muller et al., 2006; Oldroyd et al., 2008; Sanigorski et al., 2008; Timperio et al.,2004). The growing evidence based

inspired confidence for commentators to call for more initiatives to prevent disease (Awofeso, 2004; Walls et al., 2008), promote health (Herrman, 2001), increase primary health care (Crisp & Swerissen, 2003; Kang & Sanci, 2007; Kwok & Sullivan, 2007) and strengthen community engagement (Macdonald, 2008; Preston et al., 2009). There were some attempts to incorporate health promotion activities within hospital and emergency services (Playdon, 1997), however, as demand for these services was growing (Duckett, 2002), these approaches were unsustainable.

Overall, the GP-led models of chronic disease management and initiatives for improving public health had not provided answers to the issues of service fragmentation, lack of professional integration, financial pressures on the health system, and increasing levels of complex chronic disease (Watts et al., 2009). Some health experts were calling for improved integration of primary, acute and community care services (Dickson, 2009; Jordan et al., 2008; Swerissen, 2008; Swerissen & Crisp, 2004; Weeramanthri et al., 2003). In response, the Commonwealth government announced the need for a new quality and performance management system (Kalucy, 2004). Viewed in the context of the rise of neoliberalism and new public management, the focus on quality and performance management gave rise to the development and implementation of different models of integrated health care governance. One systematic review describing enablers and barriers to delivering integrated health services, identified three different models for integrated health care governance (Jackson et al., 2008). It reported the logical starting points for integrated regional governance arrangements were:

> *the need for a clear separation between governance and operational management; and the need for local communities with the vision, leadership and commitment to extend health service integration* (Jackson et al., 2008, p.57).

State governments were increasingly working with non-government providers and the private sector to maximise the effective use of scarce resources (Jackson et al., 2008; Jackson et al., 2008; Jackson et al., 2010). Managing the different modes of governance was challenging, inconsistent for facilitating collaboration and, at times, identified as a source conflict (Jackson, 2008). The need to expand and

reorientate health services was posing a significant challenge for governments, especially in terms of financing health expenditure growth and the integration of policy (Swerissen & Duckett, 2002).

Academics argued the primary health care approach to improving public health was being described in an idealised and abstract manner (van Eyk, 2001). The EPC items designed to facilitate multidisciplinary care, were intended to promote better management of, and improve, health outcomes for people with chronic illness (Newbury, 2000). Criticisms were levelled at the continual change and centred on claims the primary health care vision had not been well-articulated (van Eyk et al., 2001). Some warned the uncoordinated approach to primary health care implementation was likely to create 'reform fatigue' and 'low morale' within health professional groups (van Eyk et al., 2001). A critical gaze was turned on the sustainability of primary health care and service integration (Sibthorpe, 2005).

During the 2000 – 2009 period, the Commonwealth government focussed on planning, regulatory, and funding mechanisms for implementing primary health care (Russell, 2013). A range of new structural health reforms, outlined in the introduction chapter, were achieved when Commonwealth and state health care agreements were renegotiated to introduce systemic change designed to coordinate and improve integration across primary, acute and continuing care at the state and territory levels (Council of Australian Governments, 2011). Less attention was given to national funding for administrative and organisational strategies to promote integration of primary health and community care services (Lawn et al., 2009). It was a detrimental oversight given the health professions were still operating from entrenched ways of thinking and working in health care.

Evidence shows the longstanding cultural understandings held by the health professions were not translating well into the collaborative multidisciplinary practices required for primary health care (McKernon & Jackson, 2001). Both the medical (Martin & Sturmberg, 2005) and non-medical disciplines were trying to establish where and how they fitted into primary health care (Annells, 2007; Gibb, 1998; Keen, 2009; Reid, 2008; Taylor, 2007; Tse et al., 2003) and how their contributions could

assist in improving health outcomes (Boucaut, 1998; Clendon, 2004; Cusack et al., 1997; Hourihan et al., 2003; Jamison, 2001, 2005; Lloyd-Odgers, 2005; Sheppard, 2008; van Loon, 1998; Ward & Verrinder, 2008). There was evidence of conflict in multidisciplinary primary health care teams related to role boundary issues; scope of practice; and accountability (Brown et al., 2011). Identified barriers to conflict resolution included: a lack of time; workload; people in less powerful positions; a lack of recognition or motivation to address conflict; and avoiding confrontation for fear of causing emotional discomfort. Strategies for conflict resolution included: interventions by team leaders and the development of conflict management protocols; open and honest communication; a willingness to find solutions; and showing respect and humility (Brown et al., 2011).

Some authors questioned 'who' would lead primary health care (Dragon, 2007, 2008). Others described how their discipline might 'fit' within existing general practice frameworks to contribute to health promotion and disease prevention (Sweet, 2009). Ibrahim and Majoor (2002, p.20) boldly argued increasing the level of collaboration and consultation alone were unlikely to fix the health system because circumstantial evidence suggests it is 'rotten and corrupt'.

Although health reform was centring on multidisciplinary collaboration, the cultural differences across the various health professions constraining integrative collaborative practice were being identified and described (Fitzgerald & Teal, 2003). Differentiation was based on specialisation, generalisation, educational background, and employment status (Fitzgerald & Teal, 2003). These tenets were giving rise to cultural difference and ambiguity, which was sustaining fragmentation of the health professional groups (Fitzgerald & Teal, 2003). Similarly, Boyce (2006) reported the existence of a health 'profession community' subculture associated with the emergence of new organisational structures. She raised concerns about the authority relationship between medicine and the Allied Health Professions and put forward an alternative model for subculture development (Boyce, 2006). Studies now show that health professionals often cluster in disciplinary silos, form hierarchies and demonstrate stereotypical behaviours (Braithwaite et al., 2016). During the 1990-2009s, however, the

cultural and historical ways the health professionals were using to shape professional practice were not fully understood and were complicating the implementation of health reform and change.

In describing the experiences of one Australian health service transitioning to primary health care, Lockhart (2002) identified that a structural-local interface and an ideological-experiential dichotomy existed. Primary health care literature published during the 1990 - 2009- period provides clear evidence that alongside the perennial authority afforded to Doctors biomedical knowledge system for leading health reform, Allied Health Professional groups were drawing on different professional knowledge systems. Understood as discourse (Foucault, 1972), these different knowledge systems have the potential for being either complementary or competitive for understanding health, and how health professionals understand their role in day-to-day work in health care, service delivery and system reform. Professional discourse has been defined as,

> *the ways in which occupational and professional workers themselves are accepting, incorporating and accommodating the idea of 'profession' and particularly 'professionalism' in their work* (Evetts, 2003, p.760*)*.

The ways different health professional groups were interpreting the professional discourse to inform their habitual cultural ways of working was another one of the contextual factors influencing the implementation of primary health care practice.

During the 1990 – 2009 era there was a proliferation of primary health care programs that focused on chronic disease self-management, health promotion and disease prevention. Examples of these appear in Table 6.

Table 6 Examples of primary health care programs and initiatives between 1990-2009

Focus of Initiative	**Authors**	
Chronic Disease Management	Glasgow et al., 2008; Harvey et al., 2008;. Newman, 2008	
Specific Medical Conditions	Respiratory	Rudolphy, 2008
	Mental health:	Barkway, 2006; Blashki et al., 2005; Griffiths & Christensen, 2008; Gunn et al., 2006
	Diabetes	Cooper et al., 2007; Coulson et al., 2002
	Renal Conditions	Campbell et al., 2008
	Oral Health	Proctor et al., 2003
	Palliative Care	Campbell et al., 2007
	Cardiac Disease	Wells et al., 1997; Woollard et al., 2003
Disease Prevention	Armit et al., 2009; Crawford et al., 2008; Eakin et al., 2004; Harvey et al., 1998; Kilkkinen et al., 2007; Laatikainen et al., 2007; Marshall, 2005; Mason & White, 2008; Roseby et al., 2003; Salmon et al., 2007; Sanigorski et al., 2008; Smith et al., 2006; Wand & Murray, 2008; Wilson et al., 2010	
Health Promotion	Baade et al., 1996; Barkway, 2006; Bauman et al., 2009; Davies, 1991; Eakin et al., 2008; Fudge & Robinson, 2009; Jorna et al., 2006; Keleher et al., 2005; Marshall et al., 2005; Schroth et al., 2009; Schultz & Hanssens, 2009; Smith & Bollen, 2009; St Leger, 1999; Wake, 2009	
Target Groups		
Indigenous groups	Baeza et al., 2009; Campbell et al., 2007; Cooper et al., 2007; Curnin, 2005; Eckermann & Dowd, 1991; Flahive, 2009; Hunter et al., 2004; Leeder, 1998; Mikhailovich et al., 2007; O'Donoghue, 1999; Si et al., 2008; Spurling et al., 2009	
Older People	Nay, 1997; Sheriff & Chenoweth, 2006; Sims et al., 2000; Wells et al., 2009	
Children and Youth	Bernard et al., 2004; Doley et al., 2008	
Women's Health	Baum et al., 1998; Hirst et al., 1990	
Men's Health	Smith & Bollen, 2009	
Lesbian, Gay, Bisexual and Transgender Health	McNair et al., 2001	
People with an intellectual disability	Durvasula & Beange, 2001; Lennox & Kerr, 1997; Martin et al., 1997; Ziviani et al., 2004	

Within the literature outlined in Table 6 there is substantial evidence that GPs were making efforts to transition from primary care to primary health care (Baade et al., 1996; Davies, 1991; Marshall et al., 2005; Marshall et al., 2005; Marshall, 2005; Schultz & Hanssens, 2009; Sims et al., 2000; Wake, 2009; Woollard et al., 2003). Kamien (2002) developed a conceptual framework for general practice to assist the 'new kind of general practitioner' in their decision-making about the elements of the 'new primary care'. In this paper, 'new primary care' was described as a service approach that encompassed both primary care and population health. Whilst Kamien (2002) acknowledged that linking primary care with population health was not a new concept, he argued that the pairing had rarely been applied in the general practice setting. Recalling that language and terminology used in primary health care is largely contested, as explained in the introduction chapter, Kamien's (2002, p.857) notion of a 'new primary care', with its roots in the dominant medical model and biomedical discourse, is an example of the professional discourse shaping the way primary health care was being constructed as an extension of primary care. Whilst the Enhanced Primary Care Program and the Coordinated Clinical Trials, and some other measures were attempting to integrate services (Blakeman et al., 2001; Blakeman, Harris, et al., 2001a; Blakeman, Harris, et al., 2001b; Blakeman et al., 2002; Grimmer-Somers et al., 2010; Haines et al., 2010), the published literature was reporting other examples of service delivery initiatives focused on chronic disease management in ways that concentrated on general practice and overlooked multidisciplinary opportunities (Kamien, 2002; Turnbull et al., 2002).

During the period 2001-2009, the literature was acknowledging the challenges of caring for people with chronic disease (Harris & Zwar, 2007), the need for changes in approaches to practice (Dowell, 2009; Keleher, 2009), health knowledge (Adams et al., 2009; Whitehead, 2007), and ways clinicians interact with patients (Bodenheimer et al., 2002). The health disciplines were actively researching the outcomes of health promotion and disease prevention activities (Wilhelmsson & Lindberg, 2009). Nevertheless, a range of research papers (Chew & Williams, 2001; Kidd, 2009; Radford, 2009; Russell & Mitchell, 2002) were also explicit about GPs' unease with the directions of health reform. Based on reports that Canadian primary health care reforms were largely unsuccessful, Russell and Mitchell

(2002) posited primary health care reform in Australia was also unlikely to improve health outcomes. They reasoned the Canadian family Doctors were required to "*radically change the style, structure, and financial basis of their practices*" (p.442). The 'radical changes' being:

- Practices were to be staffed not only by physicians, but also practice Nurses and Allied Health staff;
- Phasing out of fee-for-service payments for local fund-holding; and
- The introduction of formal enrolment processes for patients.

Similarly, the doctoral study by Naccarella (2009) concluded that GP networks do matter in primary health care service provision. Naccarella (2009) argued the key qualities of GP work-related relationships, including competence, accessibility, goodwill, honesty, consistency and communication styles, had implications for other practitioners who work with GPs. It was a sentiment reflected in Russell and Mitchell's (2002) argument that maintaining a conservative model for family practice was required to ensure that GPs were not pushed into integration without the planning, nurturing and time to consider these changes. It was a stance that reflected the way Doctors continually used publications to assert their authority for leading health care reform. The Doctors, with their high degree of social power (Foucault, 1980; van Dijk, 2001), were expressing their dominance in the research and grey literature. It was an effective forum for Doctors to influence public health discourse and how primary health care was being implemented because of the value health professionals place on evidence-based practice. Social power has been theorised as a form of social control of some groups by another group (Foucault, 1980; van Dijk, 2001). The momentum for calls to recognise Doctors' medical authority and legitimise their leadership role in primary health care reform therefore grew within the Australian published literature.

Within the published literature there was a notable push-back by GPs to ongoing health reforms in the Divisions of General Practice Program. For example, Sturmberg et al. (2003) lamented that GPs were increasingly having their traditional healer role disrupted by new ideas and system pressures

due to reforms of the health care system. Chew and Williams (2001) and van Der Weyden (2003) portrayed a health system lurching from crisis-to-crisis because of health reform measures and noted that GPs were protesting they were undervalued, overworked and no longer in control.

The protests of GPs can be understood as a powerful dominant group trying to protect their vested interests. While Kamien's (2002) 'new primary care' was intended as a conceptual framework for general practice to assist the 'new kind of general practitioner', it can also be understood as a pattern of discourse control (van Dijk, 2001). Discourse control is a form of:

> *power to control various dimensions of speech and talk itself: which mode of communication may/ must be used (spoken/written), which language may/ must be used by whom (dominant or standard language, a dialect, etc)* (van Dijk, 1998, p.69).

Other examples of discourse control are evident in the literature calling for health system reform. Chew and Williams (2001) claimed one cause of the discontent that Doctors were facing was the inclusion of other health professionals in the primary health care field. van Der Weyden (2003) argued there was a growing lack of professional autonomy within general practice because of primary health care reform. Thus, while there was evidence of early service delivery initiatives focusing on chronic disease management, their implementation tended to concentrate on general practice leadership and overlook opportunities for non-medical providers to support self-management and behaviour change.

A parallel debate was concurrently emerging during the early phases of primary health care implementation. Some GPs were raising concerns about the health reform directions (Chew & Williams, 2001; Coote, 2003; van der Weyden, 2003) and citing integration at the professional level as one of the challenges to their autonomy (Lewis et al., 2003; Sturmberg et al., 2003). Researchers investigating issues that circumscribed the complexities of caring for people with chronic illnesses and comorbidities, were also making calls for health care to move away from the heavy reliance on the curative biomedical approach (Williams & Botti, 2002). The mismatch between the medical treatment

of chronic conditions, how they were characterised, and their inability to be cured was recognised (Williams & Botti, 2002). Health promotion in General Practice was now being researched to expand understanding of preventative health care versus curative medical care based on the biomedical model of disease (Raupach et al., 2001). A growing body of research was showing that the biomedical models used in general practice were impeding progress (Mills & Harvey, 2003; Raupach et al., 2001; Williams & Botti, 2002). The overarching philosophy of medicine to cure was being challenged and evidence was showing this approach was not appropriate for most patients because of their underlying chronic conditions. There were calls for more investigations into how episodic care could be integrated into the ongoing care of people with comorbidities (Harris & Zwar, 2007; Wise & Nutbeam, 2007). Others were calling for a shift away from treating and curing episodic illness towards preventing illness, promoting health and supporting people through a continuum of care (Ewald et al., 2001; Mills & Harvey, 2003).

In 2008 and 2009, the National Health and Hospitals Reform Commission (NHHRC) released two reports: The Healthier Future For All Australians Interim Report (Australian Government, 2008) and their Final Report (Australian Government, 2009b). As a result, a suite of articles began to appear in the published literature that responded negatively to the proposed new primary health care organisations and the consequent primary health care reforms. Some authors noted that primary health care had improved health outcomes and these outcomes were the result of primary medical care (Bonney & Farmer, 2010; Penington, 2009; Radford, 2009).

A discursive focus on health and wellbeing was beginning to manifest overtly in bureaucratic media. As politicians have control over parliamentary discourse and preferential access to mass media, discourses of health and primary health care began to infiltrate the public sphere. In these communicative situations these discourses did not work to reproduce the power of medical authority. In turn this gave rise to explicit concerns being published about the language used in the new proposed primary health care organisations. For example, Kidd (2008) argued that terms such as 'primary health

care' and its associated wording in the NHHRC Report would disenfranchise GPs because there was an overall lack of a specific focus on the role of GPs in leading primary care teams. The National Health and Hospitals Reform Commission Report (Australian Government, 2009b) also agitated the acute sector with calls for more beds in hospitals, rather than the focus on primary and community health care (Gough, 2009; Sammut, 2009).

There is clear evidence in the early published primary health care literature that medical clinicians were clustering in professional silos to protect their position in the hierarchy (Braithwaite et al., 2016). A professional discourse that reproduced dominant constructs of the professional hierarchy was in existence. It was a hierarchy where medicine was recognised as the authority, medical models were accepted as legitimate and biomedical discourse was uncritically imported into early attempts to transition to primary health care models. The structural approach used to drive early primary health care reform was ineffective. The health professions adopted an assimilationist perspective rather than the critical one required to address the inherent cultural ways of understanding service delivery and professional hierarchies. Kidd (2008) asserted the biggest challenge for the reform process was bringing together the different cultures of the various stakeholders in primary health care and those who were involved in direct patient care.

By the end of the 2001-2009 period, there were intense discussions around key policy areas as urgent priorities for reform (Armstrong, 2003, 2005, 2008; Lilley & Stewart, 2009; Naccarella et al., 2008; Travers et al., 2009), new frameworks and partnership approaches (Jolley et al., 2008), and regional structure change and primary health care reform (Kalucy, 2009; Taylor et al., 2001). A new culture of primary health care research and evaluation was being established (Eckermann, 2008; Eckermann & McIntyre, 2007; Murray & Jolley, 1999; Rissel et al., 1999). As a result, public health discourse was beginning to challenge the episteme of professional discourses giving rise to hierarchical health care in Australia. The following period was characterised by more intensive structural reform in primary health care. The next section addresses how the biomedical discourse and long held professional

discourses may have challenged the introductory period of the Medicare Locals, and shaped the socio-political context in which Allied Health Professionals were to lead in primary health care as Board members.

Section 3. From 2010-2015, a paradigm shift in understanding the values: Health service from service to communities

In this section, articles from 2010-2015 were critically reviewed to identify how Allied Health Professional's knowledge and value systems might contribute to primary health care being implemented within a socio-political context influenced by various biomedical, neoliberal and professional discourses.

At this point in time, the cure philosophy of medicine was being overtly and directly challenged. It was a time characterised by the new philosophy of equity, community participation, and health promotion (Hickie, 2015; Reeve et al., 2015). New expectations from the primary health care community were being clearly defined in terms of the social determinants of health (Jackson et al., 2010). The 2010-2015 era signified the introductory and operational period of the Medicare Locals and reflects the challenges associated with implementing primary health care reform that required a paradigmatic shift in health service delivery: from service to communities.

The Australian Government is one of the most powerful groups influencing health care, the health system and the health services. Foucault (1977, 1980) argues that power can only be enacted and diffused rather than possessed and enforced. Different forms of power influencing primary health care reform were therefore everywhere and diffused in language. So far, the introduction to this thesis has established how the Australian government exercised its sovereign power through controlling public and bureaucratic discourse about public health. Similarly, the first section of this literature review showed how Doctors, as another powerful and elite group, exercised their disciplinary and social power to resist and control the public health discourse in the published literature. These exemplify

how different stakeholders' access, participate and control discourse to pursue vested agendas (van Dijk, 1993).

Despite the resistance from Doctors, the Australian government through its sovereign power was able to control the context in which health care was to operate. Primary health care organisations, now known as Medicare Locals, were proposed in 2009 with the clear political mandate to make health care more accessible, improve multidisciplinary collaboration and the overall health of Australians (Australian Government, 2009b). The Medicare Locals were to achieve this by being accountable to local communities and ensuring services were effective, affordable and of high quality (Australian Government, 2011b). This might appear as a top-down display of power and control in which the government had made decisions about the form and function that primary health care would be taking. However, Foucault's (1980) argument that power cannot be enacted because it is diffused everywhere, is evident when the mandate for Medicare Locals' to improve public health is considered against the backdrop of the context in which primary health care was to be implemented. It was a complex socio-political context characterised by hidden and competing biomedical, public health, professional and neo-liberal discourses. Thus, establishing the network of Medicare Locals across Australia, and restructuring the funding models, was designed to reinforce the legitimacy of public health discourse and give authority to all health professions for improving Australia's health and wellbeing through a primary health care approach (Ashcroft, 2015).

Some of published literature during the 2010- 2015 period therefore focussed on hope these organisations would change how primary health care was understood (Sturmberg et al.,2010) and structured under the influence of primary care and the biomedical discourse (Armstrong & Kendall, 2010; Spigelman, 2010; Sweet, 2011; Yen et al., 2011). There were clear aspirations that the network of Medicare Locals would achieve broad and lasting changes to enable primary health care to respond to some of the deficits that had been highlighted in the system (Robinson et al., 2015). There were some concerns about how Medicare Locals' would operate (Dragon, 2011) and agreement that new

approaches were required to address: the fragmentation within the health sector, increasing numbers of people living with chronic and complex diseases, and shortages in the health workforce (Robinson et al., 2015).

The National Health and Hospitals Reform Commission's (NHHRC) report *A Healthier Future for All Australians* (Australian Government, 2009b) made a strong case for further health reform. The Report (2009b) recommended the commonwealth, state and territory governments review the health system under three goals:

- Tackling major access and equity issues that affected health outcomes;
- Redesigning the health system to respond better to emerging challenges; and
- Creating an agile and self-improving health system for long-term sustainability.

The Commission (2009b) focused on five priorities for improving access and equity:

- Improving health outcomes of Aboriginal and Torres Strait Islander people;
- Improving care for people with a mental illness;
- Supporting people living in rural and remote areas;
- Improving dental care; and
- Providing timely access to quality care in public hospitals.

In redesigning the health system, the Commission (2009b) noted three design elements:

- Embedding prevention and early intervention;
- Connecting and integrating health and aged care services; and
- Reshaping Medicare to create and support a comprehensive primary health care platform.

To create an agile and self-improving health system, the Commission (2009b) recommended:

- Strengthened consumer engagement and voice;

- A modern, learning and supported workforce;
- Smart use of data, information and communication;
- Well-designed funding and strategic purchasing; and
- Knowledge-led continuous improvement, innovation and research.

Release of the NHHRC Report (Australian Government, 2009b) served as a catalyst in research and health care commentary in the published literature and as a result, different aspects of the new primary health care reform agenda emerged.

Through the 2010-2015 era a large body of literature was discussing the health service considerations associated with establishing a new primary health care network. Much of this literature was focussed on health service delivery, including concerns about the organisational structure of health services, workforce profile, planning and development (Aggar et al.,2015; Gordon et al., 2014; Naccarella et al., 2010; Naccarella et al., 2011; Tham et al., 2014; Whitford et al., 2012), and how they could improve integration (Fuller et al., 2014; Nicholson et al., 2014; Russell et al., 2010; Short et al., 2015; Sturmberg & Lanham, 2014; Sturmberg et al., 2010) and performance within the Medicare Locals.

The meso-level regional governance structures proposed by the Commission's report (2009b) were supported (Jackson et al., 2010; Willcox et al., 2011) and the Medicare Local organisations were established. These organisations were responsible for funding allocations, service delivery and implementing integrated, collaborative, multidisciplinary practice to reduce service fragmentation. Donato and Segal (2013) noted that primary health care organisations needed to incorporate key structural elements, such as governance and purchasing. These responsibilities, critical for primary health care to be devolved to a meso-level organisational structure, could allow capitated single fund holding arrangements; blended payment methods for reimbursing providers; the establishment of a national quality and performance framework; and the development of a primary health care infrastructure. Nicholson et al. (2014) proposed elements for effective and sustainable integrated health governance models. These included: joint planning; integrated information communication

technologies; effective change management; shared clinical priorities; aligned incentives; the provision of care across organisations for a geographical population; use of data measurement tools; professional development opportunities that supported joint collaborative working arrangements; consumer/patient engagements models; and adequate resources to support innovation (Nicholson et al., 2014).

Collaboration between health professionals across organisational boundaries remained challenging and power dynamics and trust were affecting the strategic choices made by each health professional about whether to collaborate, with whom, and to what level (McDonald et al., 2012). One qualitative case study found power was being used by health professionals to protect autonomy and reduce dependency on other health professionals (McDonald et al., 2012). Another study reported, that even when arrangements are in place to provide increased opportunities for access to allied health, they are insufficient for building relationships or effectively sharing roles as part of a patient care team (Harris et al., 2010). Facilitation of collaborative practices was feasible but constrained by barriers of communication and trust (Harris et al., 2010).

Some argued for reasonable sized health care networks that would address the needs of the community rather than the needs of providers (Perkins & Lyle, 2010). Others made calls for primary care networks to be integrated with hospital networks and to be tasked with securing health care for their community through health promotion, primary health, community, hospital and aged care (Jackson et al., 2010). Some of this literature focussed on the needs, perspectives and activities of the health organisations to reorient their services (Booth et al., 2010; Carroll et al., 2015; Jowsey et al., 2011; Naccarella et al., 2008; Reeve et al., 2015) rather than the needs of consumers and the communities in which they would be located. These were signs a paradigm shift was occuring; a change in assumptions about the entire social system for understanding health, the health system and primary health care reform.

It was this paradigm shift in discussions and research about health service delivery, where the concern for service shifted to communities, that invigorated debates about integrative collaborative practice. Integration, another key topic of the NHHRC report (Australian Government, 2009b) more fully explored in the latter sections of this chapter, was supported at the level of the health sector (Nicholson et al., 2012) and between health professionals (Bonney & Farmer, 2010). The latter argued that just putting various health professionals under the one roof would not assist integration (Bonney & Farmer, 2010). This was an acknowledgement that cultural reform within the health professions was as important as structural reform. Workforce development was therefore seen as a priority to improve integration and planning (Naccarella et al., 2011). Chan et al. (2011) proposed more systematic development and interdisciplinary education within the proposed primary health care organisations, with funding to support this. Conversely, Naccarella et al., (2011) argued that primary health care organisations lacked the authority, power and appropriate funding to do workforce planning and that any attempt to undertake workforce planning had to align with service planning. Whilst this body of evidence reflects different standpoints, it shares similarities about the need to reengineer primary health service delivery.

Medical authors once again used publications as a medium to emphasise the importance of local, accessible, trustworthy peer-reviewed evidence for shaping health system reform, preventive health and primary health care nationally (Kalucy & Bowers, 2010; Mazza & Harris, 2010; Whitford et al., 2012). Though committed to reengineering primary health services they were once again intent on re-asserting their legitimate leadership in primary health reform. Dunbar (2011) argued that health reform in the UK, and the introduction of primary health care organisations had stifled innovation, creativity, motivation and morale for GPs and other front-line staff. He argued the government should restructure the Division of General Practice rather than establish Medicare Locals (Dunbar, 2011). Similarly, Booth et al. (2010) claimed while there had been a lot of planning and plenty of change, there was no cause and effect relationship between the two to achieve improvements in health care. These sentiments towards change were echoed by Dadich and Hosseinzadeh (2013), who argued

health reform had been associated with volatility and instability, especially in terms of staff turnover, poor morale, and uncertainty for the workforce, which had deleterious effects for health care consumers. These are further examples of what power theorists would acknowledge as some agents, in a specific context, and given their extant knowledge and beliefs, resisting the intentions of those in power (van Dijk, 1993).

The period 2010-2015 was challenging for primary health care because it was difficult to ascertain its impact on improving public health. Measures of these 'big picture' effects involved contiguous outcomes such as: increasing the health literacy and skills of the community (Dennis et al., 2012); increasing health enhancing behaviours (Walker, Hernan, Reddy, & Dunbar, 2012); improving quality of life for individuals (Bird, Noronha, & Sinnott, 2010); decreasing rates of preventable conditions and issues (Burgess et al., 2015); increasing supportive health environments (Carroll et al., 2015); increasing social capital (Smith, 2014); increasing planned and managed care (Booth et al.,2013); and decreasing acute, episodic care (Lawless et al., 2014). However, there was a significant gap in the literature on these measures and the level of evidence provided was comparatively weak. It was against this paucity of strong evidence that the Medicare Locals had been established (Bywood et al., 2013; Javanparast et al., 2015; Robinson et al., 2015). Commentators were beginning to reflect on the broader primary health care journey so far (Bryce, 2010; Li, 2011; Macintyre, 2011), question where Medicare Locals were heading (Smith, 2011) and consider whether they were addressing health inequities (Povall et al., 2013) or impacting on health-enabling lifestyle patterns (Alexander & Coveney, 2013; Kalucy, 2009). Povall et al., (2013) identified that different groups were using different modes of operation, language and values to address health inequity and, reflecting neoliberal tenets, argued these needed to be acknowledged within impact assessments as determinants of equity.

Bennett (2013) summarised Australia's health reform decade as an era for taking responsibility for preventative health, connecting care through the establishment of Medicare Locals, facing the ongoing inequities in health and driving quality performance through a transparent nationally

consistent approach to financing. Research-informed primary health care activity and robust evaluation of the outcomes of reforms, and health system performance, had become national priorities (Bath & Wakerman, 2015). Brown and McIntyre (2012) identified the themes underlying much of the Commonwealth funded research were representative of the priority areas of the National Primary Health Care Strategy. The published literature tended to report a range of outcomes, often focusing on a selective view of primary health care. Lawless and colleagues (2014) developed a model for evaluating the effectiveness of comprehensive primary health care in local communities, including activities for:

- Providing care to people with a health-related concern;
- Preventing illness and injury; and
- Promoting health and wellbeing.

In the following subsections the Lawless model (2014) has been used to organise a broad body of literature reporting specific primary health care programs and activities.

Providing care to people with a health-related concern

Most papers within this category reported on primary health care activities targeted towards addressing chronic disease. Chronic diseases were emerging as the leading cause of illness, death, and disability and in 2016 accounted for 90% of all deaths (Australian Institute of Health & Welfare, 2016). They were known to be typically long-lasting conditions with persistent effects that had linked social and economic consequences and were impacting negatively on people's lives (Australian Institute of Health & Welfare, 2016). Chronic diseases were becoming increasingly common in Australia and creating pressures on the health sector. While the previous decade had seen the emergence of self-management in chronic disease, it became apparent that more attention to preventive activities and coordinated management was required (Bennett, 2013).

To respond to the rising incidences of chronic disease, researchers sought to better understand the health needs of different communities. Evidence reporting community chronic disease profiles (Bath

& Wakerman, 2015; Ghosh et al., 2014; Javanparast et al., 2015) and population planning (Javanparast et al., 2015) emphasised the importance of community participation in planning and implementing local community programs to improve and maintain their health. Participation at a substantive level began to become a prominent feature of primary health care as community members became active participants in determining priorities and implementing solutions (Bath & Wakerman, 2015). A raft of studies soon emerged reporting activities designed to target specific chronic disease conditions. Examples included, chronic disease self-management programs (Stone & Packer, 2010) and early awareness and detection programs (Chen et al., 2010; Schattner et al., 2010).

Specific chronic disease self-management approaches used in Australia, included peer-led groups (the Stanford model) (Franek, 2013), care planning (the Flinders Program) (Reed et al., 2018), brief primary care approaches (the 5A's) (Gray et al., 2016; Stugiss & van Weel, 2017), motivational interviewing and health coaching (Lawn & Schoo, 2010). Evaluations of some of the larger primary health care initiatives also began to appear and reported findings and outcomes of various EPC initiatives (Grimmer-Somers et al., 2010; Haines et al., 2010; Skeat et al., 2010) and chronic disease management programs (Boudville et al., 2013; Morrissey et al., 2015; Price et al., 2014; Treloar et al., 2014). Emerging evidence was suggesting that, overall, activities providing care to communities through the EPC and chronic disease self-management initiatives were addressing two key barriers of access to Allied Health services – costs to patient for access and patient awareness of benefits (Haines et al., 2010; Skeat et al., 2010). Of concern, however, was the finding that gap payments were deterring economically disadvantaged consumers from attending appointments with Allied Health Professional services (Haines et al., 2010).

Information gained from such research also suggested current knowledge for addressing chronic disease was based on linear and simplified ways of understanding behavioural choices (Gray et al., 2016). There was a gap in knowledge about how to change lifestyle behaviours. More sophisticated models for better recognising the complex nature of assisting patients in behaviour change have since

been developed (Stugiss & van Weel, 2017). In turn, there was a system reliance on service delivery models and funding arrangements that favoured acute and short-term responses to health care based on a selective approach to primary health care. A good example of this selectivity in primary health care was the body of published literature reporting activities that act to prevent illness and injury.

Preventing illness and injury

Primary prevention services and activities include vaccination and screening programs, dental hygiene education and oral health services, nutritional advice and food supplementation, access to preventive services such as psychological counselling, and the provision of information on behavioural and medical health risks (WHO, 2018). The Federal Budget measures during 2010-2015 period consistently promoted incentive payments to GPs for screening of cancers, immunisation, and after-hours GP services. Various screening (Malseed et al.,2014; Smith et al., 2015), disease and illness prevention activities (Burgess et al., 2015) and lifestyle modification programs (Dennis et al., 2015; Malseed et al., 2014; Schutze et al., 2012; Tall et al., 2015) therefore emerged.

Evaluations showed the effectiveness of increasing community engagement and providing initiatives to improve peoples' knowledge of chronic disease and associated risk factors (Malseed et al., 2014). Individuals who participated in a community-based health screening activity were doubly likely to return to a clinic for a full health check or follow up services compared with those who did not participate in a screen (Malseed et al., 2014). Community events that included opportunities for health education and health screening were also found to be effective in improving chronic disease and had the potential to increase community engagement with health services (Malseed et al., 2014).

Despite gaps in knowledge about how to change lifestyle behaviours (Gray et al., 2016), there was emerging evidence that community participation programs were effective in reducing the risk factors of chronic disease (Hetherington et al., 2015; O'Connell & Gaskin, 2010; Taylor et al., 2018; Walker et al., 2012). To ensure their success each of these programs shared commonalities in how they were implemented and relied on strong consumer engagement and participation by health professionals.

Their success was largely attributed due to the involvement and trusting relationship between community members and health professionals (Taylor et al., 2018). It soon became apparent, however, that success was also contingent on people and a community's capacity to understand basic health information and services in order to make informed decisions about their physical and mental health and wellbeing.

Linked to developing activities that act to prevent illness and injury, were studies focused on investigating health literacy within the context of primary health care (Evangelista et al., 2016; Hill et al., 2011). One systematic review of health literacy programs sought to ascertain the effectiveness of a health literacy program to assist people make lifestyle changes related to smoking, nutrition, alcohol, physical activity and weight (Dennis et al., 2015). The results described how different health professionals provided health literacy interventions and were able to demonstrate improvement in health literacy (Dennis et al., 2015).

Providing brief lifestyle interventions fitted well with routine health-check consultations; however, the degree of understanding, acceptance and referral to programs was dependent on the level of facilitation provided by program coordinators (Schutze et al., 2012). Burgess et al. (2015) noted the lack of referral services for people at risk of developing vascular disease threatened maintenance of lifestyle changes. In line with the contractual requirements for Medicare Locals to improve population health planning, needs assessments and work across health organisations and networks (Australian Government, 2013a), Burgess et al. (2015) suggested they could play an important part in facilitating lifestyle modification programs. This was a good example of sections of the health field operationalising primary health care discourse to influence the operations of the Medicare Local organisations, who were soon to be criticised by Horvarth (2014) for their performance failure.

The primary health care field was embracing prevention and community education programs; however, state-managed services were tending to be selective in their approach to activities and operate as hospital outreach services for those with existing chronic disease. To this end, the literature

was largely focused on Doctors leading primary health care initiatives and the effect the public health mandate was having on general practice. There were, however, some examples of services operating from a health promoting and disease prevention community-engaged model and these are examined in the next section.

Promoting health and wellbeing

Activities designed to promote health and wellbeing in primary health care suggests a concept of health aligned with the 'Health For All' approach of primary health care (Baum et al., 2016). Activities promoting health and wellbeing demanded active engagement with communities and their involvement as active agents in their health. The inequities in the health and wellbeing of Australian families who live in disadvantaged communities were growing (Furler & Palmer, 2011; Sweet, 2010) despite a range of government initiatives designed to alleviate the impact of disadvantage and social exclusion (Australian Institute of Health & Welfare, 2016). By now there was a growing awareness and increasing understanding of the complex and inter-related issues that contribute to poor outcomes for vulnerable disadvantaged families (Marmot, 2011).

Community-based programs addressing lifestyle dimensions, such as promoting physical activity and diet (Hetherington et al., 2015), and reducing smoking and alcohol use, were becoming valuable strategies for reducing risk factors associated with chronic disease. Men's Groups and Sheds were a good example of programs that encouraged active engagement and involvement in personal health outcomes. The Men's Shed movement, established in 1993 in Australia to improve their overall health and wellbeing (Milligan et al., 2016; Waling & Fildes, 2017), has continued to grow and currently, at the time of writing, receives financial grants from the Commonwealth government. They represent an ever-growing social, health and wellbeing community service across Australia because of their effectiveness in encouraging social activities and friendships, while providing health information to their members (Beyond Blue, 2013; Southcombe et al., 2015).

Some of the most innovative health promoting activities and programs that have established best practice community participation relate to interventions emerging from Aboriginal and Torres Strait Islander communities (Baum et al., 2013). Southcombe et al. (2015) and Cox et al (2019) investigated capacity-building at the community level in Aboriginal and Torres Strait Islander Men's Sheds and reported they educated and empowered men to better connect with family and community. They also reported better health and improvements in social, cultural, emotional and economic wellbeing (Southcombe et al., 2015; Cox et al., 2019). The success of these approaches seems to be the 'top-down' policy-oriented and 'bottom-up' practice-oriented, strategies towards establishing health promoting activities and programs. MacDonald and colleagues (2016) exemplify this approach in the way healthy food policies were implemented within an Aboriginal community-controlled organisation in ways that aligned with healthy community, family and peer dietary practices. These examples show how service integration and community partnerships are critically important for successful local program implementation (Southcombe et al., 2015; MacDonald et al., 2016). The next section presents another important paradigmatic shift that was evident within the literature.

Section 4. Another paradigm shift: Beginning to move from professional silos to integrated collaborative practice

The need for primary health care services to develop more integrated and comprehensive case management approaches to care was being acknowledged (Baum et al., 2016). The selective approach to primary health care was no longer viable and the shift to comprehensive primary health care was being enacted. Health equity and a broader view of health incorporating the social determinants of health, multisectoral action and the participation of empowered communities were being prioritised (Baum et al., 2016; Freeman et al., 2016). To minimise health inequities, action on social determinants needed to be an integral component of the reform (Baker et al., 2018; Rasanathan et al., 2010). Action on the social determinants of health to implement a primary health care approach required intersectoral collaboration, universal coverage, service delivery reform and reconfiguring of health

leadership. For these objectives to be realised and fully embedded in primary health care practice the system needed to be integrated and characterised by collaborative, interprofessional practice (Bentley et al., 2018). It was to strengthen these aspects of primary health care and improve population health planning that the Commonwealth government had established the 61 Medicare Locals.

Integrated health care

The World Health Organisation (WHO, 2008b, p.1) had defined integrated care as:

> *the management and delivery of health services so that clients receive a continuum of preventive and curative services, according to their needs over time and across different levels of the health system.*

Leutz (1999) provided a broader definition by referring to an inter-sectoral approach to align the health care system (acute and primary health care) with other broader human service systems (education, housing, and town planning) (Leutz, 1999). It resonated with the Declaration of Alma-Ata's (WHO, 1978) definition of integrated care that also referred to an inter-sectoral system approach with a community and socio-political focus. Australia drew upon this latter definition to implement an integrated approach to health care.

During the 2010-2015 period, integrated health care was a strong focus of national health reform in Australia (Nicholson et al., 2012). Building integrated services in primary health care was one of the foundational strategies for improving accessibility and establishing a high-quality and affordable health system (Powell Davies et al., 2008). The National Health Reform Agreement (Council of Australian Governments, 2011) aimed to deliver reforms in primary health care through funding and delivery of health and aged care services to reduce service fragmentation (Bywood et al., 2013). The Medicare Locals were intricately involved in horizontal and vertical integration and required to operate seamlessly between health care providers (GPs, Nurses and Allied Health Professionals) and

across different levels of the health care system (primary health care, acute and tertiary care) (Brown et al., 2013).

Fulop et al. (2005) provide useful dimensions for describing the approach to service integration that was taken:

- Functional integration occurs at the macro level of health care;
- Organisational integration occurs at the meso level of health care, such as in the form of alliances between services;
- Service integration occurs at the meso and micro level of health services and includes alliances between health professionals working within and between services; and
- Clinical integration occurs at the micro level of health care in forms such as shared care pathways within teams.

At the macro level, that is the level of government, integration in primary health care occurs at a system level. The Medicare Locals were established at the meso organisational level of health care, and integration was achieved through commissioning of services, governance arrangements, Memorandums of Understanding, or service agreements (Brown et al., 2013). The driver for tackling service fragmentation and linking various stakeholders in primary health care at the local and regional level was to minimise delays, duplication and the waste of resources (Eastwood, 2017).

Fragmented health care was being reported as a continuous problem (Eastwood, 2017) and there were calls for consumers to have access to services linked across different levels (Oliver-Baxter et al., 2013b; Oliver-Baxter et al., 2013). This could only be achieved through integration at the meso level, which occurs horizontally between health professions, and vertically across hospital and primary health care services (Brown et al., 2013; Oliver-Baxter et al., 2013b). At the micro level, integration was accomplished via services, clinicians and other individuals providing direct care. For example, private nursing agencies, Allied Health services, general practice, community health services, and hospitals. These were signs a paradigm shift was occuring; movement away from the professional silos that were so evidence in the 1990-2009 era of health reform, toward integrative practice,.

Given the multi-layered dimensions of service integration, governance arrangements for the Medicare Locals were crucial to their operational success. Used in this context, the term governance refers to "*any mode of coordination of interdependent activities*" (Lemke, 2002, p.34) and signifies a mechanism to control, manage or regulate problems, at a local, national, or organisational level. This conceptualisation of governance differs from Foucault's (1979) use of the term to theorise the shifting power relations between the state, interest groups and society, a notion which is further explained in the next chapter.

Power relations, as described by Foucault (1979), and their associated modalities through governance, as described by Lemke (2002), were an important aspect of initiating integration at the meso level. Medicare Locals were tasked with promoting coordination of primary health care beyond general practice by connecting health professionals, consumers, hospitals and aged care, community, researchers, workforce and Aboriginal and Torres Strait Islander organisations (Australian Medicare Local Alliance, 2012). Wiese et al. (2011) also highlighted the importance of Medicare Locals connecting with private and publicly funded health providers which the Division of General Practices had failed to engage or integrate with, either at a governance or an organisational level. The shift in micro-level interactions between the health professions was becoming a strong and determining factor in whether the governance aims for collaboration and partnerships were to be achieved or impeded (Supper et al., 2014).

Collaboration and partnerships

Collaboration and multidisciplinary team-based arrangements are key factors in the delivery of ongoing care for consumers with chronic and complex diseases (Rieck, 2014). However, there are challenges associated with delivering coordinated multidisciplinary health care that transcend organisational and sectoral boundaries where there are competing policy, funding and management arrangements (McDonald et al., 2012). Governing regimes were promulgating primary health care discourses. However, the prevailing biomedical discourse was still influencing the perceived legitimacy and effectiveness of collaboration and partnerships. The fragmented way care was delivered, without

coordination, in the public, private, acute and community settings seemed to be impeding collaborative partnerships and working to sustain professional silos (Australian Government, 2009a).

Developing partnerships to implement health promotion programs are challenging (Eastwood, 2017). Dennis et al. (2015) explored key stakeholder experiences of partnerships during the implementation of a healthy eating, activity and lifestyle program. For community health programs to be successful, they found it was vital that partnerships met inter-organisational needs (Dennis et al., 2015). Establishing effective partnerships were contingent on time and dependent on people to champion and lead change (Dennis et al., 2015). Ineffective partnerships have been found to lead to fragmented and inefficient service response (Eastwood, 2017). Lobbying from researchers and service providers resulted in increased national policy commitment to community-led, multi-disciplinary, cross-sectoral, integrated service delivery (Eastwood, 2017). Eastwood used a collaborative design to develop a service proposal based on building partnerships, identifying outcomes and contextual factors, and implementing consultation forums and interagency planning. The resultant design proposed initiatives and service activities that were sustainable, built partnerships within the primary health care sector, provided capacity building opportunities with families and communities, and established organisational structures and processes that provided options for future growth and organisational change (Eastwood, 2017).

A careful reading of the literature makes visible the way service integration was at odds with the different ways health professionals developed their understanding of primary health care. Grimmer-Somers et al. (2010), reporting on an EPC, concluded that integrated Allied Health and general practitioner guidelines-based care in general practice clinics had the potential to improve patient access to Allied Health care and promote the role of integrated care. However, this was not the experience of others working in these programs. Skeat et al. (2010) found speech pathologists had concerns about how integration was understood, access to programs, and concluded that education

around eligibility, access and reporting requirements were needed for all parties to reduce frustration and facilitate sustainability (Skeat et al., 2010).

Whilst multidisciplinary care had been acknowledged as central to the delivery of effective and efficient primary health care, there were reports it was difficult to achieve and maintain in everyday practice (Cheong et al., 2013). A study of the role of patients in multidisciplinary care found although patients were accessing multiple health care professionals, they considered the collaboration between professionals was poor (Cheong et al., 2013).

The various mechanisms trialled to increase collaboration and partnerships between professions and services achieved limited success (Gill et al., 2017; Nancarrow et al., 2015). Nancarrow et al. (2015) evaluated whether the co-location of community and Allied Health Professionals in general practice settings resulted in better service integration and improved patient access and experience. No financial or policy levers at the primary or community level were available to truly integrate care around the patient (Nancarrow et al., 2015). However, their project exemplified the need for patient centeredness at the clinical, professional, and organisational levels to effectively improve the experience of integration.

Another mechanism to increase integration between the health professions working in primary health care was the introduction of the Australian government funded GP Super Clinics in 2008 (Butler, 2010). Modelled on the UK Darzi polyclinic model (The Lord Darzi of Denham, 2007), the intention was to co-locate general practice and Allied Health services (Butler, 2010). In the 2008/09 Federal Budget, $242.1 million was allocated to establishing 31 clinics over four years. This was expanded to 36 in 2009. In the 2010/11 Budget further funding was allocated for another 23 clinics and to provide infrastructure for 425 existing primary care clinics to enable them to provide GP Super clinic style services (Butler, 2010).

The GP Super clinics demonstrated the disparities between the health profession's authority, legitimacy and power. There were challenges associated with implementing the GP Super clinics. One health leader stated that the multidisciplinary and integrated focus of care would be 'confronting' for some clinicians due to magnitude of cultural change (Sweet, 2009). The President of the Australian Medical Association (Australian Medical Association, 2008, p.1) voiced concern for the clinics and stated,

> *the idea that the GP Super clinics would be a one-stop-shop for patients was false and misleading and that patients needed to see their GP first and not another health care professional. She also noted that GP's were the best medical experts, the most effective gate keepers and had the competent training to treat patients holistically.*

Six GP Super Clinics were evaluated for their level of integration and service alignment with community need (Gill et al., 2017). Only two used local research as the basis for their decisions on service development (Gill et al., 2017). Patients and practitioners considered service co-location was convenient Gill et al. (2017). From the health professional perspective, Nurses working in these clinics were reported to be key to facilitating the integration of multidisciplinary care. They considered communication, information sharing, trust, familiarity and the importance of process, the keys to successful integration (Gill et al., 2017). However, from the patient perspective, integration was not occurring (Gill et al., 2017) and they attributed this to gaps in communication and information sharing among health professionals (Gill et al., 2017).

A study examining collaboration between health professionals working in different organisations and patient experiences of multidisciplinary care (McDonald et al., 2012) found a complex mix of organisational and professional factors influenced health providers' decisions about "*whether to collaborate, with whom, and to what level*"(p.1). Collaboration was hindered by negative aspects such as time and effort negotiating across different cultures and perceived threats to autonomy and professional status (McDonald et al., 2012). Patients' access to services and their experiences were

beneficial to health professionals and assisted collaboration (McDonald et al., 2012). Similar studies found collaboration rarely extended beyond limited coordination for patients with routine needs. They were inadequate for patients with complex needs (Schoen et al., 2011; Taylor & Swerissen, 2010).

While the literature clearly evidences a paradigm shift from professional silos toward integrative collaborative practice was valued, the issues of autonomy, power and control had not been adequately addressed by focusing solely on incentives and exchange mechanisms. More attention was needed to understand, at a deeper level, the barriers and enablers for interprofessional and interorganisational relationships in primary health care. Griffin (Griffin, 2012, p.1), a power analyst asserts "*examining power is not just a theoretical diversion intended to enhance conceptual thinking*". Understanding how power operates in primary health care has important implications for appreciating the strengths and limitations for successful primary health care policy making.

A social network analysis undertaken by McDonald et al. (2012) revealed there was little coordination between private and public services, and limited collaboration linking clinical care with health promotion or self-management. With a sharp commitment to improving Australia's public health, the Australian government was by now more insistent on the notion of accountability. In 2014, the then Health Minister commissioned the Horvath Review of Medicare Locals to consider their structures, operations and functions. Horvath was highly critical of Medicare Locals for failing to engage with GPs and *the government should reinforce general practice as the cornerstone of integrated primary health care"* (Horvarth, 2014, p.v).

The government responded by moving away from the Medicare Local organisations and toward establishing Primary Health Networks (PHNs), which commenced operating in July 2015. The health reform legacy continues to be felt today and there were important lessons to be learned from the Medicare Local structures, operations and functions for future primary health care.

Section 5: Legacies of primary health care reform: The duality of structural reform

Medicare Locals were established during an era of significant structural health reform. Biomedical and public health discourses were in competition and different groups were using them to exercise power to control health reform, affirm their position in primary health care, and ensure ongoing access to scare social resources. Nevertheless, the Australian government was committed to the role Medicare Locals were to play in implementing primary health care and adopting integrative collaborative practice to improve health outcomes for Australians.

By transitioning the Divisions of General Practice to the new network primary health care organisations in 2011, the Medicare Locals were subjected to primary care legacies. These legacies are infused with hidden power, which, according to Fairclough (1995, p.83), is the "*power behind discourse*". Revealing and examining these dimensions of hidden power informed the decision to undertake a critical retrospective investigation of primary health care reform using Medicare Locals' as a case study. This final section of the review examines literature published in the period between 2015 - May 2019 and focuses on how the legacies of health reform may be influencing primary health care. It was important to do so because in 2015 the Medicare Locals were disbanded and replaced with the formation of 31 Primary Health Networks (PHN) in 2015. The role of these independent primary health care organisations is to commission (Booth & Boxall, 2016), rather than provide services. This key point of differentiation between Medicare Locals and PHNs represents a fundamental shift in the way regional primary health care services are planned and funded. Nevertheless, they too would be subjected to the legacies of primary health reform. Examination of the relations of power influencing the ability of Medicare Locals to achieve their vision and mission of integrated collaborative practice, therefore have ramifications for policy implementation and primary health care leadership.

The two key objectives to be achieved through commissioning include:

- Improving the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes; and
- Improving the coordination of care to ensure patients receive the right care, in the right place, at the right time (Department of Health, 2014).

Despite the centrality of commissioning as a concept in PHN operations, prior to their inception there was little known about it as a practice (Robinson et al., 2016). A review of the international literature found commissioning is a complex area and more than simply a technical or operational process, but one that is value-based and inherently relational (Robinson et al., 2016).

For Australian primary health care reform, already operating within complex relations of power, the use of commissioning as a tool for improving population health outcomes could make it even more challenging (Booth & Boxall, 2016). During the establishment era for PHNs, publications were soon suggesting the authorising environment would require policymakers to allow time for PHNs to mature into their role and called for an environment of effective collaboration amongst multiple stakeholders, including consumers (Dawda et al., 2016). Taking a broader systems logic, Meurk et al. (2018) reported there was little known about the levers that could be applied by PHNs to plan and commission primary health services at a regional level. Their review of academic and grey literature published between 2006 and 2016 identified twenty-six levers ranging from referral management through to overall health system functioning but noted further work is needed to develop a robust evidence-base for systems levers.

Effective partnerships and collaboration amongst multiple stakeholders are now recognised as critical features of effective system levers for comprehensive primary health care (Dawda et al., 2016; Takach, 2016). Articles are now emerging to describe in detail processes for achieving integration. Connor et al. (2016) outline a process map describing a model of care protocols from initial assessment to care of the patient presenting for emergency care, which is being evaluated over a three-year period (McClean & Trigger, 2017). However, there are ongoing concerns about the often fragmented and

inefficient service response and this has increased national policy commitment to community-led, multi-disciplinary, cross-sectoral integrated service delivery (Eastwood, 2017; Short et al., 2015). In a study aimed at describing realist causal and program theory to inform collaborative design of initiatives for vulnerable families, Eastwood (2017) proposed initiatives and service activities that were sustainable, built partnerships within the primary health care sector, provided capacity building opportunities with families and communities, and established organisational structures and processes that provided options for future growth and organisational change (Eastwood, 2017). Such programs are contingent, however, on collaboration between the health professions.

Cognisant of the proliferation occurring in primary health care, but limited attention to strategic workforce growth and evaluation, Harris et al. (2016) undertook a synthesis of 12 mixed methods studies that focused on the impact of reforms to primary health care on interprofessional teamwork. They reported variable impact on the position of Nursing and Allied Health services, which influenced workforce, communication and relationships between different professional groups. Similar variable results were reported for levels of job satisfaction for Nurses working in primary health care (Halcomb et al., 2018; Schadewaldt et al., 2016). Four of six studies reviewed by Halcomb and colleagues (2018) identified that nearly half of the participants intended to leave their current position.

Other studies targeted workforce skill sets and capabilities for improving the health and wellbeing of populations through collaborative community-centred practice (Cockayne et al., 2017; Hyett et al., 2016; Taylor et al., 2018). Some studies focused on developing the collaborative capabilities of the existing health workforce. For example, McKittrick and McKenzie (2018) sought to identify how GPs and practice Nurses could work together to address chronic complex disease in a collaborative general practice model. Others were focussing on preparing new graduates for interprofessional collaborative practice. For example, Murray-Parahi et al. (2016) called for health professional graduates to be better supported as they transition into collaborative roles in primary health care.

Different professionals' common interest in collaboration and their perceptions of opportunities to improve quality of care are known to facilitate interprofessional collaboration in primary health care (Supper et al., 2014). Conversely, barriers to collaboration include the lack of clarity and awareness of one another's roles and competencies, shared information, confidentiality and responsibility, team building and interprofessional training, and long-term funding and joint monitoring (Supper et al., 2015). Freeman and colleagues (2018) warn that failure to facilitate enabling factors for strengthening interprofessional collaboration could place primary health care at risk of burning out its workforce.

Partnerships are integral to collaboration but the potential to facilitate or constrain its effectiveness. Javanparast et al. (2015) examined partnerships in population health planning between five Medicare Locals and Local Health Networks in South Australia and they focused on the factors that facilitated or constrained collaboration. Participants from these organisations provided examples of collaboration, including data sharing, program implementation and community consultation (Javanparast et al., 2015). Barriers to collaboration included the focus of the Local Health Networks on acute and intermediate care, the lack of system-level strategies to support collaboration, and the constant policy and structural changes leading to uncertainty in the primary health care field (Javanparast, et al., 2015).

The competing drivers of health system change constitute one of the most significant and prevailing barriers to collaboration and service integration. For example, responsibility for public health sits within a social model of health and necessitates appropriate attention to programming, integrated service delivery and community engagement. These priorities coexist with pressures to rationalise and restructure clinical services. A study by Javanparast et al. (2018) describes the institutional forces, ideas and actors shaping the implementation of policy in Medicare Locals from 2011-2015. The policy emphasis on partnerships, limited time and financial support for collaboration with local government were identified as barriers to effective health planning (Javanparast et al., 2018). They attributed the lack of collaborative work practices to the dearth of population health activities undertaken by

Medicare Locals (Javanparast et al., 2018). As clinical service provision demanded more resources and greater effort, health promotion and activities to address social determinants of health were secondary and ad hoc (Javanparast et al., 2018).

At this point, it is evident that the primary health care fields apparent inability to achieve authentic integrated collaborative practice is largely due to power dynamics directly impacting on trust and collaboration in primary health care. Primary health care teams depend on the contributions of multiple professionals. Despite general acceptance that a strong partnership and collaboration driven approach is needed for an effective and efficient primary healthcare system, a focus on GP-led activities continues (Carlisle et al., 2016; Evangelista et al., 2016; Liaw et al., 2019). Another study interviewed GPs, primary health care organisations and policy stakeholders to examine various performance logics and tensions during the implementation of Medicare Locals (Foster et al., 2016). Once again, historical patriarchal arguments were advanced whereby Foster et al. (2016) argued for,

> *the engagement of GPs in health planning, resource allocation and broader health system decision-making in a way that is consistent with their own professional aspirations and in the direction of wider health system goals of public health* (Foster et al., 2016, p.531).

Importantly, however, they noted,

> *the issue would be whether the new primary health instrument could harmonize the inherent power and control struggles between medical professionals and emergent managers … and more so, organize GPs around a concept of population health performance that goes beyond audit accountability* (Foster et al., 2016, p.531).

Language is still being used to produce and reproduce particular understandings of primary health care that are temporally influenced and historically shaped by discourse. Different groups, including researchers, health practitioners, health consumers, and government officials, use different language frames when talking about primary health care. This review reinforces the need to investigate how

different meanings of primary health care are influenced by ideology and discourse. From the literature reviewed in the previous sections, it was clear there were already strong indications pointing to the value of examining discourse and relations of power within the health, primary health care, and social and humanity fields. The Commission on Social Determinants of Health, established by the WHO in 2005 to draw the attention of governments and society to the social determinants of health, made this imperative clear. Their final report: *Closing the Gap in a Generation: Health Equity Through Action on the Social Determinants of Health* (WHO, 2008a) made three overarching recommendations: (i) improve daily living conditions; (ii) tackle the inequitable distribution of power, money and resources; and (iii) measure and understand the problem and assess the impact of action. These recommendations gave rise to neoliberal driven management reform (Baum et al., 2016; Hendrikse & Sidaway, 2010; Labonte, 2012). As Baum and colleagues (2016, p.44) explain, neo-liberal theory "*emerged from a distrust of the potential of state-planned economies, which were perceived as autocratic and repressive of individual liberties*".

The inferences to be drawn from reviewing this literature are that Neoliberal ideology influenced the reform initiatives in ways that led to the establishment of a dual system in which primary health care sat alongside primary and acute care. This was manifest in the conflation in the terminology used, the continual tension between the focus on chronic disease and the need to improve public health, and argument over who was the legitimate leader. This accounted for the selective primary health approach that was adopted because it bridges these tensions. By focusing on concepts of selective primary health care, with emphasis on presenting certain episodic diseases, the primary healthcare reform initiatives of the 1990s through to 2009 had been effective in building capacity and coordinating the delivery of health services. However, selective primary health care does not align with the philosophy or principles underpinning comprehensive primary health care as proposed by WHO (1978). As a result, despite building capacity and coordinating services, the 1990-2009 era was less effective in tackling service integration and collection between the professions.

The 2010-2015 period was dominated by issues of politically driven health reform, which resulted in the establishment of Medicare Locals characterised by sweeping neo-liberal and new public management inspired thinking. Baum et al. (2016) linked the influence of neo-liberalism with the way health reform was promulgated to focus on cost-containment and efficiency, result-based financing, user fees, managed competition amongst service providers, increased contracting out to private providers, and an emphasis on individual responsibility for maintaining good health. New public management, one of the main drivers of reform, reflected the mandate of cost reduction and organisational efficiency in the delivery of health care services (Mickan & Boyce, 2006). The coupling of neoliberalism and new public management set up a tension between business imperatives and discourses of health. When discourses increasingly turn towards redefining abstract ideas, such as disease to health, state managed services to new public management, and primary care to primary health care orientations, they also work to reproduce society and culture (Fairclough & Wodak, 1997).

Health promotion and community engagement assist people to increase their control over the determinants of health and by doing so, assist in improving their health and wellbeing. Efforts at promoting health encompass actions at individual and community levels, strengthen health-system and multi- and inter-sectoral partnerships (Anaf et al., 2014; Kumar & Preetha, 2012). However, policy does not necessarily translate into effective practice and this has reduced the ability of primary health care services to realise the mission to improve health and wellbeing in the community (Javanparast et al., 2015). The complexity of the social determinants of health makes it almost impossible for the health sector alone to address these issues, and a selective approach that omits health promotion and disease prevention activities limits the contributions of strong primary health care (Freeman et al., 2018). If the full aspirations of the Declaration of Alma-Ata (WHO, 1978) are to be realised, a more comprehensive view of primary health care is needed (Baker et al., 2018; Freeman et al., 2018). It must be characterised by an "*approach to health care and health promotion that emphasises multidisciplinary teamwork, a social view of health, community participation, equity, disease*

prevention and health promotion as well as curative and rehabilitative services, and action on social determinants of health" (Freeman et al., 2018, pp.567-568).

In 2017, the Australian Health Ministers Council released its National Strategic Framework for Chronic Conditions, which set the new direction and outcomes to achieve the Vision that "*all Australians live healthier lives through effective prevention and management of chronic conditions*" (2017, p.1). The legacies of neoliberalism and new public movement continue to be reflected in the regulatory conditions being imposed by the Commonwealth government. Funding priorities and time schedules have been identified as the predominant forces constraining population health planning (Javanparast et al., 2018). The misalignment between the governmental and the disciplinary forces of the narrow biomedical perspective privilege medical practice and ascribe less legitimacy to action on the social determinants of health. The policy environment has favoured attention on medical services to the detriment of health promotion informed by a social-determinants focus (Javanparast et al., 2018).

Through a raft of research projects, Baum and her team have consistently argued it is time for a comprehensive approach to primary health care (Baum et al., 2017). They have identified that local government has the potential to tackle social factors affecting health and made calls for their inclusion in population health planning and action on the social determinants (Javanparast et al., 2018). Notably, however, they argue that a continued focus on medicalised service provision, while highly compatible with neo-liberal reforms, will not make inroads into disease patterns required to improve population health or reduce demand for health services (Baum et al., 2016).

There are competing discourses in primary health care (Hill, 2018), giving rise to complex power operations (Baum et al., 2016). The literature evidences the power dynamics that exist between health professionals and applied by different groups to a) protect their autonomy and b) reduce their dependency on other health professionals to maintain power. As Jackson and Hambleton (2016, p.S45) assert,

> *history has taught us that health care reform is not a finite deliverable. It is, ideally, an ongoing, relationship-based team pursuit of excellence in the community delivery and utilisation of health care — a descriptor not often ascribed to current arrangements.*

Deeper understanding of the power dimensions operating within primary health care is required to inform governance arrangements designed to facilitate service integration. These issues have not been suitably addressed by focusing exclusively on incentives and exchange mechanisms and ignoring the barriers to interprofessional and interorganisational relationships. Griffin (2012, p.1), a power analyst asserts "*examining power is not just a theoretical diversion intended to enhance conceptual thinking*". The inference to be drawn here, that has implications for the current study, is that understanding how power operates in primary health care, expressed through discourse, has important implications for appreciating the strengths and limitations for designing and implementing effective primary health care policy.

Chapter summary

This literature review has examined the antecedents, operational practices and legacies of primary health care reform following the establishment of Medicare Locals in Australia. It outlines the search strategy, inclusion criteria, the data bases used to source published and grey literature and the rationale for searching literature from 1990-2019. It began by identifying the knowledge system and power relations underpinning primary care in the decades preceding the health policy reform implemented in 2011, and how Allied Health Professionals' knowledge and value systems aligned with, and contributed to, primary health care. The fourth section reviewed the evidence heralding paradigmatic shifts in understanding and values, and the move from professional silos towards integrated collaborative practice, that occurred in the transition from primary care to primary health care. The final section explored the legacies of health reform and how the recent primary health care focus has changed.

Primary health care is contested and imbued with different agendas and interests. Reviewing the literature in chronological sets was useful for showing how the structural reform approach used to implement primary health care reform has challenged the episteme of hierarchical health care. The knowledge systems underpinning primary care in the decades preceding health policy reform implemented by the Rudd Labour Government were led by a biomedical view of health. Reforms were based on GP-led professional knowledge systems that had not improved the underlying issues of service fragmentation, poor professional integration, financial pressures in the health system and the ever-increasing rise in chronic and complex diseases. These findings provide evidence of the interplay between language, discourse and power existing in the primary health care literature.

The key points in this chapter are:

- Literature from 1990 to 2009 centred on general practice and GPs in primary health care research. There was a call for reform within the sector to address the growing issues of population ageing, an increase in chronic and complex disease and the need for a more integrated health system. These early restructurings were largely targeted towards general practice.

- Literature from 2010- 2015 centred on the period of reform that saw the establishment of Medicare Locals which were tasked with improving public health by addressing issues of service access, affordability and effectiveness and achieving this by means of service integration, multidisciplinary collaborative practice and community engagement.

- Various mechanisms were introduced to integrate services and the health professions. They were effective for increasing the capacity and coordination of service delivery but ineffective for improving integration and collaboration.

- Literature from 2015 – 2019 highlights the legacies of neoliberalism and new public movement continue to be reflected in recent health reform policy directives proposed by the

Commonwealth government. However, the mismatch between the government's vision for improving public health could be challenged by the prevailing biomedical perspective and competing discourses of health and business which ascribes less legitimacy to action on the social determinants of health.

Examining how Medicare Locals operationalised and enacted primary health care reform provided an ideal case study. These organisations were instrumental in making inroads in establishing trust and interprofessional working relationships within the health professions, between sectors and services, and with communities. To study the discursive interplay between these elements justifies the use of critical discourse analysis theories and analytical tools, which are outlined in the next chapter. The next chapter situates primary health care in a research framework that uses power as the theoretical lens for examining discourse and its effects on the way Allied Health Professionals understood their Medicare Local leadership roles and identities and thus the ways they communicated and operated.

Chapter 3. Methodology

Introduction

The previous two chapters have traced the historical, cultural and temporal factors underpinning the shift in Australia, from primary care to primary health care which gave rise to a national network of 61 Medicare Local organisations. Reviewing the literature drew attention to what was known and identified the gaps in researching outcomes of primary health care reform and in particular the contribution of Allied Health professions. Those chapters set up the logic and justification for the current study, and the case for adopting a critical approach. Furthermore, they demonstrated clearly that Allied Health Professionals were recruited to Medicare Local Boards as leaders in primary health care with the expectation that they would be part of decision-making. The mission of Medicare Locals was to implement primary health care, both as a philosophy and a set of principles, to improve public health through policy and health system reform

This study centred on examining ways primary health care is represented by Medicare Locals, and how these representations impact on the way Allied Health Professionals form meanings and therefore approach integration, collaboration and multidisciplinary ways of working. It is salient to note that Medicare Locals were established during a period of intensive health reform in which the prevailing biomedical knowledge system represented a pervasive historical legacy upon which primary health care was to be implemented. Whilst biomedical systems of knowing were given priority, parallel to this was a highly gendered construction of power in health (and elsewhere). The Divisions of General Practice were largely male (64% in the 2007-08 Annual Survey of Divisions of General Practice) (Howard et al., 2009) and Doctors (81% in 2007-08 Annual Survey of Divisions of General Practice) (Howard et al., 2009; Kalucy, 2004) and therefore well positioned to exercise control and influence, whether to oppose or support, attempts to change the status quo. In this study, Medicare Locals were therefore understood as political sites in which power and knowledge were enacted together, through written organisational texts, and practice relations. Accordingly, it made sense to adopt a methodology consistent with critically analysing the central texts that guided and operationalised how Medicare Local organisations functioned and capturing Allied Health Professionals' accounts of their leadership experiences in this model of primary health care.

Situating the study in its historical, cultural and temporal context was necessary to locate the discursive relationships between language, discourse, power and subjectivity. Language use is the site where actual and possible forms of meaning and organisation take place (Fairclough, 2015), and where subjectivity is shaped (Foucault, 1977). Acknowledging language use in primary health care had social and political consequences, meant the study required theories that prioritise social structural analysis. A self-reflexive and critical stance was therefore required to examine the multiple discourses, multiple meanings and often contradictory effects of Medicare Local policy and leadership practice. Accordingly, this chapter presents the research framework and situates the research problem in the critical tradition. The use of the power-discourse nexus (Foucault, 1972, 1977, 1978, 1980) concepts of discourse access, participation and control (van Dijk, 1993, 1995, 2001) and governmentality are

outlined for examining how Medicare Locals and Allied Health Professional Board members represented primary health care using the ideological tool named discourse. The final section outlines how Fairclough's (2001, 2015) three-dimensional framework for examining the relationships between power, discourse and governmentality.

Section 1. Situating the study in a qualitative critical tradition

The overarching paradigm for this study was qualitative and the intellectual grounding was provided by the critical tradition (Wodak & Meyer, 2009). This section outlines these paradigms and provides the rationale for their use in this study.

Study aim

The study aimed to examine the ways in which primary health care was represented by Medicare Locals and how these representations impacted on how Allied Health Professionals formed meanings and therefore approached integration, collaboration and multidisciplinary ways of working as leaders in primary health care.

The aim derives from the identified need to address the increasing impost of chronic and complex diseases, and their burden on the health system, and to shift away from the prevailing biomedical knowledge and curative approach that were dominant in primary care. The premise underpinning this study was that implementing health reform is inherently complex. Things are not necessarily what they appear to be on the surface, therefore it would be naïve to assume that the outcomes of health reform would be achieved as intended. The literature review provides evidence that the prevailing biomedical discourses and practices of primary care were informed by a set of key assumptions that led to curative interventions that overlooked health promotion and disease prevention initiatives. Complexities of health reform are further compounded by the reflexive interplay between people, systems and institutions (Giddens, 1984). In the context of this study, time, place and personal biographies were instrumental in understanding the drivers underpinning primary health reform. The study derives from an ontological position that privileges the intersection between people, time,

history, ideology and culture. It takes the view that power relations are embedded in language in ways that can empower or constrain people (Foucault, 1978; Fairclough, 2015).

With people and human experience at its centre, the study was qualitative in nature. The qualitative paradigm attempts to understand human experiences via an interpretive research methodology (Chiklisa & Kawulich, 2012). In this study of human experience, the qualitative research paradigm was appropriate because it was imperative to consider the context that affected the social practice and meanings that the Allied Health Professionals formed (Fairclough, 2001).

Study purpose

The critical tradition aligns with the study purpose to examine how Medicare Locals operationalised the primary health care policy directive, and the impact on primary health care reform of including Allied Health Professional leaders on Medicare Local Boards and in primary health care teams. That is, to look beyond the ideas of structural reform in primary health care to investigate the deeper and hidden cultural, historical and temporal associations of language, discourse, power and identity located within the practices of Allied Health Professionals elected to Medicare Local Boards, with a view to establishing whether Medicare Locals were meeting their intended vision and mission of integrated and collaborative primary health care. These considerations required more than description and interpretation: they required explanation and critical appraisal of their impact with a view to informing future primary health care reform.

The critical theory tradition emerged from the Frankfurt School in Germany in the 1930s and later migrated to New School for Social Research in New York. Habermas' theorising on communicative action ground "*the social sciences in a theory of language*" (McCarthy, 1978; 1981, p.xiv). It is a theoretical perspective that aligns with Foucault's (1978) focus on the political implications of discourse, and its effects on people and social systems. To take account of the real world, this study required a critical epistemological stance to reflect the way knowledge is both socially constructed and influenced by power relations from within society (Giddens, 1984).

Research questions

The ontological orientation and epistemological stance, along with the critical tradition used in the study are reflected in the four research questions:

1. How was primary health care constructed within written strategic documents mandating the vision and mission of Medicare Locals?
2. How did Allied Health Professionals who worked in Medicare Locals understand primary health care as it related to their leadership roles?
3. How were Allied Health Professionals within Medicare Locals positioned for achieving integrated and collaborative multidisciplinary approaches in their work as Board members?
4. Were Medicare Locals meeting their intended vision and mission of integrated and collaborative primary health care?

In this study, Medicare Locals were understood as political sites in which power and knowledge were enacted together, through written organisational texts, and practice relations. Because of the focus on human experience and the interaction of Allied Health Professionals within a complex web of social and power relations, the study required theories that consider the dynamic processes in which discourses can be both an instrument of power and its effect.

Section 2. Using the power-discourse-governmentality nexus as a theoretical lens

The theories used in this study include Foucault's insights concerning power-knowledge (Foucault, 1972; 1973; 1977; 1978; 1979; 1980; 1982) and governmentality (Foucault, 1979; 1980; 2009), and intersect these with a conceptualisation of discursively constructed professional and social identity (Erikson 1968; 1980). This section outlines these theories and the rationale for their use in this study.

In Australia, primary health care was embraced by the Australian government to improve public health because it pays attention to disease prevention and health promotion and engages a multidisciplinary model of health care (Hurley et al., 2010). The process to establish the network of Medicare locals to

implement primary health care was informed by the government published Medicare Locals Operational Guidelines (Australian Government, 2013a) and the creation of Company Constitutions for each organisation. The combination of these two written texts can be understood as the policy framework through which primary health care was to be operationalised in the business of Medicare Local work. Accordingly, for this study a rational basis was needed for critically appraising these documents to examine how these organisations were structured and operated.

Policies never exist within a vacuum; they reflect underlying ideologies and assumptions already in existence (Armstrong et al., 2000). Foucault (1977) explains documents are not merely communicative devices but are texts capable of exercising power through the (re)production of truth and knowledge, which form discourses. The Medicare Local's Operating Guidelines and Constitutions were therefore understood as 'technologies of power' (Foucault, 1975, 1991). As evidenced by the literature review, the prevailing ideologies and truths circulating through society include medical authority, biomedical discourse and power, which combine to shape professional identities and hierarchies. Foucault (1972) considers how knowledge is organised and the types of justifications deemed acceptable to support that knowledge. He moves away from top-down notions that espouse people use power as an instrument of coercion, toward the idea that 'power is everywhere' (Foucault 1977, 1978). The term 'power-knowledge' was coined to signify that power is constituted through accepted forms of knowledge, scientific understanding and 'truth' (Foucault, 1980). Ways primary health care can be known, are through 'regimes of truth' (Foucault, 1977) that pervade society in various ways: through policy, research, education and work practices. According to Foucault (1977), power dynamics are created within discourse, known as a system of knowledge production, therefore primary health care knowledge is in a constant state of circulation, negotiation and renegotiation.

Despite the various health reforms in Australia seeking changes across the whole health system to shift from a medically-centred primary care model towards a more comprehensive model of primary health care, a heavy focus on the biomedical model has remained (Javanparast et al., 2018). This

suggests that realities and assumptions underpinning health knowledge do not simply exist, but that people create truths about that knowledge through social interaction. In other words, the long-standing biomedical model people have become accustomed to for understanding health and service provision, has been consistently viewed through the truths of 'illness and cure' (Luou et al., 2014). These expressions, in the form of language, can be understood as discourse.

Discourse, ideology and truths are never static. Conceptions of health have been influenced by the prevailing ideology of different eras and seminal shifts in thinking by elite social groups holding power. For example, the 1970s era was characterised by radicalism, social upheaval, the rise of a social justice perspective, and rejection of the status quo across a range of social institutions (Hutto & Green, 2016). It was during this turbulent time the landmark conference for primary health care took place at Alma-Ata. The conference's main document - the Declaration of Alma-Ata, was approved by acclamation (WHO, 1978). The term 'declaration' suggested high importance and made calls for independence and human rights and soon became recognised by most countries as the key to attaining an acceptable level of health for all. This seminal works document was transformative in reconceptualising health. However, despite multiple attempts by successive Australian governments to incorporate this broader thinking about health, it was not enacted until the Rudd Labor government established the network of 61 Medicare Locals in 2011 (Bennett, 2013). The suite of Australian government documents published between 2008 and 2011 provide testimony of the shift in thinking about primary health care (Table 1).

The introduction and literature review chapters demonstrate how the context and culture in which Medicare Locals were to operate were shaped by neoliberalism, public health, and professional influences. In this study, these influences were understood as discourses. Discourse is used in a variety of ways to describe,

> *an ensemble of ideas, concepts and categories through which meaning is given to social and physical phenomena, and which is produced and reproduced through an identifiable set of practices* (Hajer, 2005, p.67).

Foucault (1972) defines discourse(s) as bodies of knowledge and moves away from the concept of language (grammar or linguistic systems) to a more conceptual sense of discipline.

In this study, the term 'discipline' is used to denote medicine, nursing and those professions identified as allied health. The term 'knowledge' is used to refer to the structure of human consciousness and how people interpret and shape their environment through meaning (Berger & Luckman, 1966). Discourses therefore enable understandings of social reality: people actively co-produce discourse within their own social context. A founding theoretical premise of the study was that various texts were technologies that exercised power, knowledge and truth (discourse) (Foucault, 1977; 1980). In focussing on how and by what means power is exercised, Foucault (1994) makes a distinction between sovereign power, disciplinary power, social power and biopower.

In publishing the Medicare Local Operating Guidelines, the Australian Government exercised its sovereign power, which Foucault (1977; 1980) describes as power expressed in recognisable ways by visible agents of power. Development of individual Medicare Local Company Constitutions outlined the way these organisations were to operationalise primary health care in integrative collaborative practice. While these documents were policy frameworks intended to guide Medicare Local operations in ways that aligned with the Australian government's vision for public health, the day-to-day practices of the health professional would also be by their own rule. These practices would be informed by other forms of knowledge, such as the different conceptions of health or cultural understandings of the professional hierarchy within the health professions, as well as the Medicare Local Operating Guidelines and Constitutions. Health professionals working in Medicare Locals' were therefore not regarded as passive 'subjects' who were conduits through which the Australian government operated but were instead acknowledged as 'knowing subjects' (Foucault, 1988), and

active agents capable of rationality, autonomy, choice and reflexivity (Giddens, 1984). Thus, in their day-to-day practices of Medicare Local work, the health professionals were likely to draw on different knowledges so tacit and taken for granted that it would be *"…deeply submerged in human subjectivity*" (Caldwell, 2007, p.7). This is a form of 'disciplinary power' (Foucault, 1977) that can work to regulate people – a theoretical concept that will be more fully explained later in this section.

Medicare Locals' were to operationalise the Australian government's health reform agenda. In their day-to-day practices, health professionals were therefore required to combine the defined Medicare Local objectives with their different understandings of how to work as health professionals. Both Marjoribanks and Lewis (2003) and Foster et al. (2016) point out that health reform and policy can trigger uncertainty and challenge what it means to be a health professional. Health policy reform demands change. As Foucault (1978) explains through the notion of biopower, reform introduces a political rationality that informs the administration of that change in the form of work practices. Change management represents a form of 'governmentality', which is a term Foucault (1979; 2009) uses to describe the way institutions try to produce people and groups best suited to fulfilling their policy objectives. Van Dijk's (1995) writings on 'discourse access' and 'participation' further assist in explaining how these forms of biopower (Foucault, 1978) might have been in operation in the Medicare Locals.

As newly appointed Board members, the Allied Health Professionals were able to 'access' discourses (van Dijk, 1995) availed in the organisational policy documents and 'participate' (van Dijk, 1995) in their reproduction during their day-to-day activities as leaders in Medicare Local work. Access and participation in primary health care discourse bring forward questions of "*who may speak or write to whom, about what, when, and in what context …*" and "*…who may participate in such communicative events in various recipient roles*" (Van Dijk 1993, p.86). Analysing patterns of discourse access and participation can shed light on cultural understandings of professional identity and how the identity boundaries were impacted by primary health care discourse. To realise the full potential of analysing

Allied Health Professionals' accounts of leadership within Medicare Locals the study required the theoretical lens to be extended to include the power-discourse-governmentality nexus.

The creation of multidisciplinary Medicare Locals for achieving integration and multidisciplinary collaboration pointed to the need for this study to consider Allied Health Professionals' agency more deeply than this section has done so far. In his later works, Foucault (2009) extended his concept of governmentality to explain the organised practices through which people are governed. He further conceptualised the interplay between discourse, subjectivity and agency in a way that illuminates the contested, fluid, social processes through which people access, participate and control discourses (van Dijk, 1993; 1995). The mandate to include Allied Health Professionals on Medicare Local Boards, gave rise to their access to, participation in, and ability to influence various discourses, and in doing so, the potential to transform self. Foucault (1982) describes governmentality as,

> *the constitution of a specific subject, of a subject whose merits are analytically identified, who is subjected in continuous networks of obedience, and who is subjectified through the compulsory extraction of truth* (Foucault, 2007, pp.184–185).

Here, Foucault's work had become focused on the power relations through which people are governed, the relations of knowledge that underlie this governance, and the effect power-knowledge has on the actions of people. He argued power is dispersed throughout society, inherent in social relationships, embedded in a network of practices, institutions, and technologies (Foucault, 1988). Power therefore operates on bodies and regulates them through self-disciplinary processes to subjugate sense of self (Foucault, 1988). These are the underlying features of professional and social identity.

The disciplines of Allied Health share salutogenic knowledge (Antonovsky, 1996) that values the experiential nature of individuals within their community and centralises the importance of health, wellbeing and quality of life within this knowledge framework (Mittelmark & Bauer, 2016). Allied Health discipline knowledge is therefore underpinned by discourses derived from a social model of

health. It is evidenced-based scientific knowledge that results in a discourse of norms and normality. When individuals accept discourses of normality, they voluntarily control themselves and become principal in their own subjectification (Foucault, 1977). By working at Medicare Locals, the Allied Health Professionals were engaged in various social relationships and embedded in a network of primary health care practices as prescribed by the organisation and is technologies. To make sense of these interactions, they were likely to draw on different experiences and turn an inspecting gaze upon themselves. The process of self-surveillance (Foucault, 1979) becomes a process of self-control as individuals self-regulate (Foucault, 1979) what they will think and how they will act. Thus, technologies of the self occurs (Foucault, 1979), which is strongly connected to group member's professional identity.

With antecedents in the humanity and social psychology traditions, the term 'identity' has a long tradition in Western philosophy and has been well theorised (Sollberger, 2013). Professional and social identity were the central concerns of this study because they are important cognitive orientations that people draw on to shape their attitudes and behaviour in work settings and beyond (Sollberger, 2013). As people grow, mature and socially interact they ascribe various meanings to their sense of self in a way that reflects their subjective experience (Mansfield, 2000). The seminal identity theorist Erikson (1980) suggested identity to be the form of a person's self-relation and self-conception they draw on to communicate and interact within their different social roles. In this vein, personal identity allows people to maintain an inner coherence and continuity but also allows for some extension of those personal attributes to identify and assimilate with professional groups. This is an important distinction. Erikson's work allows identity to be understood as a fundamental organising principle that provides an individual with a sense of continuity, coined as "*self-sameness*" (1980, p.23) whilst also structuring differentiation between self and others, which he referred to as "*individuality as uniqueness*" (1980, p.23).

Discourses work to construct the social world and influence the way identity is formed. The use of a particular discourse can "*maintain power relations and patterns of domination and subordination*" (Potter & Wetherall, 1987, p.109). Therefore, the language of the strategic texts used by Medicare Locals enabled an area for investigation on how Allied Health Professionals on Medicare Local Boards were subjectively positioned to fulfil or not fulfil the mandated mission of Medicare Locals. Foucault's later works (1979-1988), and specifically his introduction to biopolitics in 1976 (Society Must be Defended) and the lectures between 1978 (Security, Territory, Population) and 1979 (Birth of Biopolitics), provide insight into ways the processes of domination are linked to 'technologies of the self' and the practice of self-government (Lemke, 2012, p.3). Foucault's concept of 'governmentality' helps us to understand how power may be exercised at both the level of primary health care practice and at the level of the individual Allied Health Professional working as a Board member in a Medicare Local.

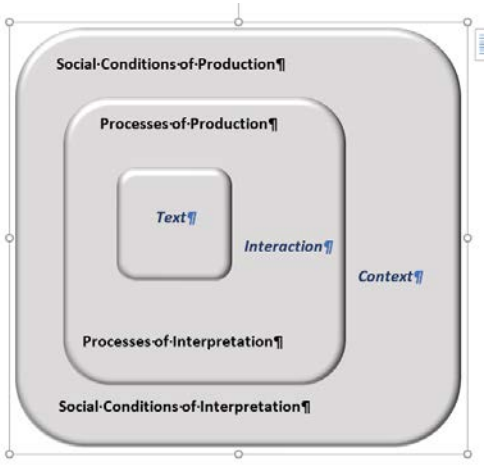
Section 3. A three-dimensional model for examining the relations of power, discourse, and governmentality

For examining the relations of power, discourse and governmentality, it was important to acknowledge their textual, discursive and social dimensions. Fairclough's (2011, 2015) writing about critical discourse analysis has two components – theoretical and methodological (Fairclough 2001). The next section outlines the theoretical component of the three-dimensional model of discourse analysis (Fairclough 2011, 2015).

The socio-cultural theories outlined by Foucault (1972; 1977; 1981) allow for a reading of discourse as a different way of structuring areas of knowledge and social practice. However, for the purpose of this study a more socio-theoretical sense of discourse was required to examine how text-and-interaction were socially mediated (Fairclough 2003; 2010; 2015; Foucault 1972, 1977,1981; van Dijk 1993, 1995). Fairclough uses the term '*social practice' to mean a "relatively stabilised form of social activity*" (Fairclough, 2001, p.231). Allied Health Professional leadership as a Medicare Local Board member

necessarily engaged them in work-related social activities and practices. They were likely to draw on their own resources for participating in these social practices. Fairclough (2015, p.57) uses the term 'members' resources' to refer to what people bring to the production or interpretation of texts. The phrase 'relatively stabilised' (Fairclough, 2001) highlights that although there are alternative ways of doing these activities, there is a dominant or mainstream way. For example, in a medical consultation, Doctors use a medical language to communicate and direct the interaction with their patient in an authoritative manner. This is not to mean that all Doctors conduct their practice in this way, but that it is the most common form of consultation in medicine. In this study 'social practice' (Fairclough, 2001) relates to the complexity of day-to-day activities within the Medicare Locals.

The language used within the social practice of Medicare Locals draws upon embedded discourses that influence what can be said and by whom. These discourses are historically, culturally and temporally mediated and conditioned by other parts of society therefore it is not possible to analyse the texts alone without considering the context, or processes of their production and interpretation. Accordingly, there was a need to adopt an approach that facilitated analysis of the relationship between these texts, the processes of their production, and the social conditions. Fairclough (2001, 2005) provides such a model (Figure 2).

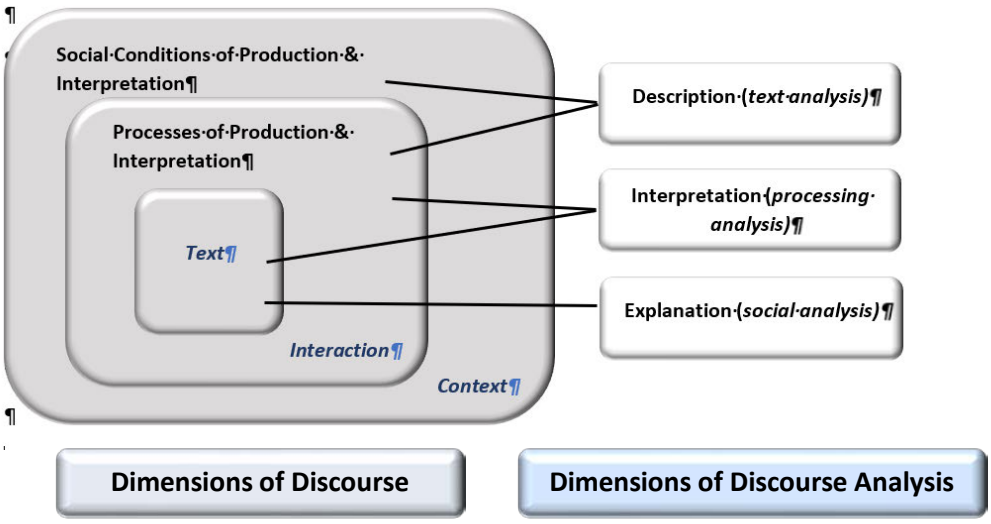


Source. Fairclough, 2015, p.58

Figure 2. Discourse as text, interaction and context

The figure depicts how the situational context, the institutional and social structures that surround social conditions can be understood as relationships between texts, interactions and context (Fairclough, 2015 p.58). It is important that discourse is analysed in terms of its relations with other elements and not in isolation. The next section outlines the methodological components of the three-dimensional model of critical discourse analysis (Fairclough 2011, 2015).

The purpose of this study was to look beyond the ideas of structural reform in primary health care to investigate the deeper and hidden cultural, historical and temporal associations of language, discourse, power and identity. These considerations required more than description and interpretation: they required explanation and critical appraisal of their impact with a view to informing future primary health care reform. Fairclough (2015) describes these dimensions of discourse and discourse analysis as description (text analysis); interpretation (processing analysis); and explanation (social analysis), as depicted in Figure 3.



Source. Fairclough, 2013, p.133

Figure 3. Dimensions of discourse and discourse analysis

In figure 3, the three stages of critical discourse are:

- Description – the formal textual properties;

- Interpretation – the nexus between text and interaction, whereby text is considered the product of a process of production, and a resource for interpretation and sense making; and

- Explanation – the relationship between interaction and social context, in which the processes of production and interpretation, shape and are shaped by social effects.

Adopting a critical discourse analysis approach in this study would allow an exploration of relations of power within discourse, so that the role of discourse is viewed in the (re)production and challenge of dominance (van Dijk, 1993). Using critical discourse analysis as a research technique can reveal contradictions within and between discourses and provides a freedom to explore the taken-for-grantedness and the power relations within each discourse (Jager & Maier, 2009).

Chapter summary

This chapter has outlined the methodology used in this study and justified the approach adopted, critical discourse analysis. The social conditions under which the Medicare Locals were established meant several discourses were already in operation as these organisations moved to implement primary health care. The Medicare Locals, with their mandate to implement a multidisciplinary approach to primary health care and population health planning, meant they were an ideal case study for examining the relations of power, expressed through discourse, and the self-governing effects of power on Allied Health Professional's professional identity formation. The nexus between the theories of power, discourse, and governmentality provide the theoretical lens for the study. The theories used include Foucault's insights concerning power-knowledge (Foucault, 1972, 1975, 1979, 1980,1991) and governmentality (Foucault, 1977, 1979, 1980), and their intersection with a conceptualisation of discursively constructed professional and social identity (Erikson, 1968, 1980). The chapter outlined a three-dimensional model (Fairclough, 2001, 2005) for examining the relations of power, discourse, and governmentality, and its goodness of fit with the purpose of the study. The model describes the three dimensions of discourse and discourse analysis as description (text analysis); interpretation (processing analysis); and explanation (social analysis). The theoretical framework provides a rationale

for using a critical discourse analysis to analyse the relationship between text, processes and their social conditions. The case that language is not just discourse but also a social practice further justifies the methodology adopted.

The key points in this chapter are:

- The Medicare Local's policy framework is understood as a technology of power that could (re)produce truth and knowledge about primary health care, in the form of discourse.
- Allied Health Professional accounts of leadership represent ways they access, participate and contribute to discourse to construct primary health care, and form meanings about integration, collaboration and multidisciplinary ways of working. Their social practices were likely to operate as technologies of self and influence their professional and social identities
- There are likely to be different forms of power in operation. While it is possible to make distinctions between sovereign power, disciplinary power, biopower and governmentality, all forms of power are exercised through discourse and social interaction.
- Critical Discourse Analysis provided a logical, qualitative, interpretative, and critical research design consistent with interrogating the outcomes and impact of Medicare Locals and the ways Allied Health Professionals understood their contributions to integration, collaboration and multidisciplinary practice.

The next chapter explains the application of this methodology and describes the methods used in this study to achieve the research aim.

Chapter 4. Research procedures

Introduction

Medicare Locals were used as a case study to investigate the language used to construct and operationalise primary health care. This study aimed to examine ways in which primary health care was represented by Medicare Locals and how these representations impacted on how Allied Health Professionals formed meanings and therefore approached integration, collaboration and multidisciplinary ways of working as leaders in primary health care. To investigate the deep and hidden associations located within the practices of Allied Health Professionals working at Medicare Locals, the study used Fairclough's (1992) Critical Discourse Analysis framework. The three-dimensional framework, outlined in the previous chapter, focuses on studying discursive events, that is, "*an instance of language use, analysed as text, discursive practice and social practice"* (Fairclough 1993, p.138).

This chapter describes the research procedures in three sections.

- Section one describes the procedures related to setting up the study, including ethics approval and its related considerations, sampling and recruitment of participants.
- Section two describes the procedures used to collect and analyse the data.
- Section three describes the processes utilised to promote rigour and trustworthiness.

Section 1. Setting up the study

In this section, procedures related to ethics approval and related considerations, document collection, participant recruitment, sampling and recruitment are outlined.

Ethics approval and considerations

An Ethics Application was submitted to the University of Tasmania's Human Research Ethics Committee and approved: Ethics Reference Number H00167776 (Appendix 4).

In line with the Australian Code for Responsible Conduct of Research (2018), participation was voluntary, confidential and anonymous and there were no consequences to the participant if they decided not to participate. If a participant wanted to cease their participation at any stage, or withdraw their information, they were able to do so without a need for an explanation. Anonymity was ensured by deidentifying all participant information, under purview of the National Statement on Ethical Conduct in Human Research (2018) and in accordance with the National Health and Medical Research Council Act 1992. To safeguard confidentiality, the deidentified information regarding the participants was coded and securely stored on a password protected, restricted access file on the University server. The data will be stored for a period of five years from the publication of the study results and will be securely destroyed thereafter, in accordance with the University of Tasmania protocols.

Sampling procedures

The method of sampling used was purposive and convenient. That is, it involved selecting a sample of key informants based on their ability to articulate the phenomenon being studied (Suri, 2011). The participants targeted for the study had professional knowledge and experience working as Allied Health Professional leaders in Medicare Locals. It was important that the key informants knew and understood the health reform landscape and how decisions were made in Medicare Locals. Rather than attempting to meet statistical generalisability or representativeness, the sampling procedure used was necessarily strategically focused and non-probabilistic. The lapse in time since the Medicare Locals were disbanded meant that web searches were used to source information regarding potential participants.

To be included in the study, prospective participants needed to be an Allied Health Professional who had been a member of a Medicare Local Board, could be:

- Male or female;

- Allied Health Professionals who were either registered with the Australian Health Practitioner Regulation Agency (AHPRA), or from another non-registered Allied Health Professional group. At the time of writing, AHPRA was the national registration and accreditation agency for15 different health professions.

Recruitment

Web searches identified a total of 59 potential participants, and of these, only fifteen were male. This gendered profile reflects the feminisation of the Australian Allied Health Professional workforce reported earlier (Australian Institute of Health and Welfare 2016). The largest prospective cohort of professions identified were psychology (17/59), physiotherapy (11/59) and pharmacy (8/59). Prospective male participants were predominantly represented in the disciplines of physiotherapy (7/11) and pharmacy (4/8) cohorts. Although the attempts made to contact potential participants did not differentiate between males or females, only females responded to my invitation to be interviewed. From the web based purposive sampling procedure, a list of 35 people were subsequently identified that met the inclusion criteria. Potential participants were contacted between September-October 2017 via email (Appendix 5) or telephone and provided with a Participant Information Sheet (Appendix 6) explaining the research and the study procedures. If they did not reply or did not want to take part, then no further contact was made. Due to the poor response rate (4 of 35), a second recruitment cycle was implemented between January and March 2018, which resulted in the recruitment of another three participants. In all, seven women were recruited to the study.

Opportunities for participants to ask questions about the study procedures were provided, and any questions raised were answered. In all research involving people, informed consent is required. Informed consent means that the participant is provided full knowledge of all possible consequences to their participation, including possible risks and benefits (Walter, 2010). To ensure prospective participants made an informed decision they were provided the Information sheet and consent form. All participants signed a Consent Form (Appendix 7) to indicate that they were fully cognisant of what

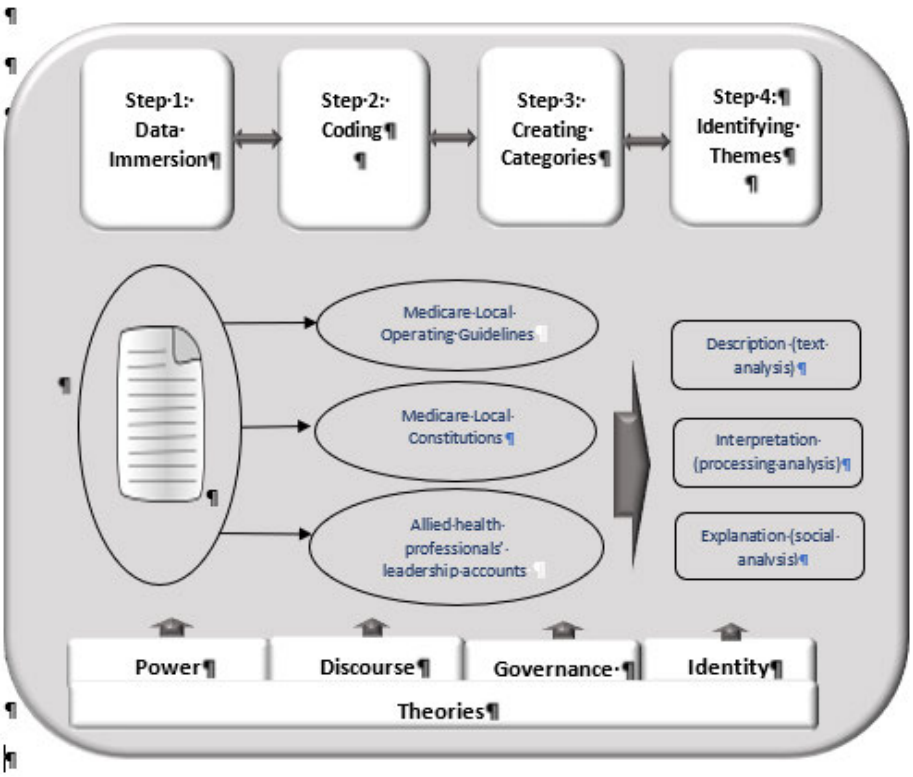
the research was about, what their participation would involve and the possible risks and benefits of the study.

The study participants were in various parts of Australia and the geographical location of the Medicare Local they worked in was identified using the ASGC-RA system described in chapter one. The geographic distribution of Australia's Allied Health Professional workforce was also described when introducing the notion and nature of Allied Health. A table depicting participant demographics is included in chapter six.

Medicare Locals classified as Metro 1, 2 and 3 were located in metropolitan areas. Metro 1 having the highest average socioeconomic status and Metro 3 having the lowest socioeconomic status. The Medicare Locals classified as Regional 1 or 2 have a middle to low socioeconomic status and an ASGC remoteness area comparable to Inner and Outer Regional Australia. Compared to Regional 1 Medicare Locals, Regional 2 Medicare Locals were either more remote, had a lower socioeconomic status, or both. Medicare Locals classified as Rural 1 or 2 were located in remote areas and had a low socioeconomic status. Medicare Locals located in a Rural 2 area would be situated in an even more remote area and had a lower socioeconomic status (National Rural Health Alliance, 2010).

Section 2. Data collection and analysis

This section describes the procedures related to collecting the Medicare Local Operating Guidelines and Constitutions and interview data. It then explains how data were triangulated for critical discourse analysis. For cohesion this section presents the data collection and analysis processes in their chronological sequence. Figure 4 depicts each step of the process reflecting the qualitative coding-categorising-theming procedures adapted from Green et al (2007). These procedures aligned with the methodological dimensions of description, interpretation and theoretical explanation drawn from Fairclough's (2005) critical discourse framework. However, in reality these processes were not linear but instead used an emergent cyclical approach.



Source. Adapted from Green et al (2007, p.547)

Figure 4. Four steps to analysing data

As the aim of critical discourse analysis is to understand the different dimensions and the social context of language use as social practice, the analytic process is rarely linear (Fairclough, 2001) and rarely involves one data set. In this study, data were derived from two sources of information. When the Medicare Locals were established, the policy directive was articulated in written Medicare Locals' Operational Guidelines. These guidelines specified what Medicare Locals were required to do and provided information about how primary health care was conceptualised at the strategic and policy level. Each Medicare Local also developed its own company constitution in line with Australian legislative requirements. These constitutions articulated how Medicare Locals were to function and informed health professionals how they were to work.

Together, the Medicare Local Operating Guidelines and Constitutions were the corpus of documents used a data source. As policy texts, they were limited for examining how health knowledge "*figures*

within and contributes to the existing social reality" of the business of Medicare Locals (Fairclough, 2015, p.6). As a result of the new health policy changes, Medicare Locals were established as integrated, multidisciplinary, collaborative organisations. For the first time in Australia's history, Allied Health Professionals were actively recruited into leadership positions onto Medicare Local Boards. Their accounts of leadership in primary health care were important in this study because they would:

a) provide contextualised accounts of how primary health care could be constructed from the available discourses; and

b) provide contextualised accounts of the identity shaping power effects, expressed through discourse, that the Allied Health Professionals might be willing or unwilling to assume.

The reasoning behind the two data sources was twofold. First, to allow for examination of the motivations behind representational language, and second, to check the consistency between the researcher's interpretation of discourses and Allied Health Professional's interpretations and understandings.

Document collection

The Medicare Local Operating Guidelines were written in English, publicly accessible at the time of the study, and able to be downloaded from government and company websites. At the time that each Medicare Local was funded there was a requirement from the Commonwealth government that they would each develop a public website. At the time data was collected, each of the 61 Medicare Locals had a website. A search was conducted, and 49 constitutions were downloaded (Appendix 8). Twelve constitutions were not made available to the Public by the Medicare Locals nor made available when requested for this study.

The Constitutions represented the largest data set in this study and included 3,132 pages of double-spaced text.

Analytic Cycle 1-Coding and categorising the documents

As shown in figure 5, once the Medicare Local Operating Guidelines and Constitutions were gathered the first analytic cycle was instigated and this consisted of three steps: data immersion, coding and preliminary categorisation of the data.

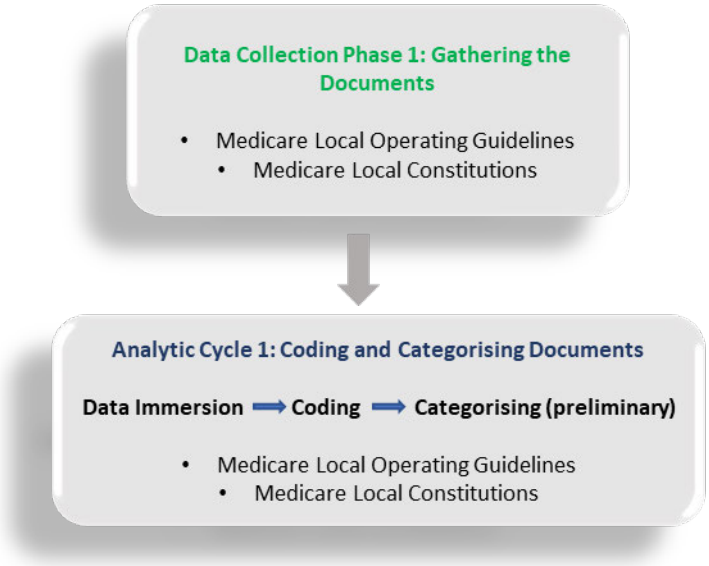


Figure 5. Analytic Cycle 1 Procedural Steps

Health and therefore health reform are multi-dimensional constructs that are complex to define, and various groups understand and therefore approach reform differently. Health and health reform are both shaped by discourse that is not always visible. As the previous chapter described, Fairclough (2003, 2013) draws various ideas of discourse together in a three-dimensional model which embraces the concept of a discursive event, which is viewed as text; a discursive practice; and as a socio-cultural practice. Accordingly, the first analytic cycle was focused on the texts of the Medicare Local Operating Guidelines and Constitutions and at this textual level the analysis sought to identify and describe discourse and its influence on the way primary health care had been constructed.

The first step of this initial analytic cycle commenced with reading and re-reading the Medicare Local Operating Guidelines and Constitution documents. This 'data immersion' process (Green et al., 2007)

allowed the researcher to become familiar with the data. By doing so, these readings facilitated an 'incubation' of ideas to arise and note early meanings and patterns (Hunter e tal., 2002).

The next step involved two phases of coding the data embedded within the documents. Codes are descriptive labels that can be applied to components of the transcript (Green et al., 2007). Coding the data sets entailed adopting an inductive process to examine and organise the information contained in the Medicare Local Operating Guidelines and Constitutions. An inductive process is important in qualitative research because the findings arise from the analysis of the raw data and not from an a priori expectation or model (Thomas, 2010).

During the coding process, the data were first sorted by examining various features within the documents. Fairclough (2015, p.130) distinguishes these as experiential, relational, and expressive textual features. Experiential values are traces and cues of the experiences of the text producer's representation of the world (Fairclough, 2015). Relational values are traces and cues to the social relationships that are ratified through the text in the discourse and expressive values are traces and cues to the producer's evaluation of their reality (Fairclough, 2015). These formal features are highlighted from the text in either vocabulary or grammatical form. Looking first at experiential values within vocabulary, these relate to contents, knowledge and beliefs. For example, 'General Practitioner' was coded separately from other clinicians in the Medicare Local Constitutions and by doing so it was possible to trace and make a link to a biomedical discourse. This shows that wherever a formal feature with a relational value occurs, it is a trace of, and cue to social relationships which come from the text in discourse (Fairclough, 2015, p.130). Regarding relational values within the vocabulary used in the document texts, specific words were coded because these were regarded as signifiers that depended on, and helped create social relationships, which were to be examined in the later analytic cycles. The underlying theoretical premise being both the Medicare Local Guidelines and Constitutions, as formal documents, were technologies of power (Foucault, 1975, 1991) that would impart authority and knowledge to readers, which shows a formality of social relations.

The second coding phase involved examining the grammatical features of the textual data. The experiential, relational and expressive values (Fairclough, 2015) were teased out even further, but in the grammatical forms of language codes. It was a process that allowed for some closer textual analysis to examine 'textual structures' (Fairclough, 2015), which were the formal organisational properties of the whole of this data set. All codes were tagged by hand using colour markers and sticky notes. As the data was read and re-read, further codes were added or merged together, and new definitions of each code were recorded.

The third step of this initial analytic cycle involved organising codes into preliminary categories. Categories are chains of codes that are connected or related (Green et al., 2007). The codes and preliminary categories derived from the textual level of analysis (Fairclough, 2005) were used to identify lines of inquiry to be explored in the interviews with the Allied Health Professionals and therefore informed the development of the interview guide.

Developing the interview guide

From the first document analysis cycle, codes were identified, which were organised into preliminary categories and used to inform the inquiry. These lines of inquiry were formulated into open-ended interview questions that were used to develop an Interview Guide (Appendix 9). The open-ended questions addressed issues such as:

- Perceptions of the Allied Health Professional role, and their understandings of primary health care, the reforms associated with the introduction of Medicare Locals, and their involvement in Medicare Local Boards.

In addition to the interview guide, prompts were used to elicit further information. Prompts are an important technique used in qualitative interviews because they can serve several different purposes. Prompting was used in this study to garner further information from a participant (Miles & Gilbert, 2005), 'rescue' the researcher when the participant responses were vague or unrelated to the

question (Leech, 2002), to help clarify the responses (Irvine et al., 2012); and explore an area that required further discussion (Miles & Gilbert, 2005).

Interviews

Drawing on the premise that Allied Health Professionals' experiences of being Board members were likely to have been shaped by the conversations that took place within Medicare Locals, it was anticipated the interviews would capture their recollections about, and reflections on, these interactions. They were important texts for analysis in this study because they provided data for analysis at the level of 'interaction' (Fairclough, 2005).

The interview questions were open ended to allow exploration of individual participants' accounts of working on a Board in a Medicare Local (Fink, 2000; Turner, 2010). The approach taken allowed for a conversational flow, which facilitated an "*openness to changes of sequence and forms of questions in order to follow up the answers given, and the stories told by the subject*" (Kvale, 1996, p.2). This approach kept the flow of conversation going in a way that motivated participants to provide rich and descriptive accounts of their thoughts and feelings (Kvale, 2007).

Six of the seven interviews were undertaken by telephone. The rationale for telephone interviews was that participants were located around Australia in a diverse range of metropolitan, regional, rural and remote settings. Interviews took approximately 30 minutes to one hour in length. One interview was conducted via email as the participant was unable to participate by phone. This email was formatted into a transcript to facilitate analysis.

To promote accuracy and transparency, the interviews were audio recorded and then emailed to an independent professional transcribing service to be transcribed verbatim. The researcher then de-identified the transcripts and removed extraneous personal information that was not relevant to the study such as 'my daughter told me yesterday…'. To ensure confidentiality of participants, a coding mechanism was devised that used a two-letter code for profession, the first letter of the participant's

last name, and a regional code for the Medicare Local they were a Board member of. For example, a hypothetical subject called John Smith, a Psychologist that was a Board member of the Inner West Sydney Medicare Local would be coded as PYSMETRO1. A list of the codes used for each Medicare Local region and profession (Appendix 10). The seven interviews created 180 pages of double lined text, that were subjected to critical discourse analysis.

Analytic Cycle 2- Coding and categorising the interview transcripts

A second analytic cycle was occurring concurrently during the period interviews were being conducted (Figure 6) using the steps of data immersion, coding and categorisation (Green et al., 2007).

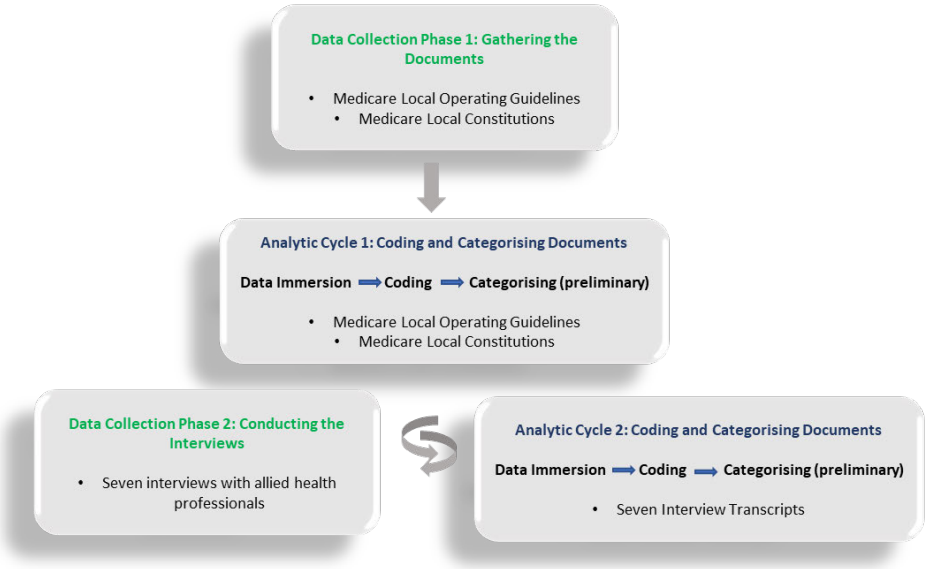


Figure 6. Analytic cycle 2 procedural steps

As the next set of texts for analysis, the interview transcripts, constituted the social and professional interaction sites where different meanings about primary health care, professional cultures and attitudes came together as the new multidisciplinary teams enacted their roles. According to Fairclough (2005), this level of analysis requires deeper interpretation because it is through interaction that meaning is formed and processed.

The same coding-categorisation procedure used for the document analysis was applied to the interview transcripts. As depicted in Figure 7, the next step of the second analytic cycle focussed on

bringing these new codes and categories together with the codes and categories identified in the first analytic cycle.

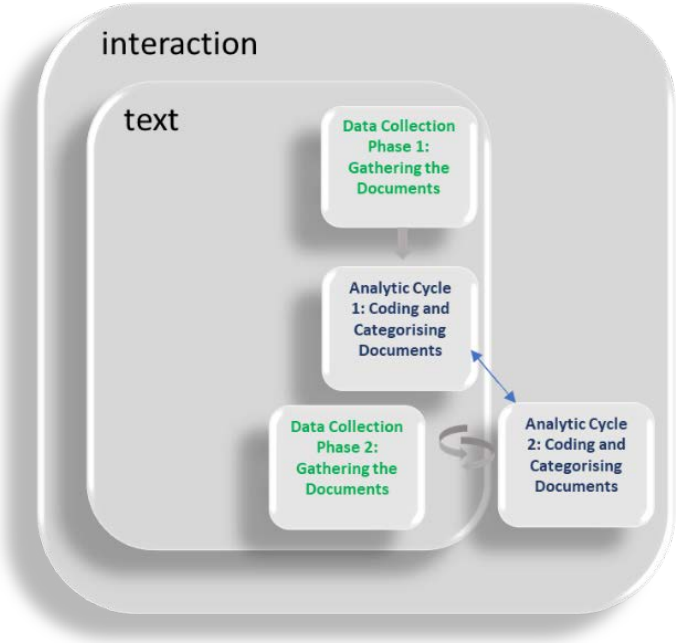


Figure 7. Analysis of processes of production and interpretation

Figure 7 reflects how the study procedures, at this stage, were informed by the first and second levels of Fairclough's (2005) model, by focussing on the interplay between 'text' and the 'processes of production and interpretation'. To move to the interpretative level of analysis (Green et al. 2007), this analytic step was focused on identifying emerging themes. It was a process that involved moving beyond describing the identified categories, to some interpretation of how the constructions of primary health care, both within the documents and the Allied Health Professionals' accounts, were shaped by discourse and influencing what could and could not be done in Medicare Local day-to-day practices. With the process of categorisation finalised, the analysis moved into a third cycle. van Dijk (1993) explains that while there are several possible discursive frames for thinking, writing and speaking about aspects of reality, ordinary people only have active access to public discourse.

The participants in this study, because of their discipline expertise as Allied Health Professionals and employment at Medicare Locals, were able to access and participate in health discourse. Centring on

this premise, the analytic focus in this cycle concerned examination of access and participation in discourse. It bought forward questions of "*who may speak or write to whom, about what, when, and in what context*" and "*who may participate in such communicative events in various recipient roles*" (Van Dijk 1993, p.86). Fairclough notes that,

> *interpretation of text is generated via a combination of what is in the text and what is 'in' the interpreter – this is the member's resources that the interpreter brings to the interpretation* (2015, p.155).

It highlights and makes explicit what is usually implicit for participants – that discursive practice is dependent on unexplained common-sense assumptions of member's resources and discourse type. In other words, this analytic cycle sought to examine the taken-for-grantedness of the Allied Health Professional's recollection of their Medicare Local experiences to interpret what this brought to the discursive practice. An example of this type of analysis relates to the interrogation of the way some participants uncritically used the word 'patient', and in doing so, were taking for granted the legitimate authority of the biomedical discourse.

In examining these patterns of discourse, access and participation, the analysis was focused on how the study participants were influenced by the processes of discourse 'production and interpretation' (Fairclough, 2005). During this interpretative stage of data analysis some emergent themes were noted as the data was repeatedly being examined via the coding and categorising processes. During these analytic stages, there was some consideration of variation in possible meanings and how these might develop as emerging themes.

Analytic Cycle 3 – Data triangulation and critical discourse analysis

As shown in Figure 8, the codes and preliminary categories identified during the first and second analytic cycles were triangulated to allow for a deeper analysis of the whole data set, which was necessary to identify themes. As explained earlier in this chapter, triangulation involves reviewing data

from different sources (Jonsen & Jehn, 2009) to ensure accuracy and credibility within the data. In this study, triangulation occurred through a close examination of data collected from interviews with Allied Health Professionals, documentary analysis of Medicare Local Company Constitutions and Operational Guidelines to align multiple perspectives, corroborate evidence and gain a more comprehensive understanding of primary health care constructions.

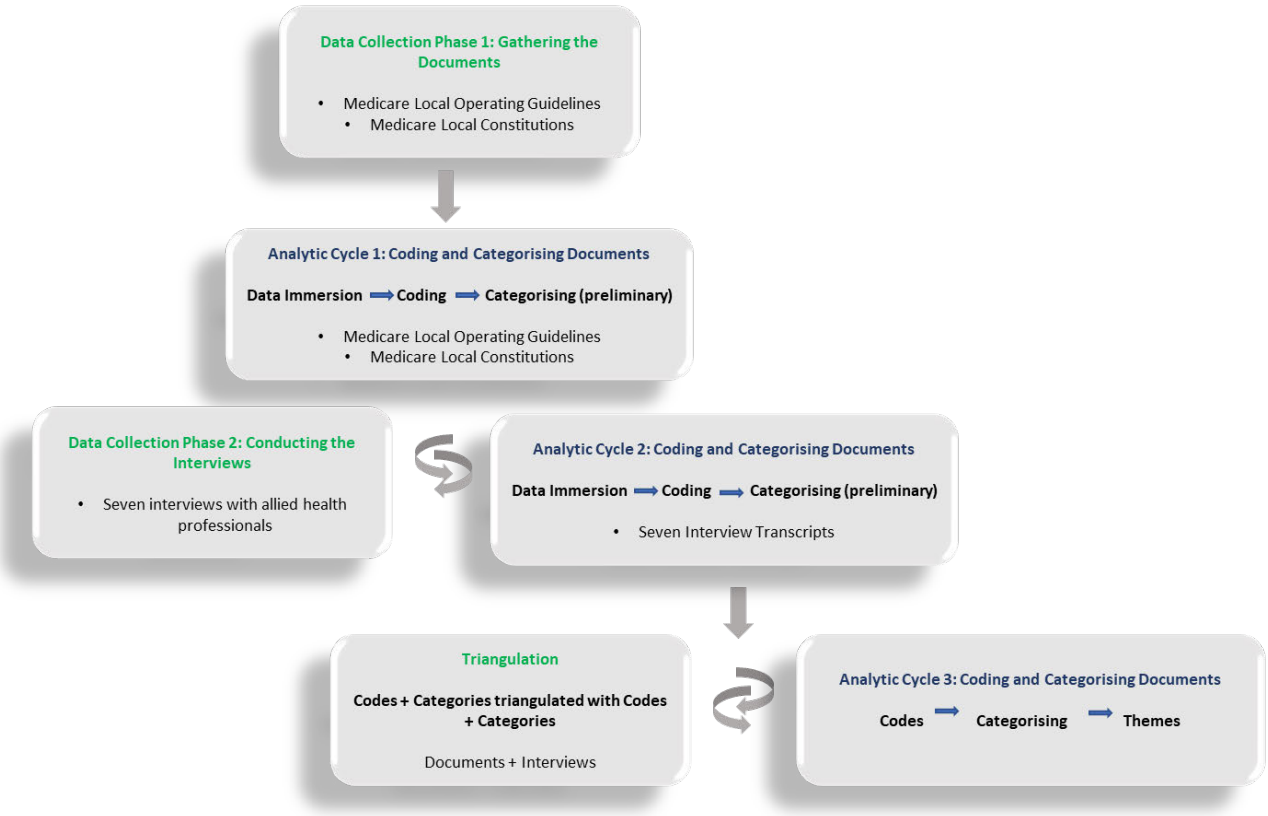


Figure 8. Procedures for identifying themes

At this stage of the study, all the methodological components of Fairclough's (2003, 2010, 2015) critical discourse analysis framework were applied in this final analytic cycle, as shown in Figure 9.

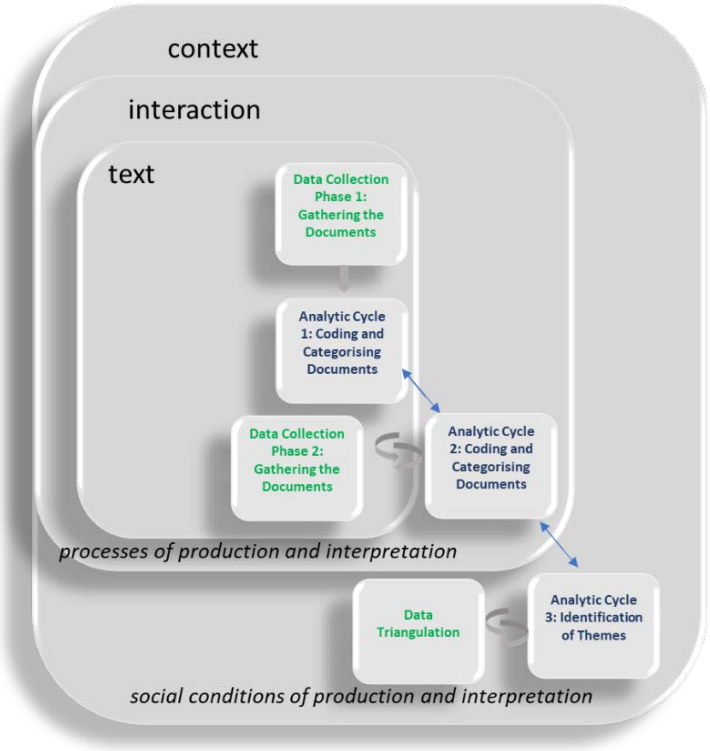


Figure 9. Analysis of the social conditions of production and interpretation

This stage of the analytic process was focussed on deeper levels of interrogation of the data across all three levels of text, interaction and context (Fairclough, 2005). This was achieved by examining the interplay and relationships emerging from the coding-categorisation processes used in the first and second analytic cycles to examine the documents and interview transcripts. There was scrutiny of the interdependency between the parts and the whole. The parts of the whole could only be based on an understanding of the whole, even when the whole could only be grasped by understanding the meaning of the parts. At this level of social analysis (Fairclough, 2005), it was possible to strengthen the analytic focus on how primary health care had been constructed, the discursive influences on how Allied Health Professionals processed and interpreted primary health care and the socio-historical conditions, which governed those processes, and influenced professional and social identities.

The final step in this analytic cycle involved testing, challenging and interrogating the emerging themes to develop the final themes. This step involved ordering and comparing the collection of clusters of categories and the preliminary themes, comparing the parts together and then considering them in

relation to the whole data set. As Vaismoradi et al. (2016) explain, it was a process influenced by the original research objectives and the new concepts that were generated inductively from the data. It was an important analytic cycle because the point of critical discourse analysis is to analyse language texts to identify discourses and through a process of critical analysis, challenge and potentially change the existing social reality in which discourses are related to other social elements such as power relations. For primary health care reform these power relations can be in the form of ideologies, political and economic policies and strategies (Fairclough, 2015), which were likely to manifest through the Medicare Local Operating Guidelines, constitutions and Allied Health accounts.

Through the full application of Fairclough's (2015) model, the final analytic cycle sought to extend beyond the interpretative endeavour to explain the relations of power and truths that were giving rise to sites of tension and struggle for the Allied Health Professionals. These explanations are possible when analysis of the social conditions of discourse production and interpretation is completed. Fairclough (2015, p.172) explains the aim of this stage is to,

> *portray a discourse as part of a social process, as a social practice, showing how it is determined by social structures, and what reproductive effects discourse can cumulatively have on those structures, sustaining them or changing them.*

It was at this level of analysis the whole data set was examined to consider how processes of discourse reproduction were connected to the processes of discourse interpretation and explanation. This required some consideration of the way discourses were working to reinterpret or reproduce other knowledges, such as biomedical or health knowledge.

Section 3. Rigour and trustworthiness

In this qualitative research, the study of the empirical world was derived from written documents as well as the viewpoint of study participants to consider how social interaction about primary health care was influenced by the sociocultural environment of Medicare Locals in which it occurred. With

this premise underpinning the basis of interpretative-critical enquiry (Creswell & Poth, 2017), it was important to acknowledge that the social practices being described by the Allied Health Professionals went beyond what was observed and captured by the researcher. Subjective meanings and perceptions of the subject of inquiry are critical in qualitative research, and critical discourse analysis is no exception. It is the researcher's responsibility to access these.

Critical discourse analysis is characterised by a range of epistemological positions, theoretical frameworks and methods and this diversity creates challenges for judging the quality and trustworthiness of knowledge generated by qualitative research (Denzin & Lincoln, 2008). Challenges associated with qualitative research include detailing the methodological framework, explaining research procedures, describing and representing data, ensuring systematic analyses, and generating and confirming substantive results (Greckhamer & Cilesiz, 2014). In this study, the qualitative and critical discourse analysis methods were both underpinned by distinctive philosophical positions and purpose, therefore use of their frameworks for establishing rigour were required. The seminal contributions of Guba and Lincoln (1982) were used because they offer criteria that can assist researchers to engage in rigorous empirical qualitative research by demonstrating trustworthiness. The study required additional criteria to ensure the study generated 'valid knowledge' (Crotty, 1998) that was coherent with epistemological and theoretical assumptions used in the study methodology. The contributions of Greckhamer and Cilesiz (2014) were used because they provide advice for researchers to ensure discourse analysis is rigorous, transparent and representative. The remainder of this section describes the efforts used to mitigate bias and establish trustworthiness.

Efforts to mitigate bias

As qualitative research is subjective in nature there is always a risk of unintended bias in text classification and analysis. The researcher is an Allied Health Professional who has worked in the health and ageing sectors across Australia and brings over twenty years' experience working in policy and program development, and clinical practice in both State and Commonwealth Government

Departments, as well as the private sector. As an employee of the Commonwealth Department of Health and Ageing, the researcher had also participated in the selection panel process for Medicare Locals in 2011. The researcher's clinical expertise was invaluable for making sense of the data through experience working with clients, the community and vulnerable populations. Similarly, the experience of working as a Public Servant in health policy implementation and reform meant the researcher had insider knowledge of the policy underpinning Medicare Locals, how they were expected to operate and what they sought to achieve. At the same time this experience meant that the researcher was also at risk of importing a bias by uncritically placing higher importance on the knowledge and value systems used for the study of health reform, and Allied Health Professionals' experiences of primary health care while working at Medicare Locals. Reflexivity was used to mitigate any unintended bias throughout the life of the study.

The insider status, as a clinician and Public Servant also influenced the critical research design and the need to manage interpretations of participant responses in the study. As a psychologist, action learning, reflection and reflexivity were familiar concepts and skills that had been well developed by the time this study commenced. Parker (1991) notes that reflexivity, to reflect on oneself is central to human agency and understanding. It is '*the point of connection between the individual and social*' (Parker, 1991, p.105). Within the context of professional psychological practice, reflexivity is required by psychologists '*to consider themselves in relation to their (social) context and vice versa*' (Donati and Archer, 2015, p.62) to assist the client-psychologist relationship. Reflexivity was used in this study to monitor the positionality of the researcher and how this may have been impacting the research, especially regarding the richness and quality of data and its analysis (Al-Natour, 2011). The relationship between the interviewer and the interviewed in qualitative research has been a recurrent and contested topic in the qualitative field of literature (Garfinkel, 1984; Naples, 1996; Bradbury and Lichtenstein, 2000; Raheim et al., 2016) and more recently in the critical discourse analysis (Greckhamer & Cilesiz, 2014) methodology literature.

The insider-outsider perspectives debate mostly revolves around researcher positionality and what it means to be an insider or outsider within research, and how the status of the researcher is negotiated throughout the research process (Raheim et al., 2016). Nader's (1972/1969) anthropological work on researcher positionality identified a range of power imbalances exist in qualitative research that gives rise to a dichotomy between studying up and studying down. 'Studying up' (Nader, 2008) occurs when study participants hold more power than the researcher and 'studying down' occurs when the researchers holds more power when working with disadvantaged and marginalised study participants. In this study, Nader's (2008) notion of 'studying sideways' denotes the power manifest in peer-to-peer research. The studying sideways notion was used for the researcher (an Allied Health Professional), to study the Allied Health Professional study participants' accounts to manage two methodological issues.

The use of interviews to collect data presented the first methodological issue that was managed by 'studying sideways' (Nader, 2008). During the interview process there was some risk of blurring the boundary between the interviewer and interviewee's contributions; the risk being the researcher might draw on a shared discipline knowledge to recognise concepts raised the study participants. By doing so, the researcher was at risk of directing the conversation rather than receiving and herein overlook the opportunity to fully enable to the voice and perspectives of the study participants.

The need for systematic and rigorous data analysis presented the second methodological issue that was managed by 'studying sideways' (Nader, 2008). The qualitative data were analysed using coding-categorising-theming procedures (Green et al., 2007) with textual analysis techniques derived from critical discourse analysis (Fairclough, 2001). Analysis was approached from the vantage of the researcher's ontological and epistemological position (Denzin, 2009), thus presenting a core methodological challenge for mixing social scientific language with the everyday professional Allied Health language (Plesner, 2011, p.477). Rather than being concerned with these mattes of language, discourse and power as a problem within the research processes, the researcher was cognisant of the

need for careful and critical examination of all instances of language use in the documents and interview transcripts. Due to the shared vocabulary and ideas that are manifest in peer talk, it was not possible to view any language use as obvious truths or common sense and all were subjected to careful textual, discursive and social analysis (Fairclough, 2015). As the primary objective of discourse analysis is to examine how discourse expresses power to influence what can be known and how it can be known (Fairclough, 2015), discourse analysis requires interpretation (Fairclough, 2015). The researcher therefore influences multiple stages of the research process.

Credibility

The study was based on a premise that primary health care was able to be constructed in multiple ways in the Medicare Local documents and Allied Health Professionals' accounts. Analysis of the constructive effects of these texts through consideration of how discourses were constitutive relied on the researcher's subjective interpretation (Greckhamer & Cilesiz, 2014). Following Greckhamer and Cilesiz (2014), the researcher aimed to engage in systematic and rigorous analysis and interpretation processes and apply a sound theoretical position instead of adopting a face-value reading of data. Data analysis was therefore entrenched in the epistemological assumptions outlined in the earlier sections of this chapter and by doing so, avoid the risk of 'over-interpretation and forcing metanarratives on the data' (Greckhamer & Cilesiz, 2014). To persuade audiences that the findings of this qualitative inquiry are worth paying attention to and worth taking account of, credibility was required (Lincoln & Guba, 1985). Credibility involves an assurance and trustworthiness between the participants views and how the researcher represents them (Tobin & Begley, 2004).

Synthesising the research findings to represent the meanings that Allied Health Professionals ascribed to their experiences as Board members of Medicare Locals was an important final stage in this study (Sutton & Austin, 2015). This was done by supporting any conclusions made in the findings through direct quotations from Allied Health Professionals in consideration and respect of their experiences and to provide a level of credibility to the research (Hammarberg et al., 2016).

To establish credibility, this study included peer debriefing with a colleague who had no association with the research. Lincoln and Guba (1985) argue the value of peer review enriches analytic interpretations that may have otherwise been overlooked (Lincoln & Guba, 1985). Peer debriefing for this study took place with a professional colleague. Throughout the life of the study, interaction with the peer reviewer focused on issues related to methodology, data, theoretical perspectives and findings. These professional interactions were crucial for strengthening the research design and testing various aspects of the analytic interpretation: such as, the logic and 'fit' of analysis. This was demonstrated through the use of participant's quotes in the finding's chapters, which were suitably attributed to their source, to ensure that discussions of the data were transparent and credible.

Dependability and confirmability

In line with the principles of ensuring systematic and rigorous analysis, it was important to ensure the study procedures were dependable and the findings could be confirmed. The literature review presented the aims, scope and questions, and describes the strategy for accessing the literature reviewed. The study procedures, as described in this chapter, communicate the pragmatic decisions related to ethical considerations, data sources, sampling, recruitment, data collection and analysis. Together these chapters make the study procedures transparent to enable readers to evaluate the rigor of the study and trustworthiness of the findings (Nowell et al., 2017). Following Lincoln and Guba, (1985), and Nowell et al (2017), the dependability and confirmability of this study was also established through the detailed audit trail.

Auditing allows another individual to assess whether the research process was robust, cohesive, systematic and appropriate (Lincoln & Guba, 1985; Nowell, et al., 2017; Korstjens & Moser, 2018). All decision making in this study was made transparent by documenting each supervision meeting and ensuring the audit trail identified and managed the study limitations, which are outlined in the concluding chapter. The research interpretations and findings were scrutinised by the supervision team to ensure confirmability (Nowell et al., 2017).

Transferability

Recalling interpretations and analysis of data in this study were intricately linked to specific contexts and social interaction between the study participants and the researcher. Here the concept of '*thick description*' was used (Creswell & Poth, 2017), a term used to reflect the process of interpreting social meaning. Thick description occurred naturally in the comprehensive policy texts used in this study. From audio taped interviews, verbatim written texts were created to form comprehensive and detailed descriptions of the language used by the Allied Health Professionals accounts. These detailed thick descriptions make it possible for others to see the findings in-context and make informed decisions about the goodness of fit and transferability of the findings to their own context of work.

Chapter summary

Chapter four outlined the research procedures related to setting up the study, including ethics approval and its related considerations, purposive sampling and recruitment of participants. It described the methods used to collect and analyse the data, including procedures related to collecting the documents and developing a guide for interviewing the Allied Health Professionals. The chapter also presented how the interviews were structured and conducted, and how the three data analysis cycles combined a coding-categorising-theming sequence (Green et al., 2007) with Fairclough's (2015) three-dimensional methodological framework for critical discourse analysis. The chapter concluded with a description of the processes used to mitigate bias and ensure rigour and trustworthiness.

The key points in this chapter were:

- Ethics Approval was obtained from the University of Tasmania's Human Research Ethics Committee: Number H00167776.
- The study was oriented in the qualitative, interpretative, critical research paradigm.
- Purposive sampling was used to recruit seven Allied Health Professionals who had been in a leadership position with a Medicare Local.

- The written and spoken texts elicited from the two data sources were triangulated and analysed using a three-dimensional framework to focus on description (text analysis); interpretation (processing analysis); and explanation (social analysis).

- Bias was mitigated by situating the researcher, applying reflexivity and adopting a rigorous and systematic approach to analysing language, discourse and power as outcomes of primary health care reform.

The following two chapters present the findings. The first findings chapters identify the way that certain discourses appear throughout the Medicare Local documents. The second findings chapter reports the accounts of Allied Health Professional's experiences of primary health care reform under the jurisdiction of Medicare Locals.

Chapter 5. Findings part 1: Operational framework of Medicare Locals

Introduction

This chapter is the first of two findings chapters. It reports the principal findings from the analysis of the Medicare Local Operational Guidelines (Australian Government, 2013a) and 49 Medicare Local Constitutions (Appendix 8). Analysis of these data were guided by the first research question: *How was primary health care constructed within written strategic documents mandating the vision and mission of Medicare Locals in Australia?* As these key documents detail the rules about what a Medicare Local could do - and how they could do it, in this study they were considered as 'technologies of power' (Foucault, 1975,1991). This chapter is structured in two sections to examine the different ways power was expressed in these documents. Section one reports the findings of the Medicare Locals Operational Guidelines (Australian Government, 2013a) that prescribed the Australian government's mandate for primary health care reform. Section two reports the ways in which Medicare Local constitutions interpreted the Operational Guidelines to enact primary health care reform.

The principal themes presented in this chapter are the *Australian Government's prescribed vision and mission for Medicare Locals*, the *Interpretation of guidelines to develop the constitutions,* and *Health For All.* The latter is divided into two subsections – *The Need for Health Improvement* and *Discursive Tensions in Health Promotion and Primary Care*. The overarching purpose and values underpinning the establishment of Medicare Locals were encapsulated in the government's operational guidelines (Australian Government, 2013a).

Section 1. The Australian government's prescribed vision and mission for Medicare Locals

The Australian Government's mandate for primary health care reform can be understood as the vision, mission and responsibilities articulated in the Operational Guidelines (Australian Government, 2013a).

The overarching vision for Medicare Locals was to become:

> … *independent primary health care organisations that work with primary health care providers, local hospital networks and communities to ensure that patients receive the right care in the right place at the right time* (Australian Government, 2013, p.4).

The vision clearly sets out the Australian government's purview to establish a network of primary health care organisations that work collaboratively to ensure people have access to the health services they need, when and where they need them. This vision situates people and communities at the centre of primary health care. However, the term 'patient' implies people are sick. It is a reductive and mechanistic language (Jayasinghe, 2011) that renders patients passive and articulates citizens relationships to their own biological bodies. Use of this term was not benign. It was being operationalised by the Australian government, one of the most powerful and elite groups, and therefore legitimised the lens through which primary health care was to be constructed.

The mission served to articulate how the vision was to be enacted:

> *Medicare Locals operate as health system planners at the regional level. They have primary responsibility for identifying and assessing the health care needs of their populations improving the coordination and integration of primary health care in local communities, addressing service gaps, and making it easier for individuals, carers, and service providers to navigate their local health care* system (Australian Government, 2013, p.5).

In delegating health system planning to Medicare Locals, the Australian government was embracing a systems approach to their implementation. In this approach all parts of the health system are utilised to optimise health outcomes (WHO, 2008b). Through the government's prescribed mission for Medicare Locals, the Australian government recognised health professionals working in Medicare Locals as legitimate experts in health service planning and granted Medicare Local organisations the authority to assess local health needs and plan and deliver health services. Unwittingly, it imported

the traditional paternalistic approach to health care in which "*health professionals assume primary responsibility for making decisions based on what they discern to be in the 'patient's' best interests*" (Sandman & Munthe, 2010, p.62). Herein, this flags an immediate tension between the vision and mission that on the one hand situates people and communities centrally, only to perpetuate paternalism. This is counter to the government's parallel endorsement of person-centredness for the delivery of safe and quality care (Australian Commission on Safety and Quality in Health Care, 2017).

Alongside the vision and mission there were a range of strategies prescribed for how Medicare Locals were to operate. These included articulating the roles and responsibilities; objectives; funding models; governance; and arrangements for service provision and engagement. The Medicare Local Operational Guidelines (Australian Government, 2013, p.5) detail eight roles and responsibilities:

1. *Making it easier for patients to access the services they need by better linking local GPs (GPs), nursing, Allied Health and other health professionals, hospitals and aged care, and maintaining up to date local service directories;*
2. *Working collaboratively with the full range of primary health care providers in their community such as GPs, physicians, pharmacists, practice Nurses and Allied Health Professionals;*
3. *Working closely with Local Hospital Networks to make sure that primary health care services and hospitals work well together for the benefit of their patients;*
4. *Planning and supporting local after-hours face-to-face GP services;*
5. *Identifying and targeting gaps in primary health care for older people, whether they live independently or in an aged care facility;*
6. *Identifying where local communities are missing out on services they might need and coordinating services to address those gaps;*
7. *Supporting local primary health care providers, such as GPs, practice Nurses and Allied Health providers, to adopt and meet quality standards; and*

8. *Being accountable to local communities to make sure that services are effective, affordable and of high quality.*

Of these roles and responsibilities, four (1, 4, 5, and 6) refer to access, including access to services, health professionals, after-hours GP services, aged care services, and to addressing non-existent services. Two (2 and 3) refer to collaboration, in terms of the full range of health care providers and collaboration with local hospital networks. Two (7 and 8) refer to the need to adopt and meet quality standards in health care, and another, (8), the need to be accountable to local communities to ensure services are effective and affordable. The government was seeking to improve access and drive appropriate service use, as well as influence the efficiency and accountability of Medicare Local organisations through strong governance and effective management (Australian Government, 2013a).

The roles and responsibilities were also reflected in the statement:

> *Medicare Locals are playing an essential role in reorienting the health system away from acute care. A stronger primary health care system is more cost effective and delivers better health outcomes for individuals at a population level.* (Australian Government, 2013, p.5)

Like the tensions between the mission and vision, the above statement captures a dichotomy between the authority of Medicare Locals as health system planners for delivering better health outcomes at a population level and creating a more cost-effective health system. This section highlights the tension between the business imperatives of Medicare Locals and the aspirations for improving health by shifting from acute care to primary health care. This reflects the New Public Management, one of the main drivers of health care reform which sought to achieve cost-reductions and organisational efficiencies in the delivery of healthcare services (Mickan & Boyce, 2006).

The Medicare Local Operational Guidelines (Australian Government, 2013) specify five key objectives (Table 7).

Table 7. Medicare Local strategic objectives

Objective	Descriptor
1	Improving the patient journey through developing integrated and coordinated services
2	Provide support to clinicians and service providers to improve patient care.
3	Identification of the health needs of local areas and development of locally focussed and responsive services.
4	Facilitation of the implementation and successful performance of primary health care initiatives and programs.
5	Be efficient and accountable with strong governance and effective management.

Source: Australian Government. (2013, pp.5-7).

The tensions demonstrated between the vison and mission were again reflected in the objectives. The aspirations of reform were intended to produce value for public money, provide greater public choice for services, improve efficiency, and increase responsiveness to customers (or consumers) of these services (Australian Government, 2009b). Realising these objectives would be constrained by reconciling the market-based philosophy and business of health with the practice of health.

The business imperative, expressed through the Medicare Locals Operational Guidelines, and carried through to the Deed for Funding, outlined the terms and conditions under which Medicare Locals received Commonwealth funding. The Deed categorised funding into one of three types: "*core funding, flexible funding and program funding*" (Australian Government, 2013, p.8). Core funding was made available to all Medicare Locals to support their ongoing operations, general

administrative costs and develop the skills and capacities of their workforce for meeting the five strategic objectives (Australian Government, 2013, p.8). Flexible funding was provided to all Medicare Locals for developing and implementing regionally-tailored primary health care initiatives (Australian Government, 2013, p.9). Medicare Locals were also able to access program funding available through other Departmental funding streams (Australian Government, 2013, p.11). The government's ability to set the parameters for primary health care reform expressed through the vision, mission, objectives and funding deed is representative of their 'sovereign power' (Foucault, 1975, 1991). Furthermore,

the government's authority to govern primary health care reform extended to an accountability and compliance framework.

The governance framework outlined in the Medicare Local Operational Guidelines (2013) consisted of accreditation, performance management arrangements, and a mechanism for reporting identified deliverables. Medicare Locals were expected to be:

> *High-performing organisations that used best-practice organisational management, planning and service delivery processes to identify and respond to the health care needs of their local communities. The Commonwealth has a range of levers in place to manage the performance of Medicare Locals* (Australian Government, 2013, p.21).

One of the levers was the Medicare Locals' accreditation standards that sought "*transparency, information sharing and a culture of continuous quality improvement*" (Australian Government, 2013, p.18). Another lever was the National Health Reform Agreement supported by the National Health Performance and Accountability Framework. The National Health Performance Authority was an independent entity established around Commonwealth legislation for clear and transparent public reporting on the performance of every Medicare Local through *Healthy Communities Reports* (Australian Government, 2013, p.21). The competing expectations of business and quality service represents a third tension in the Medicare Local Operational Guidelines (Australian Government, 2013a).

The business imperative was used as a stick to incentivise performance.

> *In situations where ongoing poor or unsafe performance has been identified, the Department may appoint a funds administrator, defer, reduce or not make payments to the relevant Medicare Local. The Deed also enables the Commonwealth to terminate the Deed or any program schedule where performance does not meet expectations* (Australian Government, 2013, p.22).

The Operational Guidelines were intended to facilitate primary health care reform by articulating the roles, responsibilities, operational requirements, governance, and performance expectations for Medicare Locals. They contain several inherent tensions and ambiguities that set up a range of competing expectations which conflate the position of individuals, communities, organisations, and primary health care professionals and limit their capacity to realise the reform vision. These competing expectations were enshrined in the individual organisational constitutions and their objects.

Section 2. Interpretation of the Guidelines to develop Constitutions

A critical aspect of policy is the way it is interpreted by people. The Medicare Local Boards were directly responsible for the overall governance, management and strategic direction of their organisation and for demonstrating corporate accountability in accordance with the organisation's goals and objectives.

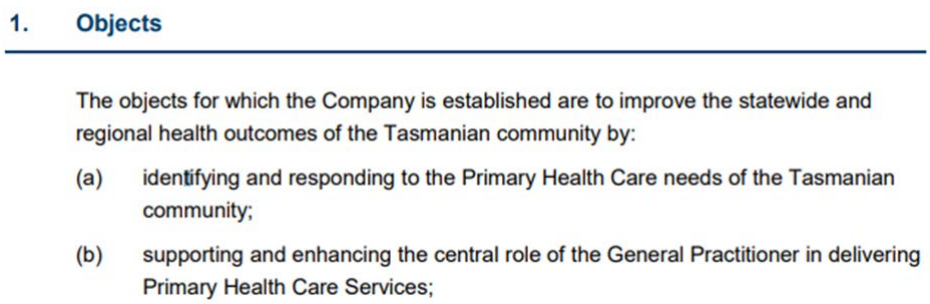
This section reports how Medicare Local Constitutions reflected the mandate specified in the Operational Guidelines (Australian Government, 2013a). A company's constitution is an important document that is used to govern internal management, the activities of the company and the relationship between company directors and members (Australian Securities and Investment Commission, 2018). As such, analysis of the Medicare Locals Constitutions provided a mechanism to examine how primary health care could be known, and how reform could be enacted.

The Medicare Local Constitutions that were analysed, used a similar structural design to document the fundamental principles governing their operations. Some of the Constitutions examined adopted verbatim, illustrative statements and objective that maintained the status quo and a more limited conception of health enshrined in primary care. Others seized the opportunity to embrace the broader holistic, person-centred collaborative health intent. This exemplifies the potential for active agents to be shaped by, or shape change.

Medicare Locals were established as businesses to:

coordinate primary health care delivery, address local health care priorities, support health professionals and improve access to primary care (Primary Health Care Research and Information service (PHCRIS), 2012, p. 4).

Medicare Local businesses were required to clearly state the '*Objects*' of their company. After listing the nature of the company (name and location), each Constitution presented the *Objects* as a list of clauses (Figure 10).



1. Objects

The objects for which the Company is established are to improve the statewide and regional health outcomes of the Tasmanian community by:

(a) identifying and responding to the Primary Health Care needs of the Tasmanian community;

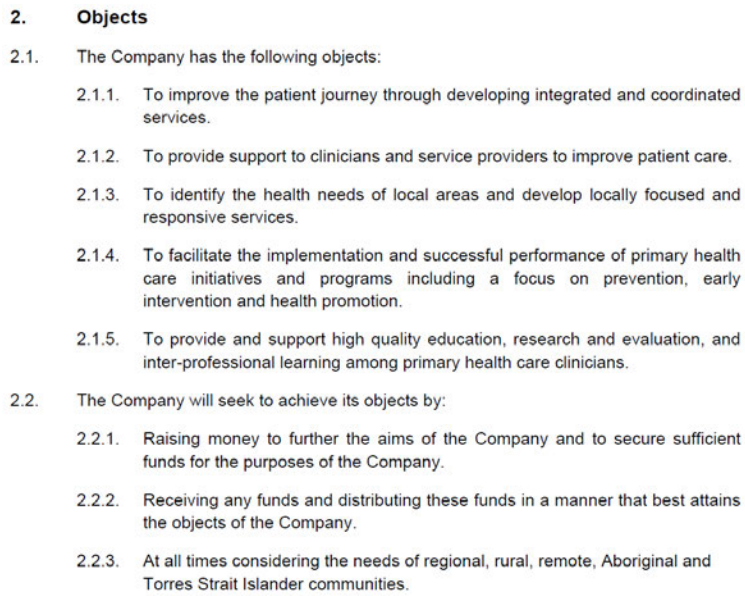
(b) supporting and enhancing the central role of the General Practitioner in delivering Primary Health Care Services;

Figure 10. Extract of constitutional object 1 from Tasmanian Medicare Local constitution

An objects clause states the purpose and range of activities for which a company operates (Tomasic et al., 2002). The word 'object' signifies a vocabulary that has been uncritically operationalised but has implicit legal knowledge systems underpinning it. Lawyers, with some collaboration with Medicare Local Boards, were the primary text producers for developing the Constitutions. To facilitate adoption of specific ways of representing concepts, experts and decision makers often import definitions and ideas from one document (the Operational Guidelines in this instance) for use in another (Medicare Local Constitutions). This is known as policy transfer and has been employed widely across a range of disciplines (Legrand, 2012). Reliance on the Operational Guidelines (Australian Government, 2013a) meant a legal discourse was used to develop the business dimensions. The business dimensions were symbiotic with the mandate for primary health care reform. In reproducing the reform language, the paternalistic, market-based vernacular was uncritically imported into the Constitutions. As legally binding documents (Commonwealth of Australia, 2017), the Constitutions operated as technologies

of power (Foucault, 1975, 1991), because at the pragmatic level they clarified the organisational purpose, delineated the basic structure and provided the cornerstone for building an effective team.

The constitutional objects would have enabled Medicare Local members and potential members, to have a better understanding of what the organisation was about and how it was to function (Figure 11).



2. Objects

2.1. The Company has the following objects:

2.1.1. To improve the patient journey through developing integrated and coordinated services.

2.1.2. To provide support to clinicians and service providers to improve patient care.

2.1.3. To identify the health needs of local areas and develop locally focused and responsive services.

2.1.4. To facilitate the implementation and successful performance of primary health care initiatives and programs including a focus on prevention, early intervention and health promotion.

2.1.5. To provide and support high quality education, research and evaluation, and inter-professional learning among primary health care clinicians.

2.2. The Company will seek to achieve its objects by:

2.2.1. Raising money to further the aims of the Company and to secure sufficient funds for the purposes of the Company.

2.2.2. Receiving any funds and distributing these funds in a manner that best attains the objects of the Company.

2.2.3. At all times considering the needs of regional, rural, remote, Aboriginal and Torres Strait Islander communities.

Figure 11. Extract of constitutional object 2 from Darling Downs – South West Queensland Medicare Local constitution

Constitutional objects were intricately connected to the Medicare Local Operational Guidelines (Australian Government, 2013a). Accordingly, they tended to reproduce the political ideologies and tensions outlined in the previous section. In figure 11 the objects 2.2.1 and 2.2.2. illustrate the neoliberal emphasis on market-based health care alongside the social justice right to health imperative, expressed in objects 2.1.1-2.15. Fairclough (2010) would argue the lists of *Objects* are more than itemised areas of priority in Medicare Local operations. They constituted '*organisational structures, semiotic in character, that can influence individuals*' (Fairclough, 2005, p. 916). The *Objects* of Medicare Locals' businesses provided information about what was considered important in their day-to-day operations and likely to influence how Medicare Local staff would think and act as they undertook primary health care activities.

The *Objects* in each Constitution point largely to the 'business' imperatives of the Medicare Locals with some emphasis on a more interconnected service (Figure 12).

2 Principal Purpose, objects and powers

2.1 The public charitable purpose of the Company is to optimise the patient journey and experience in the primary health care system by efficiently coordinating, integrating and delivering optimal services and outcomes ("**Principal Purpose**").

2.2 The objects of the Company are to achieve the Principal Purpose by, without limitation:

2.2.1 Encouraging and supporting improvements in the delivery of primary health care services to patients.

2.2.2 Encouraging, supporting and promoting health prevention to improve the health of the local community.

2.2.3 Improving the planning of primary health care services to identify health needs of the community, develop locally focused and responsive health services and address service delivery gaps.

2.2.4 Promoting primary care and the centrality of general practice for the delivery of effective integrated health management for the local community.

2.2.5 Providing support, training and education to general practitioners, other primary care service providers and practice staff to improve their patient care.

2.2.6 Actively pursuing effective collaborations to deliver more coordinated, integrated, flexible and locally responsive health services.

2.2.7 Promoting a culture of efficiency, accountability and continuous improvement in the delivery of primary health care services.

2.2.8 Seeking opportunity and funding for primary health care and distributing these funds in a manner that best meets the Principal Purpose.

Figure 12. Extract of constitutional object 3 from Goulburn Valley Medicare Local constitution

In figure 12, objects 2.2.1-2.2.6 again reflect the way Medicare Locals were expected to operate as health system planners in primary health care reform and objects 2.2.7 and 2.2.8 reflect the business service imperatives of efficiency, accountability and quality. The business language, immersed in a neoliberal discourse, manifests in the Constitutions as New Public Management in that it centres on a market-based philosophy incorporating cost-reduction and organisational efficiencies (Mickan & Boyce, 2006). Some characteristics of New Public Management include the separation of provision of services and production of services (purchaser/provider split), contracting out, performance auditing, accountability for performance, competition (such as competitive tendering), performance measurement and improved accounting processes. These elements were prevalent in the wording of the Medicare Local Operational Guidelines (Australian Government, 2013a) and Constitutions. Further evidence of this adoption of private sector approaches to service provision (Osborne & Gaebler, 1992) is reflected in the funding of Medicare Locals as private companies. However, the New Public Management agenda enacted in the Medicare Local Constitutions was inconsistent with

contemporary health care management thinking, objectives and practices geared toward universal access, equity, integration and collaborative practice. Rather, it was likely to sustain the traditional health care professionals' values of cure and care on which health services have been founded. Despite the tensions between the Operational Guidelines (Australian Government, 2013) and Constitutions, the overarching intent of Medicare Locals was to improve health outcomes and achieve health for all.

Section 3. Health for all

The structure and language of the Medicare Local Constitutions are described in this section to show how the principal theme *Health for All* emerged as the shared mandate of all Medicare Local businesses. This concern, underpinned by public health discourse, was expressed through a subtheme that recognised the need for health improvement.

The need for health improvement

Of the 49 Constitutions examined, all articulated their commitment to improving the health of the population in their *Objects*. The Constitutions indicated the need for early intervention and health promotion strategies to be implemented at the levels of individual, community and total population. For example, one Constitution directly stated that the aim of their company was to: "*improve the health of the local community*" (Partners 4 Health – Metro North Brisbane Medicare Local, p.4). Another stated they would be:

> *facilitating and supporting improvements in the delivery of primary health care services in the region including initiatives aimed toward improving disease prevention and management, raising patient awareness and improving access to appropriate services for all members of the community including high needs groups, such as Aboriginal and Torres Strait Islanders, those with non-English speaking backgrounds and chronic disease* (South Eastern Sydney Medicare Local Constitution, p.1).

A commitment to improving health rests on the premise that there is a shared understanding of the public health knowledge system. Robertson (1998) asserts that discourses of health gain and lose popularity, but they are never arbitrary, and always emerge and become accepted when they are congruent with the prevailing social, political and economic context within which they are produced. The notion of 'health' was tacitly taken for granted and therefore rarely defined.

When health was defined in Medicare Local constitutions it tended to refer to the need to:

> *facilitate the care of the whole person through an understanding of the interplay between the biological, psychological and social determinants of health and the need to provide comprehensive continuing care* (South Eastern Melbourne Medicare Local Constitution, p.4)

The definition in this excerpt places biological considerations alongside the psychological dimensions of health – it does not privilege one over the other. It then links these dimensions to the interplay between the person and their environment through the notion of social determinants of health. The discourse underpinning this definition of health epitomises Robertson's (1998) socio-environmental conceptualisation of health, which is largely derived from the social determinants of health as set out by the WHO (WHO, 1978). In other words, the health discourse operating in these definitions reflect the way health is "*the result of biological influences—linked to individual actions—as well as being socially determined*" (Keleher et al., 2007, p.16).

Instead of defining health, most constitutions tended to define the attributes of primary health care and comprehensive primary health care. For example, the Australian Capital Territory Medicare Local (p.29) constitutional object defined primary health care as:

> *socially appropriate, universally accessible, scientifically sound, first level of care provided by health services and systems with a suitably trained workforce comprised of multidisciplinary teams supported by integrated referral systems in a way that: (a) gives*

> *priority to those most in need and addresses health inequalities (b) maximises community and individual self-reliance, participation and control; and (c) involves collaboration and partnership with other sectors to promote public health and includes health promotion, illness prevention, treatment and care of the sick, community development, and advocacy and rehabilitation.*

Seven of the Constitutions aligned with this definition of primary health care. This language assumes a health discourse and aligns with the Declaration of Alma-Ata (1978) vision of primary health care whereby health is understood as a fundamental human right and that the attainment health requires intersectoral action. Gordon (1988) was one of the first authors to identify the health discourse that had emerged in the public health arena and linked its emergence to the new public health movement which was steering health back to society's social structure. The key elements of the primary health care era, as formalised by the Alma-Ata Declaration (WHO, 1978), were recognition that health care should reflect broader social and economic development, focus on health promotion, disease prevention, strategies to promote equity in health status; and intersectoral collaboration.

The Medicare Local constitutions took a broad view of community and what was needed to improve health. For example, the South East Sydney Medicare Local Constitution (p.3) states,

> *facilitating and supporting improvements in the delivery of primary health care services in the region including initiatives aimed toward improving disease prevention and management, raising patient awareness and improving access to appropriate services for all members of the community including high needs groups, such as Aboriginal and Torres Strait Islanders, those with non-English speaking backgrounds and chronic disease.*

The Perth North Metro Medicare Local Constitution (p.7) also looked more broadly for ways to improve the social and economic environment of their community, by:

> *improving the efficiency and effectiveness of health services at the local level; establishing effective collaborations between Medicare Locals, Local Hospital Networks and local Lead Clinical Groups (once established) to deliver more coordinated, integrated, locally responsive and flexible health services so that patients transition smoothly in and out of hospital and receive the right care, in the right place, at the right time; supporting the development of e-health and health information, including shared electronic health records, data provision to drive health system performance, service planning, monitoring and evaluation; supporting the ongoing development of primary health care infrastructure; and initiatives to increase and enhance the primary health care workforce to meet local community needs.*

The rise of chronic disease, an ageing population, workforce shortages and rising health costs are known to negatively impact on the health and wellbeing of Australians (Dixit & Sambasivan, 2018). Some populations, such as those living in rural and remote regions or Aboriginal and Torres Strait Islander communities, are more impacted than others (Australian Institute of Health & Welfare, 2018a). People living in regional, rural and remote areas of Australia do not have the same access to health services and health-related infrastructure as those living in more urban areas. Of more concern though, is the fact that Australians living in rural and remote areas tend to have shorter lives and higher levels of disease and injury. With all these component concerns reflected in the Medicare Local Constitutions, the textual structure uses an inclusive language reflecting fundamental human values such as rights, respect, equity and social justice (Keleher et al., 2007). This inclusive language appears to be reproduced from the WHO's Declaration of Alma-Ata (1978) and the WHO's Commission on Social Determinants of Health Report: *Closing the Gap in a Generation: Health Equity Through Action on the Social Determinants of Health* (2008). Within these global documents, 'Health for All' (WHO, 1978) is more than just a vision, it is a political statement that calls for transformation and links "health to community action, intersectoral cooperation, and the broader goal of social justice" (Bassett, 2006, p.1).

Most of the *Objects* in Medicare Local constitutions were explicitly concerned with adopting a public health approach and reorienting health services to focus on health improvement and disease prevention. For example, one Constitution articulated these goals as:

> *increasing the focus on population health including preventative care and improved chronic disease management with an increased emphasis on illness prevention and health promotion activities* (New England Medicare Local Constitution, p.1).

Longitudinal health statistics (Australian Institute of Health & Welfare, 2018a) show that chronic disease continues to rise and predictions about health suggest that the burden of disease in Australia is threatening to overwhelm the health budget. The rise of chronic disease around the world, including Australia, has meant that a different way of managing the health needs of the population is required (Willcox et al., 2011). While health care had always involved various types of personal and societal interventions; the excerpt above exemplifies the way Medicare Local constitutions placed emphasis on the need for chronic disease prevention and health promotion. This language again assumes health, and health promotion discourse (Ashcroft, 2015) and aligns with the Ottawa Charter (1986) position, in which *"[primary health care] is an approach concerned with health promotion and population health*" (Frankish et al., 2006, p.180). In Australia, the policy investment from both state and federal programs has focussed on delivering a range of population health service measures for health promotion and disease prevention. Some commentators argued these activities were fragmented and tended to concentrate on individual behaviours or specific diseases (Willcox et al., 2011), which was also a finding of the literature review reported in chapter two.

Service fragmentation was a major concern for most Medicare Locals and their Constitutional *Objects* placed emphasis on the need for integration and coordination. For example, one Constitution stated:

> *promoting well-integrated and coordinated Primary Health Care systems across primary and secondary care and facilitate partnerships to remove duplication and provide*

> *effective strategies for the early intervention, prevention and management of chronic diseases* (Far West Medicare Local Constitution, p.2).

Integration and coordination are hallmarks of primary health care (Powell Davies et al., 2008). The combination of these approaches within a partnership style, point to Medicare Local's desire to shift away from models that allowed one discipline to take sole carriage of health promotion and disease prevention. Rather, the Medicare Local's focus was on improving coordination to improve chronic disease care, access to services in rural areas and reduce avoidable hospital admissions (Powell Davies et al., 2006; Powell Davies et al., 2008). In other words, a systems approach was implemented as mandated in the broader national Medicare Local Operational Guidelines (Australian Government, 2013a).

The Medicare Local Constitutions adopted health system planning responsibilities. For example, Southern Adelaide Fleurieu Kangaroo Island Medicare Local Constitution (p.1) aimed to:

> *improve the planning of primary health care services at a population level to identify and advocate for health needs of the community, develop locally focussed and responsive health services and address service delivery gaps.*

Health care system planning is a complex and dynamic process that involves collecting information and data about the local population and service providers (Bryson, 2011). Local data are an important element of the system performance attributes of primary health care, and include accountability, efficiency and productivity (Haggerty et al., 2007). As the excerpt above shows, health system planning was connected to population health planning and embraced to ensure early intervention and health promotion strategies could be implemented at all community levels.

A community-oriented concern was another prominent feature in the Medicare Local's quest to improve health. The Greater WA Health Partnership Ltd (p.3) stated that they would:

> *provide health care and health care services to the community, including but not limited to the provision of health services.*

Discourses of health and health promotion were reproducing systems of knowledge from the Alma Ata Declaration (1978) and Ottawa Charter for Health Promotion (1986). These documents make clear that the health of populations is determined by many factors that exist outside the health care system. They look further afield to the determinants of health, which are comprised of environmental, political, economic, cultural and behavioural factors (Australian Government, 2009b). In other words, the Medicare Local Constitutions concern with the community-oriented dimensions of health import a whole-person perspective that reflect the "*physical, emotional, and social aspects of a patient's health and considers the community context in their care*" (Haggerty et al., 2007, p.340).

The need to work *with* communities rather than individual needs or specific diseases, was explicit in most of the Constitutions. For example, the Far North Queensland Medicare Local Constitution stated:

> *identifying local population health care needs and service gaps and developing locally focused and responsive health services* (Far North Queensland Medicare Local Constitution, p.7).

Integrating and coordinating services and working with communities using public health approaches are strategies that are consistent with the New Public Health approach (Baum, 2015) and its associated health promotion discourse (Ashcroft, 2014; Gordon, 1988; Robertson, 1989). In comprehensive primary health care this is also characteristic of the system planning method that concerns itself with population issues rather than those designed to cure individuals when they are sick (Baum, 2015). The approach articulated in the Medicare Local Constitutions therefore resonated with system planning theory that focuses on how changes across a whole population can be made by just a small and often insignificant amount and yet have a great impact on the incidence of a disease or problem within a community (Baum, 2015). The community-oriented dimension of health promotion includes client and

community participation, equity, intersectoral team and a population orientation (Ashcroft, 2015). Such initiatives are designed to promote health, human dignity, and enhance quality of life and by doing so, work towards the goal of achieving health for all.

Consistent with the New Public Health approach being used, each of the Medicare Local Constitutions made clear reference to the need for early intervention and health promotion activities to be implemented at the community and population level by:

> *Increasing the focus on population health including preventative care and improved chronic disease management with an increased emphasis on illness prevention and health promotion activities* (New England Medicare Local Constitution, p.1).

The Medicare Local Constitutions were attempting to reach beyond the paternalistic biomedical model that had been adopted by the Divisions of General Practice. There were clear attempts to shift the focus from disease to health at population and community levels and a push to effect this change at a systems level. The Medicare Local Constitutions were embracing a community development approach and striving to enable a strengthening of communities (Baum, 2015). These approaches support and empower organisations to protect and promote the health and wellbeing of people in their community (Baum, 2015). It was an approach that augmented with the philosophy of primary health care and the social view of health.

Discursive tensions in promoting health and primary care

The Medicare Locals were committed to working toward an overarching goal of '*Health for All*' using a systems approach for implementing early intervention, and integrated and coordinated care at community and population levels. However, due to ambiguity in the health care model the Medicare Locals were to adopt, a pervasive biomedical discourse gave rise to tensions in the way primary health care was constructed. The Constitutions reproduced the inherent tensions and ambiguities evident in the Medicare Local Operational Guidelines (2013), outlined in the first section of this chapter. The

resultant competing expectations once again conflated the position of individuals, communities, organisations, and primary health care professionals. The Constitutions blurred two key operational purposes of the Medicare Locals: promoting health and primary care.

Some of the Medicare Local Constitutions were explicit about the conceptual model of primary health care to which they were committed. For example, the Northern Territory Medicare Local Constitution used a language of "*comprehensive primary health care*" (Northern Territory Medicare Local Constitution, p.5) to describe what they wanted to do in their region. Another stated their approach to primary health care would be:

> *socially appropriate, universally accessible, scientifically sound, first level care provided by health services and systems with a suitably trained workforce comprised of multidisciplinary teams supported by integrated referral systems* (Australian Capital Territory Medicare Local Constitution, p.29).

Of the 49 Constitutions, only six reflected almost identical versions of this holistic definition of primary health care. When the imperative for comprehensive primary health care was explicit or clear, the Constitutions were able to present primary health care as a 'conceptual model' (Thomas-Maclean et al., 2008) to impart beliefs and processes for shaping how health care services were to be planned and structured. These explanations of comprehensive primary health care show an active and evidence-based thought process about the primary health care model being adopted. At the time of the study, the philosophical view of comprehensive primary health care was a relatively new concept in Australia (Baum et al., 2017). However, it had been particularly well applied by the Aboriginal Community Controlled Organisations (ACCHO's) and was reflected in some state-funded community health services, and rural and remote area multipurpose services (Hurley et al., 2010). Comprehensive primary health care looks to improving the overall health of the community and individuals and applies a community strength's-based model (Baum et al., 2017). Under this model, health services are generally provided to people who experience the most disadvantage and have trouble accessing

conventional health services (such as Aboriginal and Torres Strait islander communities, the homeless, people from culturally and linguistically diverse communities, or people from low socio-economic backgrounds) (Baum et al., 2017; Baum et al., 2016).

Some Medicare Local's presented atheoretical accounts or definitions of primary health care. For example, the Gippsland Medicare Local Constitution provided this list:

> *Primary Health Care includes, without limitation:*
>
> - *general medical practice;*
> - *private Allied Health practitioners;*
> - *public and private health services;*
> - *funded primary care services including community health, drug and alcohol treatment, mental health and youth health services, Aboriginal community-controlled health organisations;*
> - *medical schools;*
> - *regional training providers;*
> - *local government authorities; and*
> - *community groups involved in health service provision.*

And the South Western Sydney Medicare Local Constitution (p.4) suggested:

> *primary health care means the first line of health care which may be provided by a multidisciplinary team led by a General Practitioner.*

The reference to the 'first line of care' derives from the notion of primary care. It is an account of primary health care that does not align with the philosophy or principles of primary health care as outlined by the Declaration of Alma-Ata (WHO, 1978). Furthermore, the clause 'multidisciplinary team led by a General Practitioner' does not align with the perspectives of contemporary literature on interprofessional practice (WHO, 2018, Reeves et al., 2018). To afford one discipline with the authority

to lead the others is a known barrier to collaboration because differences in authority, power and expertise are reinforced (Baker et al., 2011) Primary health care has therefore been reframed

> *to select some aspects of a perceived reality and make them more salient in a communicating text, in such a way as to promote a particular problem definition, causal interpretation, moral evaluation, and/or treatment recommendation* (Entman, 1991, p.52).

The process of framing concepts creates 'genres' (Fairclough, 1992), which refer to a particular way of manipulating discourse to provide a framework for an audience to comprehend its underlying meaning. Genres' can therefore be the locus of power, domination and resistance (Fairclough, 1992). The limited engagement of these assertions with the rich literature on primary health care generated a new consensus frame where primary health care, underpinned by the biomedical discourse, invoked an abstract call for primary care based medical intervention.

The authority of the medical model and paternalistic view of health care was further evidenced by the way most of the Medicare Local Constitutions were interspersed with a prolific use of biomedical language. For example, the Central Adelaide and Hills Constitution (p.2) stated:

> *Primary Health Care means comprehensive health care and includes health promotion, illness prevention, treatment and care of the sick, community development, and advocacy and rehabilitation.*

The North Coast Medicare Local Constitution (p.7) stated that one of the Objects of their Medicare Local was to:

> *provide better outcomes to sufferers of disease and other chronic illness.*

The biomedical discourse was working to influence how primary health care could be appreciated and understood. In this instance, the discourse was constituting a sense of being and identity for

community members. To frame individuals as "*the sick*' and "*sufferers of disease*" immediately casts them into the category of '*patients*' in need of medical treatment and renders them as "…*passive components of the medical process*" (Delaney, 2018, p.120). The terms 'illness' and 'disease' are socially constructed terms, and their use in the Constitutions create evaluative categories that are founded on social ideas of what is *not* 'acceptable' or 'desirable' in health and health care (Conrad & Barker, 2010). Such language overlooks the person-centred values of respecting people (Delaney, 2018). The biomedical model has been criticised because it cannot fully explain many forms of illness (Baum, 2015). Wade and Halligan (2004, p.1398) suggests this '*failure stems from three assumptions: all illness has a single underlying cause; disease (pathology) is always the single cause; and removal or attenuation of the disease will result in a return to health*'. Even within the medical field itself, more holistic models such as the biopsychosocial model are championed to acknowledge the complex interplay between biological, psychological, and social factors (Kusnanto et al., 2018).

The inherent limitations of the biomedical discourse were manifest in patients being consistently centralised in paternalistic health care frames throughout many of the Medicare Local Constitutions. For example, the Goulburn Valley Medicare Local Constitution (p.1) espoused the value of:

> *promoting primary care and the centrality of general practice for the delivery of effective integrated health management for the local community* and *providing support, training and education to GPs, other primary care service providers and practice staff to improve their patient care.*

The Central Sydney Medicare Local Constitution (p.8) pointed to the importance of:

> *facilitating increased general practitioner focus on illness prevention and health promotion activities within their local communities …* and *improving the efficiency and effectiveness of health services at the local community level and advancing the interests of general practice patients and the general health of consumers within the community*.

These excepts are illustrative of the way the Constitutions placed GPs at the centre of primary health care and positioned them as experts around whom the Medicare Locals workflow was based. This is not only stated explicitly in these excerpts but also implied in the paternalistic construct, '*general practice patients'.* This possessive language suggests patients belong to a general practitioner. It was a very discrete form of biopower being exerted as the biomedical and professional discourses worked to legitimise GPs as the overarching authority responsible for 'patient's' health through a primary care approach. It was an example of how 'regimes of the self' were concretely established in the uncritical use of language (Foucault, 1980). Not only was the patient conceived as a '*sick person*', they were again attributed as passive recipients of applied expert medical knowledge. The Constitutions had unwittingly reinforced medical dominance in Australia and sustained the status quo where top-down, practitioner-driven models and health care priorities, interventions and decisions were controlled by medical experts.

The centrality of the general practitioner in primary health care was continually reinforced throughout most of the Medicare Local Constitutions. Fourteen Constitutions defined a general practitioner. For example, the Hunter Primary Care Constitution (p.7) suggested:

> *General Practice means the provision of primary continuing comprehensive whole-patient medical care to individuals, families and their communities…*

The Eastern Sydney Constitution (p.31) stated a:

> *practising General Practitioner means a medical practitioner, acting primarily outside a hospital who sees unreferred patients, and who may choose to refer the patient to a medical colleague and/or an Allied Health worker and who works in private practice for at least one Session per week averaged over each 12 month period from 1 July to 30 June.*

The continual references to GPs in most of the Medicare Local Constitutions affirms their centrality and importance in primary health care and renders the contributions of other health professionals as

secondary. Nine Medicare Locals attempted to ameliorate this professional siloing by either offering vague definitions such as "*Allied Health practitioner means a qualified Allied Health practitioner"* (Lower Murray Medicare Local Constitution, p.7) or using inclusive but ambiguous language such as "*Primary Health Care Service Providers means such other persons or class of persons determined by the Board from time to time*" (Southern Adelaide Fleurieu Medicare Local Constitution, p.25). However, some attempts to be multidisciplinary and inclusive tended to reinforce the centrality of GPs. The Hunter Primary Care Ltd Medicare Local Constitution (p.7) stated:

> *Primary Health Care Clinician means a clinician delivering Primary Health Care services in a manner integrated with General Practice and who has registration as a health practitioner with the Australian Health Practitioner Regulation Agency, and for the avoidance of doubt includes a General medical practitioner.*

In this excerpt, primary health care clinicians can only be understood through their differentiation with general medical practitioners. Primary care Doctors will always be important in the provision of first contact for persons with undiagnosed health concerns as well as continuing care of varied medical conditions (Rogers & Veale, 2018). However, it is only through the contribution of the whole multidisciplinary team that integrated and accessible health-care services will be authentically achieved. In part, the motivation for giving authority to one professional group exclusively in the Constitutions could be understood as ensuring patients receive the highest quality services. However, it also worked to sustain the traditional hierarchy that exists between and amongst the health professions in Australia (Braithwaite et al., 2016). While overtures were made to acknowledge the importance of other professionals in primary health care, the inequitable attribution of power to one professional group at the expense of Allied Health Professional groups, seemed to be at odds with the aspirations of promoting greater access and equity in multidisciplinary service delivery. Instead, the Medicare Local Constitutions demonstrated an uncomfortable coupling of the importance of medically based primary care with the primary health care aspirations of health and health promotion.

The Medicare Local Constitutions created a tension in centralising the importance of GPs and focusing on primary care workflow for responding to illness and the need to situate people and communities at the centre of primary health care to focus on their health, and its promotion. The Perth North Metro Medicare Local Constitution, (p.7) identified the dual need for

> *initiatives in general practice and primary health care designed to improve disease prevention and management and improve access to services*

This excerpt reflects the intrinsic tensions that could arise when biomedical discourse (and its related meanings about disease, illness, practice approaches and medical authority) sits uncomfortably with primary health discourse (and its related meanings about health, wellness, involvement of people and community as active agents and collaborative multidisciplinary approaches). The '*initiatives in general practice*' tended to focus on '*disease prevention and management*', whereas primary health care was concerned with the goal to improve access to services. This represents a fundamental tension between two different perspectives that are often confused: primary care and primary health care.

Chapter summary

The chapter presents the ways primary health care was constructed in the two key policy documents and examines how these constructions facilitated the exercise of power through the production of what can be known about public health and how it can be known.

The themes and subthemes presented in this chapter emerged from an analysis of the *Objects* stated in Medicare Local Constitutions. They make clear the interaction of biomedical and primary health care discourses, how these influence relations of power amongst health professional groups working in Medicare Locals and how specific subjective positioning is bestowed on people and health professionals.

The corpus of policy texts used in the analysis presented in this chapter were the Medicare Local Guidelines and the Medicare Local Constitutions. As 'technologies of power' (Foucault, 1975, 1991)

an examination of their structures and the use of language as a strategic device, allowed for the discovery of how primary health care, biomedical and professional discourse were produced and reproduced. '*Health for All*' emerged as the overarching discourse in the shared mandate of the Medicare Locals and this was evident through two subthemes: the '*Need for Health Improvement*' and '*Discursive tensions in promoting health and primary care'.*

The key points in this chapter include:

- The legally binding Constitutions of Medicare Locals share the common aspiration of '*Health for All'*, which is the overarching theme supported by two sub-themes, being the *Need for Health Improvement* and the *Discursive tensions in promoting health and primary care*.
- The *Need for Health Improvement* acknowledges the health of Australians is being influenced by social determinants and can be improved through a public health approach that acknowledges some populations are more adversely affected than others and health can be improved by working with communities.
- Although primary health care was recognised as the main health improvement strategy within the Medicare Locals, it was evident there were some *Discursive tensions in promoting health and primary care*.

The next chapter reports on the analysis of the interviews with seven Allied Health Professional Leaders who had been members of a Medicare Local Board.

Chapter 6. Findings part 2: The emergence of Allied Health Professional leaders in primary health care

Introduction

This is the second findings chapter. Whereas chapter five reported on how the vision and mission of Medicare Locals was articulated in the strategic documents, this chapter reports the principal findings from the analysis of the interviews with seven Allied Health Professional Leaders who had been members of a Medicare Local Board. The analysis was guided by the following research questions:

- *How did Allied Health Professionals who worked with Medicare Locals understand primary health care as it related to their leadership roles?*
- *How were Allied Health Professionals within Medicare Locals positioned for achieving integrated and collaborative multidisciplinary approaches in their work as Board members?*
- *Were Medicare Locals meeting their intended vision and mission of integrated and collaborative primary health care?*

By working at Medicare Locals, the Allied Health Professionals were engaged in various social relationships and embedded in a network of primary health care practices. Through these engagements, interactions and day-to-day social practices, the Allied Health Professionals were likely to have turned a self-regulating gaze upon themselves to make decisions about how they understood primary health care and constructed themselves in the reform process. This chapter is structured in four sections to examine these 'technologies of self' (Foucault, 1977).

The first section provides a profile of those interviewed in terms of disciplinary background, region, age and gender. The other findings are presented under three major themes. The second section addresses the theme *Bringing Allied Health Professionals To The Table*. It reports how participants temporally constructed primary health care. The third section reports participant's *Experiences of Being At The Table.* It addresses the degree of congruence between the rhetoric of Medicare Local

policy and the reality the Allied Health Professionals' experienced. This section presents the sub-themes 'Being silenced,' 'Finding voice', and 'Being heard'. The fourth section presents the theme '*Enacting Leadership To Achieve The Vision and Mission of Medicare Locals*'. The fifth and final section discusses how the Allied Health Professionals identified a gulf of difference between primary health care policy rhetoric and the reality of leading health reform within the Medicare Locals.

Section 1. Profile of participants

Seven women were interviewed. They ranged in age but were experienced in their fields prior to their work with Medicare Locals and had all served as members of a Medicare Local Board in one of five states/territories. The participants came from different geographical areas: three from metropolitan areas, two from regional areas and two from rural areas. The areas were categorised under the ASGCR classification system and ranged from Rural2 to Metro1. The participants came from six disciplinary backgrounds (Table 8). Only one participant out of the seven has continued with a role in the Primary Health Networks. During the period they were working with the Medicare Local, three were working in managerial positions in the health arena, three were working in clinical roles, and one participant was working as an academic.

Table 8. Profile of participants

Participant	Gender	Area	Interview	Profession
1	F	Regional2	Phone	Psychology
2	F	Rural2	Phone	Speech Therapy
3	F	Rural2	Email	Dietetics
4	F	Metro1	Phone	Pharmacy
5	F	Regional2	Phone	Physiotherapy
6	F	Metro3	Phone	Dental
7	F	Metro1	Phone	Physiotherapy

As previously stated, the Medicare Local Boards were directly responsible for overall governance and direction and achieving mandated goals and objectives. This meant whoever was present at the Board table could participate in decision-making processes. The next section explores Allied Health

Professionals' understanding of Primary Health Care and their accounts of joining the Medicare Local Boards.

Section 2. Bringing Allied Health Professionals to the table

It was important to examine how Allied Health Professional's understood primary health care and their views on the purpose of the Medicare Locals and what they could bring to it through their positionality on the Boards, before exploring their accounts of working in Medicare Locals.

Most of the study participants were primarily concerned about the health and wellbeing of their local community. One participant explained:

> *I could actually think, well, how are we improving the health of a population? You know, drilling and filling every day isn't actually improving anyone's health and wellbeing, because it's just so repetitive. You would see a patient, and you would fix their oral health, and then you see them 12 months later and you're basically repeating all of the work that you did 12 months ago* (DEBMETRO1, p.4)

This excerpt is illuminating in that it questions the episodic siloed approach to medical intervention as the only approach to improving health and reflects how it was socially conceived by an Allied Health Professional. Health was primarily regarded as a relative state in which an individual can function well. This aligns with the holistic discourse of health that posits for people to realise their full potential requires them to be physically, mentally, socially, and spiritually well. It also reflects public health and socio-ecological approaches that recognise the interplay between people, health, their behaviour and various influences within the social environment (Baum, 2015). It was a health orientation that aligned with the Declaration of Alma-Ata's social view of health (WHO, 1978) and situated health within the concept of wholeness (Larson, 1996). The social view of health was widely accepted as normal by the Allied Health Professionals who participated in the study.

In understanding health as a relative state, the Allied Health Professionals recognised environmental factors as variables that could be manipulated for improving health. For instance, one participant stated:

> *We need better recreational facilities. We need footpaths. We need bike paths. so that people can walk, and ride bikes, and exercise. We need to make sure there are no…what we call in the [area] - food deserts... so, our most disadvantaged populations live the furthest from fresh fruit and vegetables. You know, the fish and chip shop on the corner is a lot more convenient to get to, so therefore, that's what influences what they buy.* (DEBMETRO3, p.4).

This excerpt suggests health is influenced by the everyday environmental contexts in which people live, work and play. Diet, exercise, access to fresh food, and recreation are all social determinants of health (WHO, 2008c), which prompted the participant to question "*what can we do to actually…how do we address the social determinants of health which is the underlying cause for people having poor health and wellbeing?*" (DEBMETRO3, p.4). The drive to understand environmental influences and the local social determinants of health, align with the Ottawa Charter's (WHO, 1986) principals for health promotion.

The social view of health, social determinants of health, and a desire to promote health, constituted the frame through which the Allied Health Professionals interviewed, understood primary health care. One participant explained,

> *primary health care is the basic level of health service to be provided to clients … [in the] community, according to their needs. For example, if a community is lacking access to dental care and [is at] high risk of tooth decay in children, the organisation (PHN or ML) will look at 1) how to provide more dental care to that area; 2) how to fund the services 3) how to work on other prevention programs at the same time to improve the community's knowledge in*

> *dental care at home to prevent tooth decay. So, again this is about meeting the needs and finding ways to prevent the problem in the first place as well as improve service to minimise potential negative outcomes.* (DNFRURAL2, p.3)

This demonstrates a holistic understanding of primary health care, underpinned by the social view of health, that aligns with the Declaration of Alma-Ata (1978) vision whereby health is understood as a fundamental human right. It also reflects the promotive, preventive, curative and rehabilitative tenets of salutogenesis (Antonovsky, 1996, p.13). It also expresses an overarching goal of health promotion and a resolution and commitment to motivate individuals and the community to actively embrace healthy lifestyles and practices. Finally, this excerpt reflects recognition of the symbiotic relationships between health and illness, place and community.

The Allied Health Professionals tended to speak about the social locations of primary health care rather than its social organisation within and between health services. For example:

> *primary health care to me is, very broadly, anything outside of a hospital. So, to me… anyone outside of an acute medical issue, either living at home or some sort of residential care or other accommodation* (SPRRURAL2, p.6).

Another participant stated,

> *I understand primary health care as delivering health services to the community as their first point of call* (PYSREGIONAL2, p.4)

By locating primary health care outside hospitals, inside homes or other forms of accommodation, the Allied Health Professionals reflected commitment to embedding primary health care within the local community.

Allied Health Professionals focussed on the importance of understanding the needs of their local community and expanding activities to target various health concerns. One regional psychologist

spoke about a 25-year project to improve cardiovascular health for people living in regional and remote locations. The project sought to reduce the gap in survival rates and health outcomes between people living in rural, regional and urban areas. One participant stated,

> *telephone or face-to-face coaching for people post-hospital admission after a cardiac event because people in the cities used to survive a lot better than people in the country.* (PYSREGIONAL2, p.3).

This vision of implementing a longitudinal project to provide equitable health services to people living in rural and remote areas, indicates a major enduring commitment to community. This account exemplifies the benefit of overlaying a health promotion, and disease prevention strategy to address a condition that had already manifested in the community. This service response to a chronic medical condition represents the paradigm shifts that were occurring from primary care to primary health care and from health professionals to communities.

The commitment to community participation and to local communities was consistently evidenced by Allied Health Professionals in their accounts of primary health care. A critical perquisite to community participation was knowing community. One participant stated:

> *They weren't just fixing things here, there, and everywhere. There was a plan. So I think the best thing about the original Medicare Local, first of all you've got to find out who the hell are our patients and I don't think people knew that beforehand. They assumed a lot (PHCMETRO1, p.3).*

Getting to know the community allowed the Allied Health Professionals to gather local intelligence, which they understood as data for informing decision making:

> *Then the other thing is we've got good data about who we have, how old they are, where they're living, those sort of things (PHCMETRO1, p.3).*

Local intelligence and data was used to organise health services and build provider capacity. The participant went on to explain how understanding the community needs allowed Allied Health staff to assess service needs and organise delivery.

> *Then we developed well, what do they need? So the needs system has been extraordinarily helpful now to say well, we've looked at that community and we've got two GPs who are trying to see 10,000 patients in a week. So it started giving us data that we could interpret and I think before then there wasn't any. (PHCMETRO1, p3).*

As well as improving provider capacity, the Allied Health Professionals spoke about the need to improve health literacy across a broad range of the social determinants.

> *…it [the Medicare Local] worked really hard to bring together the service providers… primary care service providers… plus also local government, plus also education, plus also housing… Because we know that people with poorer health usually have insecure or unstable housing. They usually have low levels of education. So, if we can address those, you know…I mean obviously it takes a lot of time. But if you can address those issues, then generally people's health improves, and health literacy improves… so their understanding of how to look after themselves improves (DEBMETRO3, p.5).*

This participant's excerpt shows that health was being viewed as much more than physical health. It was an acknowledgment of the broad-based changes in the social and economic environment of local communities needed to improve health. The comment demonstrates the tenets of self-determination theory (Deci & Ryan, 2008), which are embedded within the principles of health literacy and personal responsibility. These are characteristics central to motivating behavioural change, and by doing so, can empower individuals and communities *"to look after themselves*". This illustrates how this Allied Health Professional valued people and community at the centre of primary health care and developed local capacity through improving health literacy and facilitating self-determination.

In putting people at the centre of Primary Health Care, build local capacity and align the provision of services with community need the Allied Health Professionals recognised the need to reorient service structure and form. One participant explained

*The other thing we were absolutely determined to do, from a philosophical position, was to build local capacity in the communities that we were looking after. So, wherever possible we either wanted the provider to have people live in the community or we looked at ways to… increase the skill-level of local providers. (*PYSREGIONAL2, p.1)

> *… because our goal was about lifting local capacity. What I was doing was trying to work with pharmacies and pharmacists to be able to lift capacity in local regions because there's places where there's a pharmacy but no GP (PYSREGIONAL2, p.3).*

She continued to describe how the Medicare Local distributed funding to local organisations to build local capacity within services and better utilise the health practitioners that lived locally:

> *So, for example, we had a prescribing Nurse in a small town that didn't have a GP and so, we subsidised some of the costs for that service so that it built-up the local capacity rather than shipping people in* (PYSREGIONAL2, p.1).

This Allied Health Professional was demonstrating moral agency in wanting to improve the local capacity of the community. Moral agency is a philosophical term that denotes ethical accountability for one's actions, and moral responsibility to prevent harm (Milliken, 2018). This Allied Health Professional was reflecting a sense of caring and commitment to her community, a sentiment echoed in the words of another.

> *…our Chair was about as highly-principled as you could get in terms of why we were there, what our commitment was, and absolutely, delivery outcomes for people.* (PYSREGIONAL2, p3)

These community-focused views of primary health care were shared by other participants who spoke about community as including those provided with a health service, and also those who were providing those services:

> *…so, we all work very informally as a fabulous team up here… because you know it's, so small. So, a lot of us see the same clients out here in the community, and that's where it works really well.* (SPRRURAL2, p.6).

This extract illustrates dimensions of inclusivity and connectivity between community members and service providers and also, interdisciplinary integration within the Medicare local team. Notably, this comment was made by an Allied Health Professional working in the rural context and may be an artefact of the nature of rural practice. Nevertheless, the Allied Health Professionals in this study imagined community as a whole social network characterised by inclusivity and connectivity rather than delineating boundaries between lay citizens and health services.

Understanding community as an inclusive connected social network was the lens through which the Allied Health Professionals made sense of the Medicare Locals' mission. One participant said,

> *The goal is to bridge the gap … so they want the Medicare Local to be the main coordinator so that the services can reach to the regions … the people who needed them. It's about the improvement with service access. Of course, that's including the Indigenous services as well as rural and remote areas* (DNFRURAL2, p2).

The excerpt resonates with the Australian government's mission for Medicare Locals to connect health services and communities, as expressed in the Medicare Local Operational Guidelines (2013). The participant further explained,

> *What I mean by "bridge the gap" is about getting the right services to the right locations. It is all linked back to the needs assessment. For example, in an Aboriginal Medical Service*

they always need more Allied Health service such as Podiatrists. That's the role Medicare Locals should be trying to fill … and subcontract a Podiatrist to provide that service to this location (DNFRURAL2, p3).

While this extract echoes the mission of the Medicare Locals stated in the Operational Guidelines, almost verbatim, it is reproduced within the context of her understanding of that particular community and her own disciplinary lens. Accordingly, the extract captures the alignment between sovereign will and the salutogenic disciplinary perspective of Allied Health Professionals and therefore the likelihood they would be attracted to Medicare Local Boards and embrace the health reform process.

The Allied Health Professionals interviewed considered there was a goodness of fit between their disciplinary knowledge, their clinical and leadership experiences and the mandated business of Medicare Locals. One explained,

I was a physiotherapist… I had my own private practice for about seven years from about 1998 to 2006 or thereabouts. And so, I had that experience of working in primary care space but I then I joined the, I was elected to the Board of the Medicare Local, the [name] Medicare Local in 2013 and that was shortly after I commenced in my position as the Director Allied Health [name] Local Health District. (PTMREGIONAL2, p1).

The period of multidisciplinary Board formations was protracted and the recruitment process inconsistent. For example, one participant described how she was alerted to a Board vacancy via a social conversation:

Look they're going to need Allied Health on the Board - and they put an ad in the local paper and a couple of other papers. I think they just only put it in twice and then the closing date was ten days later…..As it turned out, I don't think anyone else around here really knew what was going on, so it ended up being there were only two Allied Health

applied for this one here, and seeing as we were the only applications, we got in. (PTSMETRO1, p.1).

I don't think anyone else around here really knew what was going on so it ended up being there were only two Allied Health applied for this one here and seeing as we were the only applications, we got in. (PTSMETRO1, p.1).

At other times, the process of recruiting Allied Health Professionals to Medicare Locals Boards was intentional and formal. Appointment of Allied Health Professionals involved an application process and formal election as evidenced by the following participant's statement,

I was elected to the Board of the Medicare Local in 2013 and that was shortly after I commenced my position as the Director of Allied Health (PTMREGIONAL2, p.1).

Each Medicare Local Constitution articulated the election process and rules of Board membership, including who and how many, based on discipline, could become Board members. Some Medicare Locals had organisational membership whilst others had individual membership. This represents a form of social control, in that power was expressed through discourse that sustained medical authority and this enabled Boards to control their configuration and membership in ways that privileged Doctors. Another way the Boards privileged medical membership was by excluding sole traders and specifying that that only large practices (mostly Medical) were able to join. For example, Eastern Sydney Medicare Local Constitution specified the organisational membership base required at least two Board Directors who were practising GPs and two Board Directors who were primary care providers but not sole traders. This was not an isolated case. Overall, 34 of the 61 (55.7%) Medicare Locals excluded sole traders (mostly Allied Health Professionals) from Medicare Local Board membership.

Despite controlling Medicare Local memberships, the Boards attracted people from multiple disciplines with a broad combination of skills, knowledge and experience conducive to building well-rounded teams, with appropriate attributes relevant to the mission and vision of Medicare Locals.

> *…I was asked to be the CEO for a group of 10 pharmacies; I was doing all of the business leadership, business planning, et cetera, and coaching and customer service and performance management and all that kind of stuff… most of my work as a psychologist has been in management leadership and organisational development.* (PYSREGIONAL2, p. 1).

> *…I work at the diabetes clinic as a Dietitian as well as a diabetes educator to help people with different chronic conditions such as CVD, diabetes, metabolic syndrome etc. I also provide education to other Allied Health Professionals, community groups, disability services etc.* (DNFRURAL2, p1).

> *…because I've had such a wide experience, I felt confident enough to put my hand up and say yes, I could do that. I don't know all the actions, but I've worked with enough GPs and specialists and Allied Health people to have absorbed the understanding of each of those group's needs and contributions* (PHCMETRO1, p. 4).

In electing Allied Health Professionals as new Board members, the Medicare Local would be considering the skills, knowledge, attributes and experience needed to govern them and ensure its strategic leadership could continue.

Participants were excited to join the Boards and wanted to be included in decision-making processes to improve community health. As one participant stated:

> *These decisions are really important to the community* (PHCMETRO1, p.10).

Allied Health Professionals, perceiving a good fit between their knowledge and experience and the directives of Medicare Locals, saw becoming organisational and Board members as a way to socially

organise their Primary Health Care practices and believed they had a meaningful contribution to make. Whilst the policy directives in the form of the Medicare Local Operational Guidelines had provided a much-needed opportunity for Allied Health Professionals to become leaders in primary health care, they had to work hard to ensure these changes occurred in practice.

Bringing Allied Health Professionals to the Medicare Board table created opportunities for Boards to become more multidisciplinary and harness the breadth and scope of knowledge, experience and expertise these health professionals brought with them. However, being at the table created challenges as well as opportunities that influenced how they would work and what could be achieved.

Section 3. Experiences of being at the table

This section reports the experiences of the Allied Health Professionals on being at the table. It addresses the degree of congruence between the rhetoric of Medicare Local policy, advocating for multidisciplinary collaboration and the reality of being silenced.

Being silenced

Most Allied Health Professionals spoke about the higher number of GPs holding Board positions on their Medicare Local Boards as opposed to representation of other health professions. As one participant noted,

> *we had at least three GP's [on the Medicare Local Board] that had been in the old GP Network* (PTSMETRO1, p.1).

Board meetings were the official forums in which Medicare Local Board members met to formally talk about the organisation's business. When the Australian government commenced primary health care reform it announced that Divisions of General Practice would be replaced by Medicare Locals whose Board would not be dominated by Doctors (Tait, 2011). The Medicare Local Operational Guidelines (2013, p.12) were explicit that Boards were to comprise 7-9 people with expertise in local health care provision, the local community and business acumen and that the majority of Directors were not to

be practising in any one profession. However, the experience of the Allied Health Professionals in this study was that pre-existing configurations of the medically-run Divisions of General Practice Boards remained in the new Medicare Local structures, supplemented by the addition of Allied Health Professionals. The ratio of Doctors to Allied Health Professionals was skewed. The higher representation of Doctors on the Medicare Local Boards gave them a strong voice, which meant they were more likely to control conversations and therefore discourse.

The Allied Health Professionals interviewed considered Doctors controlled Board conversations and influenced how Medicare Local business was discussed and enacted. Some claimed Doctors were resistant to the changes mandated by the health reform process. One participant stated:

> *… the Divisions of General Practice wanted to remain as they were … many General Practice Divisions attempted to sort of go on their own and try and maintain [the status quo]* (DEBMETRO3, p.3).

Another stated,

> *… there was just so much change, and so much resistance from Divisions of General Practice, that the first 12 months was really fraught with just transmission of business requirements….the Divisions of General Practice [wanted] to remain as they were, and [they wanted] the focus to remain on supporting general practice and General Practitioners versus it being a platform to actually better coordinate health care in a region* (DEBMETRO3, p.3).

The excerpt above demonstrates how Medicare Local decision making and leadership were primarily held and directed by medical staff. Medical authority and control had become so normalised to the Doctors that they assumed a hegemonic position, and the Allied Health Professionals' role was paradoxically characterised as less important, and yet essential for complying with the policy mandate. The resistance to including Allied Health Professionals on the Medicare Local Boards and '*the Divisions*

of GP wanting to remain as they were' was most likely related to the realisation that the management practices and focus of business would change. The social power the Doctors held was being challenged and as Mohd and Aziz (2010) explain, meeting participants have different positions and interests to defend. In formal Medicare Local Board meetings, it was the Chairperson who managed the discussion, controlled the nature of topics to be discussed, and had the authority to include or shut down conversations and finalise decisions.

Most Medicare Local Boards continued to be chaired by a medical professional who tended to centre discussion on primary care and the needs of Doctors. Two participants explained,

> *there's since been a change of CEO and obviously with the change … [the] focus [is] on supporting the medical professions …there was a letter that came out that said the Board is of the view that this is about supporting general practice first and foremost.. (*PTMREGIONAL2, p.6).

> *… the General Practitioners wanted the focus to remain on supporting general practice and General Practitioners, versus it being a platform to actually better coordinate health care in a region … just a fundamental difference in purpose* (DEBMETRO3, p.3).

It was within these socio-historical and organisational structures that Allied Health Professionals found themselves joining Medicare Local Board table discussions. Their expectation that the core business of Medicare Locals would be primary health care with communities at the centre, was incongruent with the reality they encountered wherein primary care and Doctors were at the centre. The Allied Health Professionals found themselves embroiled in complex relations of power that were culturally mediated through longstanding professional discourse in which Doctors are typically recognised as dominant in the professional hierarchy (Braithwaite et al., 2016). Although Allied Health Professionals had been co-opted onto Medicare Local Boards by the Australian government, their inclusion was somewhat tokenistic and superficial.

Many of the Allied Health Professionals spoke of the challenges associated with actively contributing to Board discussions when the Medicare Locals were first established. One participant alluded to these challenges,

> *… I became a member of the Board and in our naivety we all thought 'oh you'll be a voice for allied health'* (SPRRURAL2, p.1).

Another participant explained how the Allied Health voice was constrained,

> *I'd try and put in my views on things … sometimes it was a little bit daunting with people that were fairly educated, and I'd try and say what I thought would be useful from my expertise … but you weren't always asked for your opinion. Sometimes it was hard work getting it in* (PTSMETRO1, p.11).

This Allied Health Professional held an undergraduate degree and post-graduate qualifications in her specialty and had 43 years professional experience. Despite being educationally qualified and an experienced expert in her field she found it difficult to participate in Board discussions. Much work has been done in the social studies field on the concept of marginalised voice (Nordberg, 2006; Bochel, et al., 2008; Taylor and Sutton, 2016), which is often silenced or subordinated as a means of sustaining oppressive power relations. Evidence of being silenced were captured in the words of one participant who said,

> *… some people felt they weren't appreciated enough ... but I also think it takes a certain level of confidence to be in an environment where you've got Doctors and Nurses. Sometimes the Allied Health are bit like pigeons on a wall and say nothing for a long time ... there does need to be a certain level of confidence in yourself to do it* (PHCMETRO1, p.10)

This extract again points to the existence of a professional hierarchy in which Doctors and Nurses have been positioned higher than Allied Health Professionals. It also shows that by simply being in an environment where other health disciplines were perceived as having higher professional status gave

rise to power effects. These health professionals were not exercising power in abusive ways but instead enacting it through a myriad of taken-for-granted day-to-day actions, which van Dijk (1996) explains, are integrated in 'norms and habits' that appear normal and natural. The Allied Health Professionals were being silenced by being outnumbered by Doctors, experiencing overt resistance from Doctors, and having a Medical Chair control and direct the conversations.

For the Allied Health Professionals in this study, the power effects manifested as them not feeling confident to contribute to Medicare Local Board conversations. For instance, one participant said:

> *… anything that I wasn't sure about, I used to say to my husband, what's this? Rather than asking dumb questions and stupid questions at meetings and things, you run it by him and, because he was involved with the other two Medicare Locals, he pretty much knew what it was and would always explain it to me. I wouldn't have stuck my neck out if he hadn't been around.* (PTSMETRO1, p.7).

This extract points to the participant's lack of confidence in her own ability to feel safe in contributing to Board discussions. Lawry (2017) explains that use of voice reveals complex sets of socio-political relations that cut across linguistic and cultural boundaries. Choosing to remain silent is therefore a strong indicator of representation, and the interplay of social and political hierarchies where medical voice was accepted as the legitimate and authoritative voice. In staying silent the risk is that others will seize the opportunity to speak and in speaking take the power in decision-making.

Other Allied Health Professionals spoke of feeling intimidated,

> *It was a bit daunting being on the Board there because we had an Associate Professor on the Board [who was] involved with one of the universities. We had at least three General Practitioners that had been in the old General Practice Network and they'd been off and done the AICD [Australian Institute of Company Directors) qualification, [which is] the*

> *company directors course … they were pretty efficient and really knew what they were doing…this was a totally different step up the ladder* (PTSMETRO1, p.1).
>
> *I guess she [a previous Allied Health Professional who had resigned within two months of being elected] might have felt that she was a bit overawed by the whole thing, having to sit and to contribute with these people that were, let's say, just at a different level to us* (PTSMETRO1, p.1).

It was apparent that some of the Allied Health participants felt intimidated by others on the Medicare Local Board. The effect of this sense of intimidation is they not only had trouble voicing their opinion and struggled to be heard, it was an allegory of being lower on the hierarchical ladder than their board medical counterparts. Being overawed by other Board members who are '*at a different level to us*' (PTSMETRO1, p.1) was consistently reported by the Allied Health Professionals interviewed.

Feeling intimidated and deeming themselves as unworthy and unequal gave rise to self-regulating power effects whereby the Allied Health Professionals began to accept medical care as the central concern of the Medicare Locals and therefore tended to defer to medical authority. One participant stated,

> *… the [Medicare Local] … certainly supported the General Practitioners and that's pretty important for Primary Health Care, that's for sure, particularly trying to get people out of the hospitals … they tried to get people out of going to the emergency wards all the time, and back to the GPs in after-hours situations* (PTSMETRO1, p.8).

This extract illustrates how General Practice and General Practitioners were at the centre of Medicare local operations. It was a stance that echoed the mission of the Divisions of General Practice to build capacity across governance, leadership structures, membership engagement and to improve links between General Practitioners and other primary health providers and hospitals. It represents a departure from the salutogenic nature of primary health care that values individuals and communities

and centralises the importance of their health, wellbeing and quality of life (Mittelmark & Bauer, 2016).

Rather than adopting a social model of health, some of the Allied Health Professionals interviewed were privileging biomedical understandings of health and therefore saw primary medical care as the legitimate framework for organising Medicare Local services. Such accounts suggest there was acceptance by some Allied Health Professionals, that GPs on the Medicare Local Boards were more competent. This lens shaped how some Allied Health professionals viewed their role and accounts for their deference to Doctors. One participant described her role as,

> *… a little helper for the patients and the medical team* (DNFRURAL2, p.4).

This extract demonstrates power in action – that is, the relations of power coming through the discourse and influencing a participant's subjectivity (Fairclough, 2015). In effect, some Allied Health Professionals had unwittingly relinquished their social power. Other Allied Health Professionals were not as willing to passively accept this subservient positioning and while they were initially silent, this silence also brought with it the benefit of being able to listen and therefore accumulate knowledge about how the GPs were thinking and talking about public health.

Although the Allied Health Professionals in this study had a salutogenic knowledge base suited to planning, developing and implementing primary health care activities, it was not always voiced. Staying silent was not conducive to Allied Health Professionals contributing to Medicare Local Board decision-making. Often the medical agenda shaping primary health care activities in Medicare Locals did not accommodate the Allied Health Professionals' salutogenic perspective. Staying silent meant the Doctors continued to control the primary health care agenda, which sustained medical authority and positioned them as primary health care leaders and experts. One participant noted,

> *I knew they had those General Practice meetings once per month to see if the General Practitioner needed more support to provide primary health care* (DNFRURAL2, p.2).

The reference to 'those General Practice meetings' in this extract illustrates how many Medicare Locals had established General Practice Advisory Committees that met regularly to discuss issues in general practice. Similar committees were not established to identify and respond to Allied Health issues. This participant did not question why Allied Health Professionals were excluded from the meetings and nor did she challenge why the meetings were required given that individuals and communities were to be at the centre of primary health care, not Doctors and general practice. This is another example of the way medical authority was accepted as normal and retained the focus on Doctors and general practice. It also illustrates how the Allied Health Professionals' voice had been silenced.

What these results suggest is that although Allied Health Professionals were at the table, they were being silenced in multiple ways. They were silenced by: being outnumbered by GPs, experiencing overt resistance from GPs, having a Medical Chair, being constrained in contributing to discussions, being disregarded when they did contribute, which led to them feeling intimidated, deeming themselves as unworthy and unequal, accepting medical care as the most important and deferring to medical authority.

Finding voice

This section reports the experiences of the Allied Health Professionals on being at the table. It addresses the degree of congruence between the rhetoric of Medicare Local policy, advocating for centralising the community, health promotion and disease prevention and the reality of experiencing Doctors being the locus of control and centre stage. Realising this incongruence created a tension for them as Primary Health Care leaders and this was the catalyst for recognising they needed to find voice.

Some Allied Health Professionals, who had been silenced by Doctors resisting change to progress their interest in retaining a strong medical focus, realised that listening to Board conversations gave them direct access to important information. Two participants explained:

> *… because I was on the Board of the Medicare Local I had a clear line of visibility.* (DEBMETRO3, p.9).

> *I've got more insight than I would have if I had not been involved in it. I've got a much deeper understanding of the politics, policies, challenges, risks and the opportunities of them.* (PHCMETRO1, p.9).

The extract illustrates how these Allied Health Professionals were aware their presence at the table allowed them to witness Medicare Local discussions to accumulate knowledge. As the dominant group, Doctors had control over much of the Board conversations, such as the topics (medical problems), service solutions (primary care), and service leadership (GPs). While the Allied Health Professionals were unable to control the interaction, they were not always passive recipients who accepted the medical attitudes and ideologies. Driven by the assumption that knowledge would assist with their professional growth as Board members, the Allied Health Professionals intentionally adopted the practice of listening as an embodied method of learning. The practice of listening was a powerful practice because, as Foucault (1972) explains "*knowledge is power*".

Through the act of listening and accessing information at Board meetings, some of the Allied Health Professionals paid careful attention to the content and meaning that was being expressed. One participant evidenced this form of listening:

> *…now their (GP's) clinical skills can come in, in any other discussion, particularly in the other committees, about how we increase immunisation or something like that. That's very much GP driven, but really, what we want is the intellect of these people who can problem solve issues* (PHCMETRO1, p.9).

In this extract the Allied Health Professional has listened to the contributions from the Doctors and extended the act of hearing for understanding to engage in a reflective process. She has recognised and acknowledged the Doctor's clinical and medical expertise as valuable for discussing immunisation,

and also identified the need for a higher-level, whole of community solution to the problem. That is, increasing immunisation levels requires more than one medical encounter. The need for broader community-based problem solving identified in this excerpt illustrates the Allied Health Professional's insight into addressing the deeper issues associated with improving public health.

Some of the Allied Health Professionals realised their knowledge and professional experience positioned them well to contribute to primary health care conversations:

> *I've been involved in primary health care probably for the last 13 years - I've always worked in public oral health …then moved into primary health care, so I've been in primary health care since 2005. [I] have held various kind of management roles within the community health sector but predominantly always managed - well began with managing primary health services, then moved into corporate services, corporate governance type roles within community health.* (DEBMETRO3, p.2).

> *… it wasn't just about having all GP's or all people from a particular area; we looked at our primary health qualifications and our backgrounds in marketing, communication, strategy, IT systems, engagement, contract-management* (PYSREGIONAL2, p.3).

The Allied Health Professionals brought a raft of knowledge, skills and experience to the Medicare Locals. This diversity in backgrounds, viewpoints, experiences and interests were in keeping with funding provided to Medicare Locals to support the skills and capacity required to achieve the five strategic objectives (Australian Government, 2013a). The Allied Health Professionals were aware they could contribute to primary health care health reform in a different way to the biomedically-based model of primary care.

Although the Allied Health Professionals were aware that Doctors had assumed the leadership and expert positions in Medicare Locals, some realised that remaining silent and listening was no longer an option.

> *You've got to be engaged in the discussion. You can't just sit there and say, Oh, yeah, I agree. You've actually got to contribute otherwise it's a waste of time* (PHCMETRO1, p.10).

However, as these Allied Health Professionals began to find their voice, speaking up was sometimes met with resistance:

> *Some of the others were pretty good at being a bit more forthright I suppose. But, yeah, I'd try and put in what I could that I felt would be helpful, that's for sure* (PTSMETRO1, p.11).

> *Sometimes you felt like you weren't always listened to but sometimes down the track when what you'd said earlier was justified you thought, ok, I didn't open my mouth and look an idiot at all, what I said was pretty correct, that's for sure. I mean one minute they want all the Board of Directors to throw in their opinion and the next minute you feel well if you did throw it in sometimes, with their knowledge being greater than mine… you felt like it was dismissed a bit…If you sat there and said nothing they probably felt you didn't contribute, you just had to be selective at times with what you said.* (PTSMETRO1, p.11).

In the latter extract, the reference to the need *'to be selective at times with what you said*' is illustrative of this Allied Health Professional's awareness that some things could and could not be said at the Board table. Despite the multidisciplinary Board configurations, medical authority continued as the status quo. During the Medicare Local era medical authority was being legitimised by key medical professional bodies that mandated Medicare Local Boards must include strong general practice presence (Royal Australian College of General Practitioners, 2011).

Although at times some of the Allied Health Professionals interviewed found it difficult to speak up at Medicare Local Board meetings, they were more confident talking about holistic approaches to primary health care.

> *I am looking at a client or case from the holistic approach. From a Dietitian aspect, generally people know what a healthy food is, and what they should be eating. It's about the other barriers that stop them from achieving the healthy eating approach. So, I think my understanding of primary health care is about sourcing the solutions to a certain degree. It's about giving them the education and practical skills to learn eating healthy could be cheap and [with]in the budget, such as access to frozen vegetables, baked beans for breakfast, tinned fruit* (DNFRURAL2, p.3).

When an Allied Health voice was used, the Allied Health Professionals were able to express their views about public health and found themselves beginning to make meaningful contributions to primary health care.

This section has demonstrated that being at the table was beneficial in that it enabled the Allied Health Professionals to be present and gave them access to conversations and information not previously available to them. While the Allied Health Professionals interviewed considered themselves leaders in Primary Health Care, they realised they were not recognised as such by others. Being present allowed them to realise they had a broader holistic view of primary health care than the GPs whose vision was more limited to their clinical expertise and a curative mindset. In doing so, they recognised that they brought innovative ideas about accessing people and communities and designing and coordinating services. They also realised that to a large extent, the operational focus of Medicare Locals was on GPs and Primary Care and so remaining silent was not an option.

Being heard

The previous section suggests that when Allied Health Professionals got to the table, they saw it as a powerful move because it gave them access to powerful others and allowed them to strengthen their capacity (power) to influence and progress primary health care. This section reveals how their experience of being at the table was influenced by historical relations of power that existed between the health professions and indicates that some Allied Health Professionals were finding their

leadership voice to negotiate difficult cultural encounters and make their way in the new world of primary health care. Others were not. This section shows the Allied Health Professionals interacted within existing discourses to be heard in their pursuit of primary health care.

Allied Health Professionals recognised and valued their ability to access people and communities and not have this mediated by GPs and a hospital:

> *I really liked the fact that we did have Allied Health Professionals on our Board, because we looked much more widely at options. And I suppose when you're working in regional areas where you don't have a concentration of GP's and hospitals, so you have to get a bit creative about 'how can you provide access for people where they are?* (PSYREGIONAL2, p.6).

Getting '*a bit creative'* is a way of talking about conceiving new ways of working and points to a recognition that Allied Health can make a difference without having to subscribe to the medical models as a sole solution. New ways of working with communities were emerging with some Medicare Locals being receptive to the ideas promulgated using an Allied Health Professional voice.

Vocal confidence grew to the point that Allied Health Professionals were keen to be heard and knew they had meaningful expertise conducive to realising the reform agenda:

> *I've been noisy since I felt confident enough. I'll have a go at that. Once I had the confidence that I'd worked in sufficient workplaces, both in acute care and in primary care, and had done significant research… So [had] a really clear understanding of the processes that need to be well organised and in place for whatever clinical conditions presented…* (PHCMETRO1, p. 9)

When Allied Health Professionals spoke up, engaged in the Board conversations and were heard, they observed their multidisciplinary perspective broadened the primary health care agenda:

> *What I noticed was a better organisation. They weren't just fixing things here, there, and everywhere. There was a plan. So, I think the best thing about the original Medicare Local, first of all, you've got to find out who the hell are our patients and I don't think people knew that beforehand. They assumed a lot. Then the other thing is we've got good data about who we have, how old they are, where they're living, those sorts of things.* (PHCMETRO1, p.3).

These excerpts highlight how the dominant focus on general practice and primary care had begun to give way to learning more about the community for aligning the right services. In coming together as a multidisciplinary team, there is evidence the Medicare Locals were beginning to realise the health needs of local communities and develop locally focused and responsive services.

> *… as a Medicare Local, we had to prioritise. So, what are our top three health issues in our region? How are they different in various regions and what's the best way for us to make a sustainable difference? And that's why we were so focused on local skill-development because we just wanted to make a sustainable difference …I was quite passionate about the direction that we took. I just thought we were so clean and unblemished in our commitment to what we stood for… which was improving the health outcomes for people across our region…I really liked the fact that we did have Allied Health Professionals on our Board, because we looked much more widely at options. And I suppose when you're working in regional areas where you don't have a concentration of GPs and hospitals, you have to get a bit creative about how you can provide access for people where they are.* (PYSREGIONAL2, p.5-6)

Finding voice and being heard were magnified through the different multidisciplinary relationships which increased the Allied Health Professionals' spheres of influence in Primary Health Care and contributed to building effective integrated teams:

> *It's great that we all know each other, and we work well together, and we can just send a text to someone and say hey you need to see this person. It's very easy. And we believe it's a great service for our clients.* (SPRRURALP2, pp.5-6).

> *Cross referral to other Allied Health in my team happened very often. For example, a psychologist appointment for weight loss, a podiatrist appointment for people at risk of foot ulcer and a referral to social worker for family conflicts and issues. Because all other factors in life would potentially impact on their lifestyle changes and behaviour.* (DNFRURAL2, p. 4)

Many of the Allied Health Professionals who held Medicare Local Board positions underwent a transition from regarding themselves as ancillary members of the Boards to seeing themselves as leaders in primary health care. One participant noted:

> *I moved from being in direct client care to a leadership and management role, where I could actually think 'well how are we improving the health of a population?* (DEBMETRO3, p.5).

In recognising themselves as leaders, many of the participants described their aspirations for improving public health and regarded themselves as agents of change in the reform process. Allied Health Professionals were beginning to work collaboratively to co-create the contexts for improving community health and enacting leadership.

Section 4. Enacting leadership to achieve the vision and mission

This section provides evidence of the transformative, inclusive and democratic leadership styles enacted by the Allied Health Professionals interviewed and exemplifies coaching leadership acts.

Contributions to health planning

Being at the Medicare Local Board table and being heard meant the Allied Health Professionals were able to articulate their vision for primary health care and inspire a broader commitment from other

Board members to the Australian government's intended vision and mission for Medicare Locals to effect service integration and multidisciplinary collaborative practice.

The sense of being an 'active agent' on the Medicare Local Board, enacted through the primary health care leader identity, led to a confidence in Allied Health Professionals contributing to the mission of primary health care and the Medicare Local objectives. For example,

> *[The] Medicare Local completed need assessments in their catchment areas to find out what is working and what is not, what more services are needed in each community. [and then] trying to contract / subcontract other organisations to provide those services.* (DNFRURAL2, p.2).

> *…we did a lot of good work…mapping need…and mapping local primary health service provision, so… where was there a physio? Where's there an OT? Where's there a diabetes educator? etcetera, et cetera… so mapping where people were so that we could connect people …[to] people who could provide a service. … The third thing that we did really well, was some targeted projects to lift the skill capacity of people living and working in the communities* (PTSMETRO1, p.4).

> *What we were looking at is how do we get health outcomes, particularly in rural areas? How do we skill the community? How do we lift the capacity, and how do we have whoever's there to help, being able to use what they have to offer and lift and improve the health outcomes for the community?* (PYSREGIONAL2, p.2).

These extracts evidence the way these Allied Health Professionals adopted system planning roles by mapping health needs and devising interventions targeting health service provision at the local level. The Allied Health Professionals were aiming to improve health outcomes by identifying service gaps and making it easier for individuals to access health services. The practice of working with teams to identify changes that were needed, create a vision to guide those changes through inspiration, and

execute the change in collaboration with other team members was a form of transformational leadership (Bradd et al., 2017).

Leading primary health system transformation

These Allied Health Professionals began to influence Medicare Local operations in ways that placed communities at the centre and subsequently brought forward the need to change the recruitment process to build suitably skill mixed multidisciplinary teams. Their adoption of distributed leadership engendered an inclusive and democratic culture that valued relationships and personal differences.

Some of the Allied Health Professionals realised that the right team with the right skill set, and who understood how they fit, was critical for transforming service provision. One participant explained,

> *…these decisions are decisions that are really important to the community. If you've just got people sitting on those Boards nodding and not contributing, it's a real waste. In fact, some of the Board members who left saying, "I can't see how I can contribute. My skill set doesn't match", which is why we very much now, when we recruit to the Board, we don't just go and pick people. We actually have a framework that must be complied with to get onto the Board* (PHCMETRO1, p.10)

This extract illustrates the Allied Health Professionals' insight that for Medicare Locals to be effective in health reform, the Boards required members who were a good fit in primary health care and understood how their knowledge, skills and experience aligned with the organisational objectives. To build effective teams some of the Medicare Locals had implemented a recruitment process that ensured applicants' knowledge, skills and professional experience aligned with the framework for appointing new Board members. It represented a shift away from the way some Allied Health Professionals had been appointed to Boards in tokenistic ways and towards encouraging a collaborative culture for the Medicare Locals, as evidenced by the following participant:

> *We called for some more nominations and one of the people was actually a local psychologist and a couple of pharmacists and I said, well why don't we have a psychologist really because so many of the programs are mental health ones. So, in the end she ended up getting the position and she's been pretty useful because she's actually working in the system clinically, seeing patients and sort of has a depth of knowledge of how the ATAPS* [Access to Allied Psychological Services] *program goes and some of the suicide programs and all the ones that we had, she could make a better contribution than I could on some of those things* (PTSMETRO1, p.2).

Creating multidisciplinary Boards, targeting skill mix and advocating for a collaborative culture was breaking down medical authority and normalising the need to seek advice and support from different disciplines. Simultaneously emphasising the need for interdisciplinary practice whilst providing guidance about how it was to be achieved is illustrative of the Allied Health Professional enacting coaching leadership (Goleman, 2000).

There was evidence that when some of the Medicare Locals embraced integrated collaborative practice, specific leadership responsibilities were more likely to be distributed across different disciplines. For example,

> *I took a fair interest in clinical governance…and communications, and strategy… we were also reviewing a lot of the contracts, policies and strategic direction… and I was doing all the business leadership, business planning and coaching and customer service and performance management. (PYSREGIONAL2, p.1).*

> *I ended up on the Finance Committee because I feel I'm reasonable with figures, although I've got no accounting degree or anything like that.* (PTSMETRO1, p.7).

These extracts illustrate how Medicare Local leadership shifted from the top-down medical authority approach toward a shared, collective and extended leadership practice approach. Each of the

Medicare Local Board members interviewed brought a unique and diverse range of valuable leadership skills, attributes and capabilities to the table. There is evidence of distributed leadership (Bennett et al., 2003) emerging from multidisciplinary group activity and operating within the relationships of the different Board members, rather than as a result of the action of any one discipline.

Glue in the system

Having Allied Health Professionals on Medicare Local Boards and enabling them to find their voice and be heard, created the conditions for a paradigm shift from professional silos to a more inclusive multidisciplinary culture. The resultant cultural shift supported other Allied Health Professionals to find their place in primary health care as '*the glue in the system*'. Allied health contributions to service planning, coordination and management consolidated their position as the glue in the system.

Some Allied Health Professionals spoke of their ability to connect, manage and coordinate services and interventions:

> *… the other way to look at it, [is] we [Allied Health Professionals] are the glue in the system. You know… that kind of get things happening. So yes, we have a primary care system … where we have GP's, but they are reliant on Allied Health services to provide the clinical interventions that are required to conservatively manage a range of conditions, chronic disease, healthy ageing, all of those sorts of things* (PTMREGIONAL2, p.6).

Here the Allied Health Professional is taking a juxtaposition in talking subserviently about their everyday practice as '*conservatively manage a range of conditions*', while also asserting that '*GPs … are reliant on Allied Health services to provide clinical interventions*'. Constructing these dichotomous professional boundaries avoids conflict and also positions GP's as equal members of the primary health care team. Lawry (2017) explains a less prominent voice can be heard when more powerful groups are attuned to the legitimacy of the content, meaning and ideas being expressed. As the Allied

Health Professionals began to reconsider traditional professional boundaries, they were realising the legitimacy of their place, voice and need to be heard in primary health care.

There were other indicators the professional boundaries were being redefined and the voice of Allied Health Professionals was growing in strength. Some Allied Health Professionals recognised the value of the different knowledge, experience and world views they brought to the Medicare Local Board:

> *… if they were all GP's you would only get a GP view of the world* (PHCMETRO1, p.11).

> *The Medicare Locals did have that broader focus that was inclusive of allied health… I think there was a change of focus and a change of direction, so the Medicare Locals did a lot to raise the awareness of the importance of Allied Health Professionals in the primary care space* (PTMREGIONAL2, p.8)

> *…because I was on the Board and because I was part of creating the vision, and because our Chair was crystal-clear …And we had a very, very good balance of skills. So, it wasn't just about having all GPs or all people from a particular area, … we looked not just at our Primary Health qualifications, but also our backgrounds in marketing, communication, strategy, I T, systems, engagement, contract-management and that kind of thing…* to make sure that the Board had a good spread of capacity to deliver (PYSREGIONAL2, p.3).

This way of talking reflects a shift in the way Allied Health Professionals were positioned at the table. They were no longer considered tokenistic members, but instead valued as credible team members. There is evidence that some of the Allied Health Professionals interviewed began to shift away from considering Doctors as the automatic primary health care experts as an artefact of their discipline and medical authority. Instead, they repositioned Doctors as another discipline contributing unique skill sets to compliment those of the broader Medicare Local team. This is an example of how some of the Allied Health Professionals were beginning to operationalise their active agency and value being heard rather than passively remaining silent and accepting the subservient subjectivities available to them.

The distributive leadership evident in the Allied Health Professionals accounts of being Medicare Local Board members helped form trust and build collaborative relationships conducive to building the capacity for change and improvement:

> *…we've looked at that community and we've got two GPs who are trying to see 10,000 patients in a week. So it started giving us data that we could interpret…* (PHCMETRO1, p3).

> *I knew where the money was… We'd identified that there was a weakness in the system. Having been involved in the Medicare Local and understanding where the funds come from and how you apply for funds, how you report on your funding, meant that if you were clear about that you could be quite nimble and get a project up that was really important for your community. One example is… when they announced that they wanted to innovate general practice in general, I said, well, something I've always wanted to do, and I know they are doing in the U.K. … was why not have a pharmacist in your general practice? A pharmacist who can sell the drug, issue it to the patient in the practice, with information that was useful, rather than guessing. So, I managed to get a significant amount of funding for three general practices here in [location] to be funded to have pharmacists in those practices. They had about 12 months' time in there and they had to give in reports. Those three pharmacists are now fully employed by those practices, not paid at all by government. The practices realised what a huge difference it made to the management of patients.* (PHCMETRO1, p.5).

When Medicare Local Boards worked as effective multidisciplinary teams, some of the Allied Health Professionals were able to actively contribute to discussions about the purpose, direction and activities of primary health care. The extracts above illustrate how two of the Allied Health Professionals were devising innovative health service design and attracting resources for reform projects and initiatives. Rather than directing or prescribing what should, or should not be done, the Allied Health Professionals were adopting data driven practices and accessing funding to ensure

activities could be appropriately resourced. These approaches engender support for staff to work effectively as a team, rather than operate as a collection of individuals under one organisational unit. These Allied Health Professionals were enacting inclusive and democratic leadership centred around relationships and valued personal differences (Wylie & Gallagher, 2009).

This section has demonstrated that some Allied Health Professionals enacted different forms of leadership in their roles as Medicare Local Board members. Their ability to see the need to simultaneously shape the professional culture of Medicare Local Boards while responding to primary health care reform, suggests these Allied Health Professionals had found their place and were confident in their leadership roles. However, they also became aware of various tensions between the directives for health reform, and the rhetoric and reality inherent in leading change.

Section 5. The tension between the directives, rhetoric and reality

This section reveals the gap and anomalous tensions Allied Health Professionals identified between primary health care policy rhetoric, the operational directives and their reality of leading health reform within the Medicare Locals. They understood what was expected of them, expressed commitment to the principals and values of primary health care and were aware of the Australian government's vision for how the Medicare Locals were to implement the reform process.

> *I read all the stuff that the government put out that they wanted. They had an aspirational vision and we had to operationalise that vision* (PHCMETRO1, p.4).

These participants were describing the relationship between primary health care policy and the Medicare Local organisations' operating environment, particularly the ways the reform directives influenced how willing individuals were to organise their work to align with policy. During the 2009-2015 period, primary health care policies were framing Medicare Local activities within the rhetoric of partnerships. One Allied Health Professional expressed this notion as a partnership between herself and the local community:

> *In my role, it is was about looking at their biochemistry and making dietary recommendations to address those, such as how to deal with high blood pressure, cholesterol level and fatty liver as those conditions could be managed with lifestyle changes to prevent negative outcome* (DNFRURAL2, p.4).

Another participant described the partnership between the Medicare Local organisation, local health providers and the community:

> *We undertook to develop a panel of private providers … because of the very clear model of care that would be easily adapted by your private practitioners, we were able to assemble a panel and … we picked up the referrals off the waiting list at the hospital and distributed those amongst the private practitioners* (PTMREGIONAL2, p.5).

The partnership between the Medicare Local and the Australian government was described by one participant:

> *it's about skills, the skills to do it and I think we can't underestimate also you need people who have got power, who leverage government* (PHCMETRO1, p12).

These accounts of partnerships reflect the Australian government's key policy areas that had been identified as urgent priorities for reform. Adopting the policy mandate meant Allied Health Professionals, through their contributions to Medicare Local Boards, were developing various partnerships to design and implement new frameworks for changing regional structures and local health service delivery. This further demonstrates how Medicare Locals were beginning to draw upon the breadth of experience and expertise the Allied Health Professionals had brought to the reform process.

Some Allied Health Professionals interviewed were, however, critical of the somewhat nebulous, multidirectional and unmeasurable mandated objectives for Medicare Locals:

> *The Medicare Local's goals were very, very broad…and they weren't really measurable. My practice… is quite focused in some ways to clients with communication and swallowing issues. So…the Medicare Local goals are very broad…, they were supposed to [align with], but I guess my criticism is, they didn't align, and the goals were too broad in how they were written* (SPRRURAL2, p5).

As the extract above states, when organisational objectives are unclear, it is difficult for them to be measured because of the lack of any prior expectation or criteria against which to assess them. In the absence of clearly articulated objectives, performance tends to be measured in ways that satisfy the people involved. The words of one participant suggest the objectives Medicare Locals were working to had been imported from elsewhere, were problematic and not fit for the purpose:

> *the goals we were given as a Board were taken from the Medicare Local Alliance I think it was called … they were just rewritten, well not even rewritten … just taken from the Alliance and published as the goals of the Medicare Local, as per the Alliance. We never worked with those. I don't think anyone did and in part [while] those goals led to projects or funding opportunities, we would take those opportunities on Board but otherwise we just kept running our practices.* (SSPRRURAL2, p5)

The extract is illustrative of how, in the absence of clarity, people in organisations can interpret policy and justify almost any activity espoused by an individual so long as it resonates with the objective. The Allied Health Professional perceived the policy direction from the Commonwealth government regarding funding parameters as loose and was able to opportunistically take advantage of grants and funding schemes.

Other Allied Health Professionals were critical of the way the Australian government tightly controlled different funding programs for Medicare Locals to implement primary health care initiatives. An

argument against the controlled nature of funding distribution was expressed by the following participant:

> *Sometimes they [Government] had no insight into the political challenges of going into different environments. For example, we had the Indigenous Health Service team … who is highly political and really don't want anything. They want the money paid directly. They don't want us to have anything to do with it, but of course the contracts say it must be done in cooperation. So, we've got money that we can't spend in some areas because the Indigenous community say, "Unless you give it to us, we're not interested. We don't want you interfering in there at all." So, there are barriers that haven't really been thought through by government when they developed their view of what will happen.* (PHCMETRO1, p4).

This excerpt demonstrates the inherent tension between the policy rhetoric that Medicare Locals were to form partnerships with communities and yet Commonwealth funding was so tightly controlled that is constrained community participation. In this instance, the Indigenous community had not been involved in the planning for which the funding had been granted, therefore it overlooked their cultural and social needs. The reality of accessing and using primary health care funding was so tightly controlled, it constrained the likelihood of realising any health promoting benefits because the community was resistant to being controlled. Such a rift between policy rhetoric and the reality of implementing health reform limited the ability of some Allied Health Professionals to enact leadership reform.

Another source of tension was the perceived lack of policy direction and support for Allied Health Professionals to lead primary health care programs at the local level. One participant discussed her frustration about being unable to access data about what Allied Health Professionals were actually doing in primary health care:

> *…as Allied Health Professionals we weren't able to access data about what Allied Health Professionals do in the primary health care space and so their activity is not looked at by government agencies. Government agencies do not know the extent of the work that Allied Health Professionals do in that primary care space and that makes it difficult to engage with to get an understanding of how much work there is done, and where to target priorities that affect Allied Health Professionals* (PTMREGIONAL2, p.8).

Given that some of the Allied Health Professionals were committed to data driven approaches to plan and implement primary health care, the inability to access data was problematic for some of them. It would have been difficult for Medicare Locals to appropriately plan programs or measure the impact of program implementation due to the lack of access to data. Instead, they were reliant on the information generated by their community needs analysis and service mapping activities to inform community-based planning, population priority setting and inform stakeholder discussions for primary healthcare planning. This finding may also account for why some Allied Health Professionals experienced tension from their colleagues working in community based private practice.

Participants referred to experiencing concern from sole trader Allied Health Professionals who were delivering private Allied Health services in the local community alongside the Medicare Locals:

> *A lot of our Allied Health Professionals were not happy about it as the Medicare Local employed Allied Health Professionals. So, our members looked to me and said 'well what's with that? We're here, we have a business. Now they're competing with us* SSPRRURAL2, p.3).

The notion of competition was linked to the service boundaries created by institutional structures of the Medicare Locals and the notion of competition arose in accounts of the business dimensions of health service delivery. The idea of competition in health care was contested because of the

juxtaposition of needing to increase access to health services while at the same time reducing service duplication and inefficiencies. It was a source of tension for the participants who had been charged with the need to build relationships and strategic alliances with key stakeholder groups at the local level.

The Allied Health Professionals referred to themselves in ways that inferred a high degree of ethical integrity:

> *…we took the…, high ethical ground and said, "We will not use our resources or our people to spend on putting in a bid when we still have a Constitution and mission to deliver." So, we were so squeaky clean.* (PYSREGIONAL2, p7).

The Operational Guidelines (Australian government, 2013) mandated that Medicare Locals operate in ways that ensured accountability to the government and their local communities. The reference to being "squeaky clean" infers this Allied Health Professional took seriously the need for the Medicare Local to have "transparent and visible processes" (Australian Government, 2013a). However, it was also evident that some of the Allied Health Professionals perceived the Australian government as being remiss in its own public accountability.

One Allied Health Professional referred to the constant change in primary health care policy as the Australian government playing political games:

> *I think we were all pretty disappointed with the politics of the whole thing. I mean it's just one government didn't like what the other government did so they want to stamp their thing on it… the cost of winding it all down and changing over was enormous. It could easy have cost… What did you have, 61 MLs or something like that, it was well over $130, $140 million I would have said, or over $100 million. That money could have gone into programs really.* (PTSMETRO1, p5).

This extract illustrates the politics of public health policy. It also points to how the bounded rationality of health reform decision making for improving public health is so powerfully influenced by fragmented political factions, ongoing resistance from groups with vested interests, and financial constraints and limitations. The participants spoke of the impact this political game playing had in undermining their health reform efforts.

The capacity for Medicare Locals to realise the full potential of comprehensive primary health care reform was thwarted by the precipitate, large-scale policy shift in 2015 to disband Medicare Locals and transition to Primary Health Networks. Some of the Allied Health Professionals described examples of designing and implementing service innovation and the various impact of the abrupt cessation of these organisations. For example:

> *Pharmacists tend not to be seen in Primary Health or as Allied Health Professionals because it's a slightly different way that it works in the health system. So, we did run a pilot to have diabetes interventions in pharmacies… but it didn't go very far because Medicare Locals finished before we got very far in evaluating that.* (PYSREGIONAL2, p4).

> *I have been able to leverage my awareness and my contacts … to our advantage* (PTMREGIONAL2 p.4)

> …….*and I think there has been a strong engagement there between the Local Health District and private practice … that may not have happened had I not had some contacts and awareness of what was happening in the private sector* (PTMREGIONAL2, pp.5-6).

These extracts evidence the way Allied Health Professionals were taking part in leading primary health care reform. Not only were Medicare Locals becoming a good spring Board for Allied Health Professionals, by becoming more inclusive in their engagement with a wider range of professionals, they had also started to address the broader goals of primary health care. They were actively

redefining professional boundaries, and this was an important element of working towards a collaborative multidisciplinary, innovative, integrative, and community-driven sector.

One participant explained,

> *…and that's what I loved about Medicare Locals… we didn't have a narrow view. What we were looking at is how do we get health outcomes, particularly in rural areas? How do we skill the community? How do we lift the capacity and how do we have whoever's there to help being able to use what they have to offer and lift and improve the health outcomes for the community? It was so idealistic and effective. I loved it!* (PYSREGIONAL2, p.10).

The impact of policy change on the ability of Medicare Locals to realise their full potential has been and will likely remain hidden. From these findings, it is clear that having Allied Health Professionals on Medicare Local Boards enabled these organisations to effect some significant reforms, contributed new ideas and broadened their approach to Primary Health Care. However, rather than realise their full potential to achieve the outcome of comprehensive primary health care, their abrupt cessation meant they were limited to achieving incremental reform and many of their initiatives being prematurely aborted and remaining incomplete and unevaluated.

This section has explored the tensions and sometimes gulf between the policy rhetoric, implementation process and the lens through which the Allied Health Professionals perceived the reality of primary health reform. It explained why these issues created a policy rhetoric-reality gap and why constant changes in policy directives are likely to be counterproductive and continue to undermine the efficacy of health reform.

Chapter summary

This chapter outlined the ways Allied Health Professionals accounted for and interpreted their everyday practice in leadership roles as Medicare Local Board members and addressed three research questions.

- *How did Allied Health Professionals who worked in Medicare Locals understand primary health care as it related to their leadership roles?*
- *How were Allied Health Professionals within Medicare Locals positioned for achieving integrated and collaborative multidisciplinary approaches in their work as Board members?*
- *Were Medicare Locals meeting their intended vision and mission of integrated and collaborative primary health care?*

The first section provided a profile of those interviewed in terms of disciplinary background, region, age and gender. The other findings were presented under four major themes:

1) *Bringing Allied Health Professionals to the table;*
2) Participant's *Experiences of Being at the table, including* Being silenced, Finding voice, and Being heard;
3) *Enacting leadership to achieve the prescribed vision and mission* of Medicare Locals, including *Contributions to health planning, Leading primary health system transformation* and *The glue in the system;* and
4) *The gulf between the directives, rhetoric and reality* Allied Health Professionals experienced.

By working at Medicare Locals, the Allied Health Professionals were engaged in various social relationships and embedded in a network of primary health care practices. These engagements, interactions and day-to-day social practices, provide evidence of the Allied Health Professionals turning a self-regulating gaze upon themselves which influenced their understandings of primary health care and professional identity formation.

In taking up leadership identities in primary health care, some Allied Health Professionals were able to resist the power relations operating in the Medicare Locals and provide an alternative view of how the primary health care system could operate. Furthermore, by taking up the leadership opportunity, Allied Health Professionals were able to articulate and enact a holistic, community-centred,

integrated, multidisciplinary vision of primary health care and contributed a unique set of skills conducive to making possible '*Health For All*'.

The key points in this chapter were:

- *Bringing Allied Health Professionals to the table* created opportunities for Boards to become more multidisciplinary and harness the breadth and scope of knowledge, experience and expertise these health professionals brought with them.
- *Being at the table* created challenges as well as opportunities that influenced how Allied Health Professionals could work and what could be achieved. There was incongruence between the rhetoric of Medicare Local policy advocating for multidisciplinary collaboration and the reality of *Being silenced* in multiple ways. Realising Doctors were the locus of control and being placed at centre stage in primary health care, the Allied Health Professionals moved through a period of *Finding voice* that saw some of them enact a primary health care leader identity for *Being heard*.
- In recognising themselves as leaders, many of the participants described their aspirations for improving public health and regarded themselves as agents of change in the reform process. The Allied Health Professionals were beginning to work collaboratively to co-create the contexts for improving community health and *Enact leadership*.
- Some Allied Health Professionals found their place and were confident in enacting different forms of leadership, however, as leaders they became aware of various tensions between the directives for health reform, and the rhetoric and reality of leading change.

The next chapter interprets and explains the significance of the study findings and discusses the effects of bringing Allied Health Professionals to the Medicare Local Board table.

Chapter 7. The effects of bringing Allied Health Professionals to the Medicare Local Board table

Introduction

The previous two chapters reported the study findings. Chapter five presented how Medicare Locals, with their mandate of primary health care reform, were established within a legacy of primary care and professional and biomedical discourses that sustained the status quo of medical authority. The findings reported in Chapter six suggest how these organisations were sites of tension for the Allied Health Professionals appointed to Medicare Local Boards. The Allied Health Professionals drew upon their salutogenic knowledge system and used discourses of health and health promotion to construct primary health care as a holistic, multidisciplinary, integrated and coordinated health care approach. At times, however, these understandings were at odds with Board member colleagues who were Doctors that espoused the biomedical tradition and Primary Care.

There was evidence of an intent to achieve two paradigm shifts. A shift from GPs and general practice being at the centre and another from medical authority to multidisciplinary collaborative practice. Bringing Allied Health Professionals to the Medicare Local Board table involved them having to navigate a range of tensions which led them to move from being silenced to finding voice and being heard. In the process they adopted two distinct professional identities, one of which enabled them to enact leadership and make inroads at the Board level for progressing the Primary Health Care reform agenda despite the inherent tensions between directives, rhetoric and reality.

This chapter reflects on the main findings of the study in terms of its aim, purpose and the research questions. The aim of the study was to examine ways primary health care was represented by Medicare Locals, and how these representations impacted on the way Allied Health Professionals formed meanings and therefore approached integration, collaboration and multidisciplinary ways of working. The chapter, presented in three sections, situates the findings within the literature and identifies their implications for future policy and primary health care practice. Section one discusses

the value of bringing Allied Health to the Medicare Local Board table. Section two discusses how processes of othering emerged as a manifestation of those complex power relations. It explores how Allied Health Professionals experienced being othered and negotiated belonging in the Medicare Local by either adopting the Doctors Support Identity or the Allied Health Professional Leader Identity. It also discusses how communities were marginalised as other. Section three discusses how future primary health care reform could be improved by preparing Allied Health Professionals as leaders and developing evidence-based policy reform.

Section 1. The value of bringing Allied Health Professionals to the table

To shepherd primary health care reform, the Australian government released the Medicare Local Operational Guidelines (2013a) to articulate its vision for Medicare Locals. They were to be independent primary health care organisations that collaborated with providers, hospitals, and local communities to ensure patients received the '*right care in the right place at the right time*' (Australian Government, 2013a, p.5). Although the overarching national guidelines sought to situate people and communities at the centre of primary health care, they contained several tensions and ambiguities that set up a range of competing expectations that conflated the position of individuals, communities, organisations, and primary health care professionals. These tensions were reproduced in the Constitutions each Medicare Local had developed and impacted on the way multidisciplinary teams worked together in primary health care.

The findings of this study indicate Allied Health Professionals brought to the Board table of Medicare Locals, the knowledge, values, and skills of primary Health care, an array of leadership experience, and aspirations of contributing to and influencing change. However, the recruitment process was somewhat arbitrary. As a result, Allied Health Professionals recruited to Boards had variable insight and understanding of their new professional identity and the roles they could or would play. To some extent these differences constrained their capacity to forge new territory, erode the status quo and

fully realise the reform agenda. However, there is evidence their contribution went some way to expanding the horizons of some GPs and creating a paradigm shift from silos to communities.

Medicare Locals were reported as instrumental in making some inroads in establishing trust and working relationships and the importance of learning about the experiences of these organisations has been stressed (Javanparast et al., 2015). Current and future primary health care requires strategic planning, strong leadership, stable organisational structures and effective networks that draw on strong personal relationships (Javanparast et al., 2015). Change management is needed in primary health care and therefore leadership needs to be adaptive and transformative (de Melo Lanzoni et al., 2016; Javanparast et al., 2018).

Leadership is often driven by values. Values are often subjective and can vary, (Jackson et al., 2016), however, there is recognised merit in drawing on the co-creation experiences of consumers and stakeholders to move beyond a focus on the structural reform ideals of optimising health outcomes, to addressing the deeper cultural dimensions associated with organisational improvement, and integrative collaborative practice (Jackson & Hambleton, 2016; Jackson et al., 2016; Oliver-Baxter et al., 2017). Recent efforts to revert to a previous model of care that privileges biomedical knowledge and discourse and positions Doctors at the centre of Primary care, risk undermining the achievements gained and limit the potential for improving Primary Health care, addressing the social determinants of health and promoting health equity. Baum et al. (2016) argue that the state-managed services' mandate was changing from a health promoting and disease prevention community-engaged model to a hospital outreach service for those with existing chronic disease. Features of neo-liberalism have worked to encourage and support this narrowing of the primary health care service mandate to a selective approach (Baum et al., 2016).

Another finding was the Medicare Local Operational Guidelines (Australian Government, 2013a), the Constitutions, and the experiential accounts of the Allied Health Professionals interviewed were infiltrated by prevailing biomedical discourses, which was manifest in patients and GPs being

consistently centralised, and inferences to paternalistic health care frames. The biomedical and various multifactorial models, such as the biopsychosocial model (Cooper et al., 1996; Engel, 1977, 1980), web of causation model (MacMahon & Pugh, 1970), and the ecological model (Hancock, 1985) are criticised for their focus on health interventions focussing on lifestyle or behaviour modification and health education aimed at the individual (Germov, 2009). The limitations of these models are apparent when health issues are imagined as social issues and diseases are acknowledged as being strongly influenced by social factors (Germov, 2009; WHO, 2008a). The social model, with its premise that health is a social responsibility, seeks to treat the social causes of illness rather than just disease by examining the social determinants of individuals' health status and health-related behaviour (Germov, 2009). However, as Germov (2009) points out health and illness are social constructs that are temporally mediated and reflect the culture and politics of a particular society.

In the current study, the paternalistic biomedical health care frames being adopted were reflecting the agendas of medical authority. These agendas sat alongside, and competed, with the aspirations for Medicare Locals to achieve integrative collaborative service delivery at the local population levels. The paternalistic frames reinforced medical authority as the status quo, therefore the Constitutions consistently articulated definitions of 'GPs' as a group distinct from 'primary health care clinicians' or 'Allied Health Professionals''. When a group defines itself as a united "us", while other people are constructed as fundamentally different, united as "them", the distinctions give rise to the act of 'othering', which Foucault (1972) attributes to the effects of power and knowledge. The next section discusses Allied Health Professional experiences of being othered and negotiating belonging when they joined the Medicare Local Boards.

Section 2. Allied Health Professionals: Being othered and negotiating belonging

In Australia, various health professions have moved through periods of establishment, professionalisation, regulation and control. As each profession was established, a professional identity emerged to which each member of that profession ascribes to claim an exclusive role and status in

society. Professional identity is often based on meanings from a logic of pairing (Heartfield, 2005). For example, the police and the criminal; the professional and the client; or the Doctor and patient (Davies, 2002). Hegel posits these understandings of 'self' are constituted through the juxtaposition towards 'the other' (Heartfield, 2005). It was evident in this study that Allied Health Professional identity understandings were juxtaposed against those of GPs. Being othered meant Allied Health Professionals were subsequently required to negotiate their sense of belonging when they became members of the Medicare Local Boards. The remainder of this section outlines othering as an outcome of power and discourse and moves on to discuss two main professional identities the Allied Health Professionals were willing to take up to traverse this terrain.

The notion of 'othering' draws on several philosophical and theoretical traditions that highlight different aspects of the term. Three forms of othering were evident in the study findings. First, the paternalistic language used in the Constitutions consistently affirmed the centrality of GPs as the recognisable and dominant 'Us" group. Second, the consistent categorisation of all other health professionals to the vague 'Them" groups of primary health care clinicians or Allied Health Professionals. Third, the continual references to 'local communities' created an unrecognisable group defined only by its exclusion from the health professional groups. The former two othering categories, Us and Them, provide important insights about how the hidden and tacit cultural dimensions of the hierarchy still in existences within the health professions, challenged the objectives of multidisciplinary, integrative collaborative practice.

Doctors Support: An invisible and subservient identity

To negotiate a sense of belonging, some of the Allied Health Professionals assumed a Doctor's Support identity. This was an invisible and subservient identity whereby Allied Health Professionals thought and acted in ways that silenced them at the Medicare Local Board table.

The Medicare Local Operational Guidelines (Australian Government, 2013a) mandated the primary health care organisations were to adopt the principles of integration and coordination, which in turn

demanded multidisciplinary collaboration. The historical GP dominant Boards were therefore reconfigured to include Allied Health representatives. The organisational constitutions defined these broader 'primary health care clinicians' or 'Allied Health Professionals' in vague and uncertain ways that meant they could only be understood through differentiation with general medical practitioners. This is a process Doctors, normalised as the recognised dominant group in health care, employ when they recognise individuals who do not conform to this normal social standard, and respond by relegating to the status of 'the other' (Roberts & Schiavenato, 2017).

The process of othering evident in the Medicare Local Constitutions implies the traditional paternalistic professional hierarchy was still in existence during the 2011-2015 primary health care reform era. Reflecting these paternalist tenets, de Beauvoir (2010) examined othering through a feminist lens to describe the way that men are portrayed as the norm and women as 'other'. She argued 'the other' as a construction opposes and constructs 'the self', and in turn, produces a subjectivity since '*women exist – and are only conscious of themselves – in ways that men have shaped*' (Hughes & Witz, 1997, p.49). A growing body of evidence reports the paternalistic nature of the dominant-subordinate/Doctor-Nurse relationships in various health care settings (Roberts & Schiavenato, 2017; Weeks 2004, 2005, Jackson, 1999, Canales 2000). There is a paucity of evidence reporting othering or the othering effects in Allied Health, it is a gap to which this study contributes.

In this study, Allied Health Professionals experienced being othered when they joined their medical colleagues at the Medicare Local Board table. They spoke of often being outnumbered by the Doctors and were aware of the Doctors ease with leading the primary health care conversations. Othering, as a process of differentiation, works to influence self- and professional-identity by reinforcing the dominant-subordinate relationship (Roberts & Schiavenato, 2017). Lacan (1964) points out language plays an important role in constituting identity, and that identity is constituted through the gaze of the powerful (Gingrich, 2004). The findings show how Allied Health Professionals opted to take up different social identities by either allowing themselves to be silenced or by speaking up. Individuals

do have the choice (or agency) to create their identities according to their own beliefs and yet negotiating identity equally depends upon the negotiation of power relations. This can be expressed as:

> *social identities are relational; groups typically define themselves in relation to others. This is because identity has little meaning without the 'other'. So, by defining itself a group defines others. Identity is rarely claimed or assigned for its own sake. These definitions of 'self' and 'others' have purposes and consequences. They are tied to rewards and punishment, which may be material or symbolic. There is usually an expectation of gain or loss as a consequence of identity claims. This is why identities are contested. Power is implicated here, and because groups do not have equal powers to define both self and the other, the consequences reflect these power differentials. Often notions of superiority and inferiority are embedded in particular identities* (Okolie, 2003, p.2).

Some of the Allied Health Professionals in this study chose to take up the subjugated social identity that rendered them invisible and subservient. Being othered and constructed as 'non-Doctors' had availed a Doctor's Support identity to the Allied Health Professionals. It was an identity influenced by medical dominance and outcome of the normalising effects of Doctors being the authority in health care, whilst all other health professionals were viewed as secondary. The contestation of identities is important in this regard as Allied Health Professionals were not only 'othered' but those who took up the Doctor's Support identity were rendered silent and invisible. Althusser utilises Lacan's ideas of how language constitutes identity to posit the term 'interpellation' (1971), which denotes how individuals are called upon by ideology to occupy certain subject positions, and therefore achieve identity. The act of being othered in the written and spoken Medicare Local texts communicated a perception that health professions secondary to Doctors were weaker, which in turn legitimised Doctors' authority in health care. It was a subtle use of language that implied a hierarchy. It served to keep power where it already lay with the Doctors and render all other health professionals in support

roles. Established in this way, the Doctor's Support professional identity, set a boundary that emphasised the differences rather than the similarities and connections between the health professional groups.

Reflecting the impact of the paternalistic imposition of medical dominance, the Allied Health Professionals who adopted The Doctor's Support identity understood themselves as assistants or 'little helpers' to the medical profession. As an exclusionary identity, the Doctor's Support identity manifested through being othered – it was a symbolically located identity that existed outside the boundaries of a Doctor, and therefore a leadership, identity. Although the Doctor's Support identity enabled some of the Allied Health Professionals to give meaning to their contributions to primary health care as Medicare Local Board members, these contributions would never be in the form of leadership because they would always be mediated by the Doctors' as the recognised authority. In other words, the Allied Health Professionals, because of situating themselves outside the boundary of Us, had devalued themselves and therefore chose to remain silent. Creating identity through this form of exclusionary othering has been shown in other studies to occur in similar ways, such as:

> *framing the Doctor as active and decisive and the patient as passive, compliant and grateful. It is there in the division between qualified and unqualified staff. It is there in the discourses about fundamental social divisions of class, gender and race, where a dominant group defines what is valued and what is normal in reference to itself and hence excludes and oppresses others* (Davies, 2002, p.32).

With Allied Health Professionals using the Doctor's Support professional identity to understand their role in primary health, it would be unlikely that Medicare Locals would meet their intended vision and mission of integrated and collaborative practice. As evidenced by this study, it was a limiting professional identity that saw the Allied Health Professionals wait and take their cue from the Doctors. It reified the biomedical view of primary health care in which the Doctor was the expert and health care professional leader in charge. However, gender and capitalism (the rise and enshrining of 'small

business') were also important factors. As a business enterprise the GP practice had been previously protected by the cloak of the 'Divisions'. The new Primary Health Care reform agenda, philosophy and way of operating Medicare Locals threatened the status quo and position of general practitioners. The reform had the potential to hit the hip pocket nerve of GPs as well as their way of conceptualising and delivering care.

Whilst ambitious and arguably remiss, to simply overlay the existing structure by mandating the inclusion of Allied Health Professionals on organisational Boards of management, it was also naïve. The power effects of the historical cultures in health meant Allied Health Professionals tended to relegate themselves to support roles. Furthermore, some Allied Health Board members were not active, equal participants, or had the leadership skills vital for building a primary health system that was integrated and cohesive. These effects should have been anticipated because by 2013 when the Operational Guidelines were released (Australian Government, 2013a), there was already substantial evidence demonstrating long-standing cultural values and norms held by the health professions were not translating well into the collaborative multi-disciplinary practices required for primary health care (Dragon, 2007, 2008; Harris et al., 2010; McKernon & Jackson, 2001). There was also evidence that non-medical disciplines were trying to establish where and how they could fit into primary health care (Annells, 2007; Boucaut, 1998; Clendon, 2004; Cusack et al., 1997; Gibb, 1998; Hourihan et al., 2003; Jamison, 2001, 2005; Keen, 2009; Lloyd-Odgers, 2005; Reid, 2008; Sheppard, 2008; Taylor, 2007; Tse et al., 2003; van Loon, 1998; Ward & Verrinder, 2008) and evidence of conflict and challenging power dynamics in multidisciplinary primary health care teams (Brown et al., 2011; McDonald et al., 2012). Ibrahim and Majoor (2002) warned that simply increasing the level of collaboration and consultation was a strategy unlikely to achieve the aspirational vision for primary Health care reform.

In this study, professional cultures fragmented the health professional groups and different disciplines were afforded varying degrees of power and legitimacy for collaborating and working together. The findings revealed how the Allied Health Professionals in this study were at risk of participating in a

game with Doctors by taking an indirect communication approach to discussions in Board meetings. For example, by remaining silent in meetings and deferring to GPs as the keepers of all knowledge relating to primary health care. This exemplifies how 'othering' was impacting on the way Allied Health Professionals thought and acted in their Board positions and role in Medicare Locals. It is akin to the well documented phenomenon known as 'the game' amongst health professionals – mostly the 'Doctor-Nurse game' (Fagin & Garelick, 2004; Sweet & Norman, 1995; Willis & Parish, 1997). The 'Doctor-Nurse game' was first identified in the 1960's (Stein, 1968) as a communication strategy used by Nurses to covertly guide Doctors in their clinical decision-making. The object of the game is for the Nurse to appear passive, whilst being bold, showing initiative and taking responsibility for their recommendations.

The rules of the game ensure that there is no open disagreement between the Doctor or Nurse - thus the Nurse makes suggestions to the Doctor without appearing to do so. Meanwhile, the Doctor must request the recommendation without appearing to be asking for the recommendation (Stein, 1968). It is a complex game that puts the Nurse in a position of powerlessness, in that the Doctor may disregard the Nurse's covert recommendation or take it up, at will. The game highlights how the medical profession has held significant power and authority over the nursing profession and continues to impose this dynamic. Whilst there is some evidence that the game has evolved (Stein et al., 1990), as Nurses are beginning to offer direct advice, resist handmaiden tasks, and assert their role as a health professional, the relationship continues to be vexed by defending professional boundaries, and resisting regulatory and financial restrictions that occur within all health care services (Reeves et al., 2008). In a qualitative study that explored the extent to which Nurses were willing to challenge Doctors practice in everyday situations in an acute NHS hospital, Churchman and Doherty (2010) found that whilst Nurses believed that they were challenging the Doctors practice and advocating for patients, the data revealed that Nurses only challenged Doctor's practice under specific circumstances and would not challenge them if they perceived that this would result in conflict or stress or were afraid of the Doctor or feared reprisals.

More recently, this hierarchical communication dynamic has been documented in the '*radiographer-referrer game*' (Squibb et al., 2016). Radiographers lost their autonomy in interpreting radiographic images in 1925 when it was decided that only the medical profession could diagnose and interpret them. This essentially disabled the radiography profession from a core piece of their work at the time: the interpretation of images. As a result, radiographers use covert strategies, such as '*side-stepping*' or '*hint and hope'*, to alert the medical profession to abnormalities that have been picked up on radiographic images (Squibb et al., 2016). Whilst radiographers have attempted to address this with a 'red dot system' to alert referring medical practitioners to abnormalities on patient images, this has not been consistently taken up by the radiography profession and ignored, or not entirely understood, by the medical profession. Once again, the historical hierarchical relationships of medical dominance manifest where medical practitioners hold the power and authority over the radiography profession who have lost their autonomy over a key piece of work. The most defining feature of medical dominance is autonomy, as medicine "*has the authority to direct and evaluate the work of others without in turn being subject to formal direction and evaluation by them*" (Freidson, 1970, p.136). Professional autonomy therefore has important implications for primary health care and health policy, as the medical profession influences the type of health care that is administered. Those in the medical profession have a high level of autonomy in their work and are protected from outside scrutiny in many ways, even since the advent of quality processes and standards. Doctors can still make clinical or technical decisions without being accountable to others, especially from outside of the profession.

Whilst the nursing and radiography professions have developed 'work-arounds' to attempt to communicate with the medical profession, this method of communication is not always successful as much of it is indirect (Squibb et al., 2016). For example, in the case of radiography, the technique of 'side-stepping' is used, in which radiographers will highlight the need for an urgent report for Doctors to be aware of. This does not guarantee that Doctors will consider the report as urgent and can disregard this information at their leisure. Other radiographers may use red dots to signify abnormalities on photographic images, although this is not a universally accepted method in the

radiography field and is also not well understood by other professions, including Doctors who it is aimed at. Radiographers may also use a 'hint and hope' technique with medical professionals, to indirectly hint at issues with a patient's image and hope that the Doctor will act on the hint (Squibb et al., 2016). This tactic avoids direct language between the professions and puts the radiographer in a more subordinate role, showing the dominance of medicine (Squibb et al., 2016). In this study, there was no evidence of work arounds but rather, they remained silent or transitioned to find their voice, be heard and enact leadership.

If Allied Health Professionals continue to remain silent, take up the role of Doctor's support and behave in subservient ways, the field is at risk of a 'Doctor-Allied Health Professional game' emerging. If this subservience continued and a game emerged, it was unlikely that Allied Health Professionals would have achieved an integrated, interprofessional and collaborative way of working. Foucault (1976, p.101) reminds us that,

> *discourse can be both an instrument and an effect of power, but also a hindrance, a stumbling block, a point of resistance and a starting point for an opposing strategy.*

Accordingly, some of the Allied Health Professionals resisted the biomedical discourse and by doing so managed to dissolve the powerful 'othering' effects of subservient subjective positioning. The next section discusses the way that Allied Health Professionals constructed themselves as leaders in primary health care.

Primary Health Care Leader: An empowered and confident identity

Some of the Allied Health Professionals in this study were unwilling to adopt the subservient Doctor's Support identity and adopted a Primary Health Care Leader identity. This was a visible, empowered and confident identity the Allied Health Professionals used to be heard, lead conversations, and instigate changes in primary health care.

The Allied Health workforce is an important component of the health system and is in a strong position to meet the challenges that the health care system is currently facing, such as an ageing population, higher incidents of chronic disease and predicted workforce shortages (Markham, 2015). Where once Allied Health was described as "*just the jam between the bread-and-butter roles of nursing and medicine*" (Marks, 1999, p.169), it has been emerging as an equal partner with other health professions and is making a substantial contribution to health care reform (Boyce & Jackway, 2016). As growth rates in the Allied Health Profession workforce were out-performing both the nursing and medicine workforces at the time of the Medicare Locals (Australian Institute of Health and Welfare, 1996; 2003; 2009; 2013), Allied Health was in a prime position to demonstrate both leadership in health care and health workforce reform. In the current study, some of the Allied Health Professionals interviewed saw themselves as the glue in the primary health care system, capable of coordinating, connecting and managing services and interventions.

The 'Primary Health Care Leader' identity was powerful in primary health care because it allowed Allied Health Professionals to refuse to play the well-documented game that exists amongst the health professionals. Instead of constructing themselves as Doctor's helpers they understood themselves as leaders and innovators in primary health care reform. Some theorists assert the public act of naming a group as leaders is an important and "*magical act through which the practical group – virtual, ignored, denied, or repressed – makes itself visible and manifest*" (Bourdieu, 1991, p.224). The Allied Health Professionals thought of themselves as important and therefore led discussions and directed conversations at the Medicare Local Board table. By actively developing their leadership identity, some Allied Health Professionals used positive and effective leadership attributes to ensure their voice was heard to drive the primary health care agenda. The findings illustrate how the Allied Health Professionals were creative with their solutions, looked widely at options, and coordinated and connected services.

In making the leadership identity visible and enacting leadership qualities, the Allied Health Professionals attested its existence and laid a claim to be recognised as a legitimate authority in primary health care reform. As a corollary of enacting the leadership identity, safe and effective primary health care interactions were fostered at the Medicare Local Board table. Thus, the othering practices had been revealed and disrupted to transform the health care environments to support authentic multidisciplinary practice and collaboration. The ability to transform the social world in which health professionals operate and represent themselves is an important finding for health care reform policy. If this transformative dimension was better understood it could be engendered in entry-level Allied Health Professional education. If the future generation of health professionals could develop and evolve as primary health care leaders, there may be an opportunity to obviate exclusionary othering processes and instead create new inclusionary reformations of 'we'.

During the Medicare Local era, the primary care literature reported collaboration and integration were not being achieved in primary health care (Cant, 2010; Sturmberg, 2011; Wiese et al., 2011). Conversely, the leadership literature was reporting that the Allied Health workforce were effective collaborators, with other professions and health consumers, and were contributing to an integrated approach to health (Joubert et al., 2016). Both consumer-centred care and consumer engagement are recognised as critical elements to providing a positive experience of health care (Markham, 2015). Allied Health Professionals provide holistic care to consumers and ensure local communities are at the centre of everything they do, which brings forward the significant leadership contribution they make to health reform. Chapters five and six touched on the way communities were rarely at the centre of discussions about primary health care implementation. Rather, they were subjected to the third form of othering' – that is framing communities as 'THEY'.

Marginalising communities as other

The tacit but pervasive dimensions of the paternalistic medical authority evidenced in this study sometimes challenged the objective of working with communities to ascertain their health needs and

engage them in codesign processes for developing system solutions. These dimensions of power and discourse worked to marginalise communities as other.

The findings chapters show how the objects of the Medicare Locals Constitutions privilege a discourse of biomedicine that positions the local communities as 'THEY': who are sick and in need of help. As the previous sections discussed, 'othering' is often established as a natural phenomenon and therefore often viewed as natural and taken-for-granted (Okolie, 2003). Social identities are *not* natural –in fact, they represent an established social order – a hierarchy where certain groups are established as being superior to other groups. This form of othering provided a clarifying frame that was based on common processes that propagated group-based marginality.

Marginalisation, as a dynamic, multi-dimensional relational process driven by unequal power relations, leads to the exclusion of some groups from engaging fully in social life (Popay et al., 2008). By constructing the community as 'THEY', the Medicare Locals relegated the community to 'other' and therefore excluded their voices in the language of the Medicare Locals documentation and thus from fully engaging with the planning of their own health needs. As argued in chapters five and six, there was a continual use of language that cast 'patients' as 'deviant' which implies disease and illness that occur within their dysfunctional bodies (Roach Anlou, 2009). This is also extended to the local communities in which the Medicare Locals are situated. For example, positioning a local community as "*sufferers of disease and other chronic illness*" (North Coast Medicare Local Constitution, p.7) ensures that the community is subjugated to a non-healthy, deviant role that is reminiscent of Parsons 'sick role' (1951).

The 'sick role' is a medical sociological term described by Talcott Parsons as a social process in which people felt ill or became injured and in so doing took on a new role: that of the 'sick role'. This meant that the person was unable to continue with their normal functioning and therefore deviated from that norm (Burnham, 2014). Whilst the 'sick role' term has wavered in its popularity over the recent

decades, the essence of the concept is used here to articulate how the physician-patient dyad has been institutionalised as a fundamental social system in biomedical discourse.

The language of the Medicare Local Constitutions constructs the community as 'other' or 'THEY'. The use of language in the Constitutions objectifies the communities and in doing so renders them as socially different and constructs two binary categories – US and THEY and in doing so represents them as being different to each other (Foucault, 1972). This then functions to shape society within a social hierarchy that views Doctors as being socially superior to those in the community who may need health care services. Utilising a biomedical discourse consistently frames the communities as sick and in need of medical treatment which is in direct conflict with a primary health care discourse whereby consumers are partners and co-creators of solutions to improve their health (Baum, 2015). The selective view of primary health care is reflective of this biomedical discourse and the Medicare Locals utilised this framework to promote GPs as the medical 'experts' that can prevent illness in a top-down, practitioner-driven model that negates other health practitioners and the role of the community in maintaining their own health and well-being.

The act of subjugating and marginalising communities is in direct conflict with the philosophical underpinnings of primary health care. Contemporary primary health care underpinned by the five action areas of the Ottawa Charter (1986) places emphasis on the need for stronger community involvement in health care reform to create supportive environments. A substantial evidence base suggests effective health promotion rests on communities that are empowered and involved in planning local level solutions to their health needs (O'Connor-Fleming & Parker, 2001). The decade just prior to the establishment of Medicare Locals saw calls for stronger community-based advocacy, community participation in decision-making, and a commitment to achieving a new social order in power relationships (O'Connor-Fleming & Parker, 2001). The act of excluding community-driven responses to health care undermines the principles of primary health care and reifies the medical authority and biomedical discourse that has been ever present in primary medical care. It is time to

address this marginalisation of communities through advocacy, participation in political processes that effect public policy, and generating research that continues to reveal factors that contribute to marginalisation and oppression.

Primary medical care is not grounded in a social determinants approach (Baum, 2013). Primary medical care has failed as a sole approach to health care, and alone does not provide the response needed to fix Australia's health care system. As argued throughout this study, a more comprehensive view of primary health care is required to address the social determinants of health, improve equity and access to services in an integrated and coordinated manner (Baum & Simpson, 2006). The templar of a best-practice model is already in existence in Australia within Aboriginal Controlled Health Organisations and Community Health services (Baum et al., 2017). This comprehensive primary health care model uses a community strengths-based approach that promotes engaged participation, aims for community control and utilises health professionals on a '*on tap not on top*' basis (Baum, 2003, p.516). The National Aboriginal Community Controlled Health Organisation has become the national peak body representing 143 health services at the Commonwealth level (National Aboriginal Community Controlled Health Organisation, 2011). As a peak body, it represents a clear, united and distinct voice about Aboriginal health and is the leading and preferred provider of culturally safe primary health care to Aboriginal and Torres Strait Islander people (National Aboriginal Community Controlled Health Organisation, 2011). The strength of the NACCHO model can be attributed to the conscious move away from the deficit model implicit in much discussion about the social determinants of health, to instead adopt a strengths-based cultural determinants approach to improving the health of Aboriginal and Torres Strait Islander people (Baum, 2013). In other words, community is at the centre of the model.

Rather than adopting best practice, research informed and evidence models, primary health reform has taken a backwards step since the introduction of the new Primary Health networks in 2015. Whereas, Medicare Locals were attempting to reduce fragmentation of care by integrating and

coordinating health services, collaborating across health services, and leveraging and administering health program funding, the policy imperative that informs the operations of the Primary Health Networks has reverted to the biomedical approach. The two main objectives of the new Primary Health Networks, as stated on the Department of Health's website, are:

> *increasing the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes, and improving coordination of care to ensure patients receive the right care in the right place at the right time (Department of Health, 2016, p.7).*

The focus on an integrated, multidisciplinary approach to tackling the social determinants of health has been replaced with a GP-led response to health care. Furthermore, the biomedical language has once again been reproduced and continues to reify people as patients, position Doctors as experts, and marginalise communities as the silent, passive and dependent 'other'. The patriarchal medical authority is once again dominating the language used to establish and guide the Primary Health Networks. Reproduction of the biomedical model in understandings of health care and this latest round of health reform is indicative of a retrograde step that the Australian government has taken. The government's ongoing focus on primary medical care services may come at the expense of population health, and will no doubt challenge the way various stakeholders work together, including: primary health care stakeholders, including health professionals, Local Health Districts, nongovernment organisations, research institutions and local communities (Booth et al., 2016).

Under the Primary Health Network structure, GP-led Clinical Councils have replaced broader, multidisciplinary and integrated mechanisms of governing. The Australian health system requires a strong primary care infrastructure and a robust public health sector, however, a higher level of integration than currently exists is needed (Levesque et al., 2012). The Primary Health Networks focus on *individual* experiences of health care, including access, efficiency, effectiveness and quality of

health care (Booth et al., 2016). People will require a higher degree of system connectivity than currently exists to navigate these aspects of health care.

Community participation and empowerment are also absent and have been replaced by Community Advisory Committees. These Committees re-represent local communities and fail to include or actually represent them. The use of the term 'advisory' also sets these committees under the authority of medicine, who can dismiss or include their recommendations at will.

Section 3. Improving future health reform

Allied Health Professionals bought a range of skills, knowledge and values to the table in Medicare Locals. The future of primary health care in Australia requires strong leadership, effective networks, strategic planning and transformative leaders (Javanparast et al., 2015) and Allied Health Professionals could play a significant role within this.

Developing Allied Health Professional Leaders

In 2019, there is a general consensus that comprehensive primary health care is the preferred model for improving Australia's health, however the mechanisms for fostering innovation and leadership to inspire it have been identified as lacking (Russell & Dawda, 2019). This is concerning as it is well established that effective clinical leadership improves the quality and safety of healthcare service provision (Mohr et al., 2002; Nicol, 2012; Penlington & Holmstrom, 2013). If Allied Health Professionals take up the leadership mantle and are not drawn into playing the game discussed in this chapter, they will be in a very powerful position as primary health care leaders who can disrupt the medicalised and medical expert driven approaches that continue to exist today. In the current study, Allied Health Professionals drew on their salutogentic knowledge systems and used discourses of health and health promotion to construct primary health care as a holistic, multidisciplinary, integrated and coordinated health care approach. While these understandings were initially at odds with Board member colleagues who were Doctors that espoused the biomedical tradition and primary care, there was

evidence of an intent to achieve two paradigm shifts. A shift from GPs and general practice being at the centre and another from medical authority to multidisciplinary collaborative practice.

Giving more voice to Allied Health leaders could influence the social organisation of health care in Australia. Involving Allied Health leaders in co-creation processes that reflect the experiences and perspectives of all stakeholders, might facilitate the shift required to move beyond the structural reform ideals of optimising health outcomes, to addressing the deeper cultural dimensions associated with organisational improvement, and integrative collaborative practice (Jackson & Hambleton, 2016; Jackson et al., 2016; Oliver-Baxter, Brown, & Dawda, 2017). There is already evidence the Australian government is changing the way it organises, funds, delivers and uses its health services. In the last ten years, a number of specific initiatives have been implemented by the government targeted at Allied Health Professionals. These include:

- Increasing consumer access to Allied Health items in the Medicare Benefits Schedule
- The Better Outcomes in Mental Health Care Program
- More Allied Health Services
- Better Access Initiative
- Nursing and Allied Health Rural Locum Scheme
- Education and Training Support

The overall goal of these initiatives is directed at improving access to Allied Health services for the management of chronic disease and improving the health status of Australians in rural and remote areas. Most Australian states now have in place Allied Health taskforces, strategies and programmatic activities to grow their local Allied Health workforce (Boyce & Jackway, 2016; Dawber e tal., 2017; Joubert et al., 2016). These structural reform activities exemplify how Allied Health Professionals are being identified in planning and policy forums as being crucial to service innovation and their quality of decision-making (Mason, 2013, p.23-24). They have been instrumental in the successful implementation of innovative models, such as Allied Health assistant models and advanced practice

roles, that ensure that all elements of the workforce are working to their potential and maximum scope of practice (Dawber et al., 2017; Markham, 2015). There has also been an increase in cost-effective and enhanced quality and safety measures in Allied Health-led services that have recently been developed (Markham, 2015). These innovative models have enhanced consumer outcomes, reduced waiting lists and provided high-quality outcomes to consumers. This drive for innovation by Allied Health Professionals has put them in an enviable position to demonstrate leadership in health care reform. However, more needs to be done to develop Allied Health leaders given that various State reports have identified they are underrepresented and not highly visible in the health leadership strata (Boyce & Jackway, 2016; Dawber et al., 2017; Joubert et al., 2016).

On a precautionary note, however, whilst Allied Health Professionals have been shown to be effective multidisciplinary and interprofessional collaborators, there is a taken-for-granted notion that they have been equipped with the knowledge, skills and values requisite for this. Resources in leadership development are badly needed, however a strong basis of interprofessional collaborative practice must also be resourced at the very start of the undergraduate journey.

Greater access to organisational leadership development pathways is required for Allied Health Professionals (Bradd et al., 2017). Leadership development requires support at all levels: strategic system, organisational and individual, and designed for different target groups: undergraduate and early career professionals, emerging Allied Health Leaders, growing Allied Health leaders and established leaders (Bradd et al., 2018b; Joubert et al., 2016). To drive quality, safety and productivity in health care, Joubert et al, (2016, p.3) identified a number of recommendations to progress Allied Health leadership development, including: a) adopt a strategic and transformation approach to building collaborative, multidisciplinary and inclusive leadership opportunities for Allied Health Professionals, b) Expand Allied Health Professional representation in existing leadership and clinical improvement initiatives within organisations and monitor progress and outcomes, c) Promote organisational and structural reform to strengthen Allied Health leadership development and deliver

equity of opportunity, d) Expand access to tailored and varied leadership development opportunities for Allied Health Professionals, e) Consider resourcing implications of the proposed strategies, and f) Identify future research directions. Realising these recommendations might be challenging given the limited evidence base related to Allied Health leadership development.

There is an abundance of leadership literature but a paucity of robust published reports in relation to Allied Health leadership (Bradd et al., 2017; Bradd et al.,, 2018a; Bradd et al., 2018b). Nevertheless, Allied Health Professionals are beginning to investigate what the leadership practice and practitioners of the future will look like (Bradd et al., 2017; Bradd et al., 2017b; Wylie & Gallagher 2009; Markham, 2015; Boyce & Jackway, 2016; Dawber et al., 2017; Joubert et al., 2016). In this study some of the Allied Health Professionals demonstrated transformative, inclusive and democratic leadership styles, which reflects quantitative evidence reporting the transformational leadership skills of some Allied Health Professions (Arensberg et al., 1996; Firestone, 2010; Gellis, 2001; Joubert et al., 2016; Snodgrass & Shachar, 2008; Wylie & Gallagher, 2009). Wylie and Gallagher (2009), argued the challenge to reform traditional models of care depends upon an Allied Health "*leadership revolution*" to achieve "*effective clinical leadership at all levels*" of the health care system but some Allied Health groups might require more leadership support (pp.65-66).

In their review of Allied Health leadership development programs, Bradd et al (2017) found unlike studies published by other disciplines, such as nursing, there were no studies reporting leadership elements such as specific competencies or impact on colleagues or standards of clinical care. Bradd et al (2017) suggests there is an opportunity for further research to examine the many facets of leadership as they pertain to the Allied Health disciplines. This study found that participants recognised themselves as leaders and provides evidence of significant Allied Health leadership outcomes. As Medicare Local Board members, Allied Health Professionals were in a unique position to lead primary health care due to their holistic understanding of health, disease prevention, and focus on health promotion, restoration and rehabilitation. As they enacted leadership to ensure their voice

was heard and leveraged this to drive the primary health care agenda, some of the Allied Health Professionals fostered inclusive, multidisciplinary cultures. It is important these capabilities for leading effective interprofessional collaborative practice are acknowledged and reflected in Allied Health leadership development programs.

The Framework for Action on Interprofessional Education and Collaborative Practice developed by the WHO (2010) identifies mechanisms that shape effective collaborative teamwork and practice and outlines action items that can be applied in health and education settings. It is these innovative and system-transforming answers that will not only provide solutions to health workforce distribution, supply and mix issues, but will also allow for further development of future Allied Health leaders that are practice-ready collaborators (WHO, 2010).

Developing, implementing and evaluating Allied Health leadership programs will necessarily take some time. Time will also be important to effect cultural changes within the Allied Health disciplines and between other health professional groups. Furthermore, it is crucial the importance of time to effectively implement reform is factored into policy and practice in health and education. Time needs to be dedicated to systematically implementing change using a strategically developed change management plan, establishing and consolidating relationships and communication pathways, developing programs and evaluating outcomes from multiple perspectives. As seen by Horvath's report, there was evidence that some of the reform agenda was being achieved, however progress was disrupted by prematurely and abruptly ceasing funding and imposing a new policy that saw the implementation of the Primary Health Networks. The Primary Health Networks, whilst reproducing some of the broader objectives from the Medicare Locals, were explicit in their key objectives of:

- *increasing the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes; and*
- *improving coordination of care to ensure patients receive the right care in the right place at the right time* (Australian Government, 2014).

The Primary Health Networks used a more primary care approach that focuses on a medical model and dissolved the need for multidisciplinary, integrated service delivery in favour of commissioning of medical services. Potentially, this later round of reform may or may not achieve improved health outcomes but as it is not evidence-based, this is questionable.

It is at this point, the discussion needs to look forward to generate insights and recommendations about how policies are being made, identify factors influencing policymaking and assess to what extent evidence is used in the process of ensuring primary health care leads to better health.

Developing evidence based primary health policy reform

The importance of evidence-informed health policies in improving health and understanding the mechanisms involved for reducing health inequities and contributing to economic development is increasingly recognised (Evans-Agnew et al., 2016; Hanney et al., 2003). Reports calling for more resources to improve health, and global pressures to improve accountability, draw greater attention to the need for research-informed policy-making (Hanney et al., 2003). The uptake of findings from primary health care research into policy-making remains a complex, non-linear and arguably, under-utilised process. This is largely due to the complexities associated with measuring health improvements as an outcome of primary health care. Projected and long-term challenges still remain for researchers to improve the uptake of health care research findings and for policy-makers to use such research evidence in their work (Galipeau et al., 2015; Kim et al., 2018; WHO, 2004). This section presents the contribution that critical discourse analysis can make to critically evaluate policy and inform future primary health care reform.

Policy development is a complex, multi-step process which is influenced by multiple stakeholders, and contextual factors, such as special interest groups, policy makers, and the broader socio-political environment in which it occurs (Brownson et al., 2009). Policy analysis in primary health care research can provide insights into how systems support and promote health and well-being in populations and may provide data and advice for decision-makers (Althaus et al., 2017). However, most policy research

analysis operates within a post-positivist framework that makes assumptions that the political and social contexts in which it has been created are fixed and measurable (Evans-Agnew et al., 2016). Critical discourse analysis, in contrast, seeks to analyse and criticise, and ultimately change the existing social reality by understanding the relationship that discourse may have to other social elements, such as ideologies, policy, power relations, and economic and political strategies (Fairclough, 2015).

Critical discourse analysis has been used to explain or critique existing patterns in society, local communities and various policy making institutions, such as government departments (Lester et al., 2016). It is a useful tool for questioning taken-for-granted assumptions about the ways that policy has come to exist and known by policy actors, implementers and policy stakeholders. Critical discourse analysis also offers alternative understandings and insights about how these issues can inform decision-making and transform social practices which influence policy (Evans-Agnew et al., 2016; Lester et al., 2016).

In health research, critical discourse analysts have provided insights into power relations and hierarchies between the health professions (Wong et al., 2016); health care delivery, organisational management and workforce development (Smith, 2007); power relations and social assumptions surrounding youth homelessness (Kuskoff, 2018) and ethical considerations of pandemic influenza preparedness plans (Garoon & Duggan, 2008). Foucault's work has been particularly useful to policy research, as his ideas on the production of discourse provides new possibilities in thinking about interrelations and connections involved in governing, rather than centring analysis on procedures, structures, government publications and policy (Hewitt, 2009). Foucault's writings on power highlights the diverse influences of social and political relations on policy and makes sense of the struggles of discourse, the operations of power and the social practices that shape it. Discourses are embedded in customs and rituals, values and practices and individuals and institutions are regulated by these social processes (Hewitt, 2009).

Critical discourse analysis, therefore, is useful for policy analysts in several ways:

a. It is a useful tool for researchers to examine critically, ideas such that all policy is a "well-intentioned" passive construction of words and sentences (Unger et al., 2014);
b. It can provide alternate understandings for revising and transforming social practices which influence policy (Evans-Agnew et al., 2016); and
c. It can provide in-depth examination of ethical challenges in health policies, such as Garoon and Duggan's (2008) ethical review of National Pandemic Influenza Preparedness Plans.

The use of critical discourse analysis in policy research and analysis is a useful methodology that allows for an analysis of power relations in policy formation, such as the underlying medical dominance that was highlighted throughout the Medicare Local Constitutions. Critical discourse analysis then provides new opportunities for primary health care researchers to advocate for change in social practices and to look towards a future of primary health care that truly reflects 'Health For All'.

Medicare Locals were reported as instrumental in making some inroads into establishing trust and working relationships. Javanparast et al., (2015) stress the importance of learning about the experiences of these organisations. Current and future primary health care requires strategic planning, strong leadership, stable organisational structures and effective networks that draw on strong personal relationships (Javanparast et al., 2015). Change management is needed in primary health care and therefore leadership needs to be adaptive and transformative (de Melo Lanzoni et al., 2016; Javanparast et al., 2018). Leadership is often driven by values. Values are often subjective and can vary, (Jackson & Hambleton, 2016), however, there is recognised merit in drawing on the co-creation experiences of consumers and stakeholders to move beyond a focus on the structural reform ideals of optimising health outcomes, to addressing the deeper cultural dimensions associated with working to achieve organisational improvement, and integrative collaborative practice (Jackson & Hambleton, 2016; Jackson et al., 2016; Oliver-Baxter et al., 2017).

The most recent epidemiological studies evidence ongoing health gaps in Australia (Marmot, 2017), and some populations, such as Aboriginal and Torres Strait Islanders, need specific frameworks to

address them (Cheng et al., 2019; Freeman et al., 2018; Jancey et al., 2019; Reed et al., 2018; Strobel et al., 2018). Also gaining popularity are new frameworks and tools for designing and assessing quality improvements in primary health care (Borg et al., 2019; Obucina et al., 2018). While such advances in health reform are encouraging, large scale reviews of implementing new models in rural and remote primary health care tell us that shared decision-making, negotiation and consultation with communities is important and should be used to promote feasible strategies that improve access to community-based primary health care services (Lyle et al., 2017). Furthermore, as Javanparast et al. (2019) argue, improving primary health care and local government collaboration can strengthen action on social determinants and, by doing so, advance population health and health equity.

Chapter summary

There were different discourses being produced and reproduced in the social practice of primary health care located within Medicare Locals. Power expressed through the different and sometimes competing discourses worked to give rise to three forms of othering: US, the health care leadership collective historically recognised as GPs; THEM, the newcomers to health care leadership, recognised as Allied Health Professionals; and THEY, the communities in which the Medicare Locals were to provide services. The othering made two main subjective positionings available to Allied Health Professionals which they drew upon to shape their professional identities: '*Doctor's Support*' and '*Primary Health Care Leaders'*. The Doctor's Support identity can be seen as a disabling subjective position for Allied Health Professionals to develop as future leaders and for the field of primary health care to meet its aspiration of integrated services and professional collaboration. The Primary Health Care Leader identity is an enabling subjective position for Allied Health Professionals to progress primary health care as the public health discourse intended. It also worked to challenge and disrupt the status quo of medical authority that had been so long-standing in health. These findings together with new theoretical insights illustrate the valuable contribution that critical discourse analysis can make to critical policy studies for informing future primary health care reform.

This study has shown the following:

- As Medicare Local Board members, Allied Health Professionals were in a unique position to lead primary health care due to their holistic understanding of health, disease prevention, and focus on health promotion, restoration and rehabilitation.
- Some Allied Health Professionals actively developed their leadership identity, and enacted leadership to ensure their voice was heard and leveraged this to drive the primary health care agenda. A corollary of this leadership confidence and active agency to foster inclusive, multidisciplinary cultures.
- The Allied Health Professionals who participated in this study had gained confidence, found their voice, and were leading conversations and instigating innovative, community-centred, needs-based changes in primary health care.
- There were different forms of othering at play that conspired to silence some Allied Health Professionals and marginalise communities and undermine the principles and philosophy of Primary Health Care; the antithesis of the reform agenda
- Critical discourse analysis as a means of analysing primary health care policy facilitated a rich and informative analysis of the latent power relations embedded in policy formation, representation and implementation and shed light on the gulf between the reform agenda, policy and operational directives, rhetoric and the reality experienced.
- There is an urgent need to re-think the approach to health policy reform. The tendency to reactively lurch from one direction to another without time to realise its potential, consider robust evaluative research or consult with communities and clinicians, is economically and socially counterproductive.

Chapter 8. Conclusion

Introduction

This chapter concludes the thesis by situating the findings and discussion in the context of the study aim and research questions. The aim of the study was to examine ways primary health care was represented by Medicare Locals, and how these representations impacted on the way Allied Health Professionals formed meanings and therefore approached integration, collaboration and multidisciplinary ways of working as leaders in primary health care. It brings together key tenets of the critical qualitative research process and reports the findings as outcomes of that process. Data were sourced from two forms of Medicare Local policy documents: Operational Guidelines for Medicare Locals and the Constitutions of 61 Medicare Local organisations, and interviews with seven Allied Health Professional Board members who worked in Medicare Locals. This approach generated in-depth insights into how and in what ways the inclusion of Allied Health Professionals on Medicare Local Boards contributed to the vision and mission of the primary health care reform agenda and answered the following research questions:

1. How was primary health care constructed within written strategic documents mandating the vision and mission of Medicare Locals?

2. How did Allied Health Professionals who worked in Medicare Locals understand primary health care as it related to their leadership roles?

3. How were Allied Health Professionals within Medicare Locals positioned for achieving integrated and collaborative multidisciplinary approaches in their work as Board members?

4. Were Medicare Locals meeting their intended vision and mission of integrated and collaborative primary health care?

This study contributes new knowledge and insights that have not previously been considered in the field of primary health care. It sheds light on how Medicare Locals were set up and operated, the

tensions within and between policy texts and the constraining and enabling influences of discourse. The different knowledge systems underpinning primary care and primary health care, coupled with neoliberal drivers, and differing professional values opened up new ideas about working with communities to achieve the reform agenda, yet, unwittingly created tension around service delivery. Appointing Allied Health Professionals to leadership positions at the Medicare Local Board table was an intentional structural political reform initiative. It was designed to disrupt the status quo of medical authority and move away from a reliance on primary care towards comprehensive and holistic primary health care. Including Allied Health Professionals on Boards gave them a credible voice which was critical to achieving the paradigmatic and cultural shifts necessary to realise the intended outcomes of integrated collaborative practice. The results of this study demonstrate that despite the tensions between the rhetoric and reality, Allied Health leaders were making inroads into transforming primary care into a community-centred, integrated, interprofessional and collaborative approach consistent with the notion of comprehensive primary health care as espoused in the Declaration of Alma-Ata (WHO, 1978). The study contributes to understanding the interface between policy and its implementation structurally, operationally and culturally.

The chapter begins with a synopsis of the thesis before answering the research questions. It then appraises the strengths and limitations of the study, draws on the implications of learning from the past to influence the future and makes some recommendations for improving current and future primary health care policy reform.

Synopsis of the thesis

Chapter one introduced the study by looking back into the history of primary care in Australia as a foundation for looking forward to primary health care reform. The chapter outlined how primary health care was temporally situated in a period of political and policy reform that drove structural reform enacted to integrate services and forge strong links between local communities and health professionals. The period was characterised by differing commitments by key stakeholders to the

health care reform agenda, resulting, at least partially, to a tension between primary care and the philosophical ideals of primary health care. Primary health care emerged from a public health philosophy that was advanced to reduce health inequalities and social disadvantage and was contingent on the integration of services, collaboration of health professionals and multidisciplinary care. In contrast, primary care emerged from a medical model that relied on people becoming unwell before seeking medical attention through first points of contact with the health system. While both terms use a similar language, their underlying knowledge systems, or discourse, are quite different. The chapter concluded by identifying the disparate conceptualisations of the term 'allied health' and comparative invisibility of Allied Health leadership and suggesting the lack of clarity and visibility have likely reinforced medically-oriented approaches to health care.

Chapter two reported how primary health care was constructed in the published and grey literature as the strategy used to transform Australia's health system, its structure and health services. The review of the literature in chronological sets, was useful for demonstrating how structural reforms used to implement primary health care reform challenged the traditional understanding of hierarchical health care. Analysing the effects of primary health care policy reforms on health and wellbeing were complicated by the inevitably long-term nature of measuring improvements in health and a range of contiguous variables. These variables included increasing the health literacy and skills of the community; increasing health enhancing behaviours; improving quality of life for individuals; decreasing rates of preventable conditions and issues; increasing supportive health environments; increasing social capital; increasing planned and managed care; and decreasing acute, and episodic care.

Given the challenges associated with reporting health and wellbeing outcomes, the 2010-2015 body of primary health care literature tended to report outcomes related to structural change and programmatic descriptions that often presented a narrow and selective view of primary health care. A critical reading of this literature revealed that while structural reform was important for working

toward primary health care, historical cultures and behaviours within and between the health professions were influencing the way reform was perceived, implemented and evaluated. It was evident that different discourses (biomedical, public health, primary health care and professional) were at play within the research field, which suggested that medical dominance and a biomedical stance remained a pervasive influence in the way that primary health care was conceptualised. Furthermore, other ways of knowing primary health care were obscured because the voices of Allied Health Professionals were difficult to locate in the literature. The implication for this study was that structural reform in primary health care without consideration of the pre-existing cultural dimensions and tensions within the health professions, overlooked the complex aspects of ideology, strategy, language and practice, and complex relations between power and knowledge, that is, ways of knowing and working.

The premise for this study was to look beyond the ideas of structural reform in primary health care by adopting an approach that would investigate the deeper and hidden cultural associations of language, discourse, power and identity located within the practices of Allied Health Professionals elected to Medicare Local Boards. The study purpose reflected the need to adopt a methodology as a tool for evaluating policy to learn about the consequences of public health policy using a case study approach. The study required a sophisticated and complimentary theoretical framework and research design for examining the discursive practices of primary health care to identify the ways in which power was exerted and therefore influenced how Allied Health Professionals thought and acted as leaders in their Medicare Local Board member roles.

Chapter Three argued that a theoretical framework capable of examining processes of discourse ‘control’, ‘access’ and ‘participation’ were the central theoretical concerns in this study. The ideological tool named discourse and the nexus between the theories of power, discourse and governmentality, provided the theoretical lens and analytic framework for examining how Medicare Locals and Allied Health Professional Board members represented primary health care. The theories

used included Foucault's' insights concerning power-knowledge and governmentality, van Dijk's insights on discourse access, participation and control, and their intersection with Erikson's conceptualisation of discursively constructed professional and social identity. Fairclough's three-dimensional model was used to examine the relations of power, discourse and governmentality. The chapter concluded that critical discourse analysis, underpinned by a theoretical framework drawing on theories of discourse and power, and identity, would be useful in analysing policies and spoken accounts of primary health care to examine ways primary health care was represented by Medicare Locals and how these impacted on how Allied Health Professionals formed meanings and approached their role as leaders.

Chapter Four described the research procedures used in the study including the use of Fairclough's three-dimensional model of critical discourse analysis to analyse the Medicare Local policy texts, namely, Medicare Local Operational Guidelines and Medicare Local Constitutions, and interviews of seven Allied Health Professionals working in leadership roles. Data were thematically analysed to identify the discourses embedded within the texts, presence of competing discourses, identity formation, and outcomes of the interplay between discourses.

Chapters Five and Six, presented the findings. Chapter Five identified how primary health care was represented in the Medicare Local Operational Guidelines and Medicare Local Constitutions and produced and reproduced through the mandate of Medicare Locals. Examination of their structures and the strategies of text, allowed for the discovery of how primary health care, biomedical and professional discourse were produced and reproduced. 'Health for All' emerged as the overarching discourse in the shared mandate of the Medicare Locals and this was evident through two subthemes: the 'Need for Health Improvement' and 'Discursive Tensions in Promoting Health and Primary Care'.

Chapter Six, the second chapter of research findings, examined how Allied Health Professionals on Medicare Local Boards talked about, and interpreted, the everyday practice of their leadership roles as Medicare Local Board members. The first section provided a profile of those interviewed in terms

of disciplinary background, region, age and gender. Other findings were presented under three major themes. Bringing Allied Health Professionals to the Table, reported how participants constructed primary health care and conceptualised their role in the reform process. Experiences of being at the table addressed participants' understanding of primary health care, their expectations about how it would be constructed. Their 'Experiences of being at the table' included the sub-themes: 'Being silenced', 'Finding voice', and 'Being heard'. The fourth section presented the theme 'Enacting leadership to achieve the vision and mission' of Medicare Locals and included 'contributions to health planning', 'leading primary health system transformation' and 'the glue in the system'. The final section identified and exemplified the 'Tensions between directives, rhetoric and reality' experienced by Allied Health Professionals leading the health reform occurring within Medicare Locals.

Chapter Seven reviewed the key findings in terms of its aim, purpose and research questions, situated them within the literature, and identified their implications for future policy and practice. The first section discussed the value of bringing Allied Health Professionals to the Medicare Local Board table. Section two discussed how processes of othering emerged as a manifestation of complex power relations and explored how Allied Health Professionals experienced being othered and negotiated belonging by either adopting an identity as the Doctor's Support or Primary Health Care Leader. It also discussed how communities were marginalised as other. The third section discussed how future primary health care reform could be improved by ensuring that primary health care policy reform is evidence-based and developing Allied Health Professionals as leaders.

Answering the research questions

Research question 1: How was primary health care constructed within written strategic documents mandating the vision and mission of Medicare Locals in Australia?

During the Medicare Local era, primary health care was not well defined and understood in different ways by different groups. The Operational Guidelines for Medicare Locals expressed the Australian government's commitment to improving *Health for All*, which was a vision reproduced in the legally

binding Constitutions for Medicare Locals. In these documents, primary health care was predominantly constructed as a level of care and an approach to service provision characterised by multidisciplinary teams supported by integrated referral systems. Whereas the reform agenda situated communities at the centre, the conflation between the concepts of primary care and primary health care embedded within these documents privileged medical authority and reinforced the historical GP-led approach to health service delivery. These constructions facilitated the exercise of power through the production of what could be known about public health and how it could be known. There was an ambiguous interaction between biomedical and social understandings of primary health care which engendered tensions between promoting health and providing primary care services.

Research question 2: How did Allied Health Professionals who worked with Medicare Locals understand primary health care as it related to their leadership roles?

As the different groups used these policy documents, they applied their own cultural understandings to primary health care. The competing views of primary health care and primary care evident in the Medicare Local policy documents created conditions for conflict, confusion and tension between the different health professions leading these organisations.

Allied Health Professionals' accounts of primary health care were based on a need to understand root causes of poor health in communities and driven by a commitment to working with communities to ensure equity in accessing health services and information. They drew on discourses of health, health promotion and community dimensions to construct primary health care as a means to addressing the social determinants of health and ensuring equity of service access for communities. At times, they found these understandings were at odds with medical colleague Board members who espoused biomedical traditions.

The Allied Health Professionals recognised the importance of becoming Board members and considered being at the table critical for having their voice heard in primary health care. Being at the table brought them together with general practitioners who were experienced in organisational operations and confident in their leadership roles. The Allied Health Professionals were challenged by managing the complex, culturally mediated interplays of power and discourse. They experienced being silenced and some transitioned to finding voice, being heard and came to regard themselves as the glue in the system. In these instances, the Allied Health Professionals provided an alternative view about how the primary health care system could operate and contributed to discussions about health for all.

Research question 3: How were Allied Health Professionals within Medicare Locals positioned for achieving integrated and collaborative multidisciplinary approaches in their work?

In taking their place at the Board table, the Allied Health Professionals were willing to take up two different subjective positions. The Doctors Support identity reflected the way some Allied Health Professionals considered themselves as subservient assistants to Doctors. It was an identity that rendered them silent and made them invisible on the Medicare Local Boards because they often chose to passively support the general practitioners' position and decisions.

The primary health care leader identity reflected the way some of the Allied Health Professionals shaped themselves as leaders in primary health care reform. It was an identity that enabled and empowered them to find and use their voice for leading conversations, challenging instances of primary care logic and instigating changes in Medicare Local operations to better align service delivery with the tenets of primary health care.

The two identities had important implications for primary health care and how the health professionals worked together. The Allied Health Professionals who enacted leadership demonstrate how, despite long held cultural understandings of professional hierarchy, it was possible to build

mutual respect and trust within the developing multidisciplinary teams. This is a professional identity that should be nourished within the Allied Health Professions. The results demonstrate the policy mandate for appointing Allied Health Professionals to governing Boards in primary health care organisations was a successful strategy for building relationships that embrace collaborative integrative practice.

Research Question 4: Were Medicare Locals meeting their intended vision and mission of integrated and collaborative primary health care in Australia?

The marginalisation and othering of communities was a concerning finding. However, there was evidence the Allied Health Professionals who enacted leadership had begun to engage local communities in service planning and facilitated stronger community participation. They were devising innovative ways of working with communities, promoting health, preventing disease, and influencing the way health professionals related to each other and worked together. The capacity for Medicare Locals to realise the full potential of comprehensive primary health care reform was thwarted by the precipitate, large-scale policy shift to disband Medicare Locals and transition to Primary Health Networks.

The effects of abrupt policy change compromised the ability of Medicare Locals to address the broader goals of primary health care. The premature cessation of these organisations has prevented them from realising their full potential and their actual impact on public health will never be known. However, this study provides evidence the Medicare Locals were achieving the vision and mission by actively redefining professional boundaries, an important element of working towards a collaborative multidisciplinary, innovative, integrative, and community-driven sector. It demonstrates how constant changes in policy directives are counterproductive and undermine the efficacy of health reform.

Strengths and limitations of the study

The critical discourse analysis research design provided a means for examining the experiential, relational and expressive textual features of the Medicare Local Operational Guidelines (2013), Constitutions and the seven interviews with Allied Health Professionals. The design facilitated examination of the relationship between these texts, their processes of production and interpretation (interaction) as well as the social conditions of that production and interpretation (context). This enabled investigation of the ways primary health care was represented in Medicare Locals and how these representations impacted on the way Allied Health Professionals formed meanings and therefore approached integration, collaboration and multidisciplinary ways of working.

By situating primary health care in its historical-socio-political context it was clear this study required a theoretical framework that could analyse and explain the discourses created and the interaction between language, discourse, social practice and power. Using discursive theories provided such a mechanism.

By using power as the theoretical lens, the study examined how primary health care was constructed and operationalised through both sovereign and disciplinary interests and the influence these had on the ways Allied Health Professionals thought and acted (biopower) within primary health care. These forms of power accommodate agency, structure, culture and their influence on representations of 'truth and knowledge' (Foucault, 1972), known as discourse.

Concepts such as discourse (Bacchi, 2016; Di Ruggiero et al., 2015; Porter, 2006), power, knowledge, and governance (Malmmose, 2009; Ravn et al., 2016) have featured in the published health care literature. Several international studies within the field of primary health care and public health had examined the links between language use in policy texts and the social practice surrounding these texts from hegemonic and discursive perspectives (Garoon & Duggan, 2008; Unger et al., 2014). However, at the time of this study, they had not been used to investigate the cultural dimensions inherent in the structural reform used for advancing primary health care in Australia. Anchoring this

study in the critical tradition was instrumental in examining the relations of power, expressed through language and discourse, to reveal the tacit, explicit and implicit knowledge systems underpinning the reform agenda. Critical discourse analysis was valuable for examining how relations of power operated within primary health care and how they might have enabled or inhibited the inclusion of other healthcare professionals into leadership positions and worked to nurture a more comprehensive view of primary health care (Baum, 2015; Germov, 2009; Willis, 1989).

The findings suggest the discursive constructs underpinning primary health care policy in Australia need further attention to expand and clarify the body of knowledge around the cultural aspects for building an integrated, collaborative, multidisciplinary primary health care system.

The Medicare Locals used as the case study in this research were disbanded before their impact and outcomes could be meaningfully measured. This study provides some in-depth insights about how primary health care was constructed in policy texts and enacted by Allied Health Professionals who were members of Medicare Local Boards. It addresses a gap in knowledge about the contribution that Allied Health leaders made to moving towards integrated collaborative practice. It also sheds light on how Medicare Locals were working towards realising the Australian governments' intended vision and mission for Primary Health Care reform.

During the course of the study, Medicare Locals were replaced by Primary Health Networks. This reflects another structural change and therefore another twist in the windy road of primary health care reform in Australia. The impact of this latest change remains unknown. However, these findings suggest that unless the relations of power and discourse reflect the value of including multidisciplinary voices and perspectives, vested interests will prevail and jeopardise maintaining and building on the achievements gained through the Medicare Local initiative.

Further examination of the language-power-discourse and identity nexus inherent in this latest policy implementation would strengthen discourses that are conducive to realising comprehensive primary

health care. Exposing discourses that are counterproductive could help to disrupt the barriers and impediments that constrain primary health care.

The study provided an illustrative account of the day-to-day practice of primary health care by localising it to a small group of Allied Health Professionals. It addressed the gap in knowledge about Allied Health Professional leadership in primary health care. Given the subjective nature of qualitative research there were no aspirations to generalise from the findings (Creswell & Poth, 2017). However, the findings of this study may resonate with others and readers may use their interpretations of this thesis to transfer recommendations to their own context.

Issues of sample size were not a concern (Creswell & Poth, 2017). While the sample was small, this did not mitigate eliciting rich and meaningful insights about Allied Health Professional leaders' experiences of working in Medicare Locals. Though studying Allied Health leadership more comprehensively was beyond the scope of this study, there is a pressing need for more research into the broader and complex nature of Allied Health leadership in primary health care and to examine and evaluate the outcomes, intended and unintended, of health policy reform from multiple perspectives and applying a range of methods to shed more light on the cultural ways health professionals work together.

Learning from the past to influence the future

At the time of writing, Australia does not have a primary health care policy in place. The document *Building a 21st Century Primary Health Care System: Australia's First National Primary Health Care Strategy* (2010) has been removed from the Commonwealth Department of Health's website, and furthermore, the *National Primary Health Care Strategic Framework* endorsed by the Standing Council on Health in 2013, has not been updated or revised. The lack of a policy framework is reprehensible given the health landscape in Australia is facing major long-term challenges: an unsustainable health system, aging population, health inequities, service access and delivery issues, and prevalence of some

groups engaging in risky lifestyle choices. To succeed in improving health outcomes there needs to be meaningful, considered and evidence-based transformative change.

Leadership succession is one of the most salient changes of the democratic political process in Australia. New leaders and the reconfiguring of political parties are catalysts for new policies and health reform. The contribution of an evidence-based approach to effective and efficient health reform depends on context, history, and the primary health care objectives to which it is directed. Objectives are never static and should be adapted regularly to reflect changing needs in the health landscape. However, revisions should be informed by robust evaluative and analytical processes to enable broad and comprehensive assessment of policy impact. The Council of Australian Governments (COAG), the peak intergovernmental forum in Australia, embraces an approach to national reform agenda that reflects what is needed in ongoing health reform. It posits that completion of the old political agenda is not sufficient; and that good regulatory design, reduced bureaucracy, efficient infrastructure provision and human capital, are central to innovation and productivity (Banks, 2008). Whilst evidence-based policy making is being espoused by the government, it was not reflected in the rapid dissolution of Medicare Locals and immediacy of the shift to Primary Heath Networks.

Without systematic evaluation of initiatives such as Medicare Local organisations and pervasive review of policy, the degree to which evidence can influence policy direction and outcomes is compromised. Health policy and future reform decisions are at risk of being influenced by values, interests, powerful groups with vested interests, and circumstance. Without robust and rational analysis, policy makers are reliant on ideology and discipline-informed wisdom. This study demonstrates how conventional wisdom in health, healthcare and health system formation has been heavily influenced by medical authority and how Allied Health Professionals offer new ways of thinking about health and approaching integrated service delivery and team work. Addressing structural reforms through the lens of medical authority without addressing the cultural changes

needed between the health professions, will inevitably constrain the meaningful changes that can occur in primary health care reform.

On the basis of the findings there are five key recommendations.

Recommendations

Recommendation 1: *To better prepare students and health professionals for authentic interprofessional collaboration and teamwork through entry-to-practice courses, post-graduate programs and professional development activities.*

Recommendation 2: *To develop, implement and evaluate evidence-based primary health care policy which makes primary health care ideology and philosophy clear without conflating it with primary care.*

Recommendation 3: *To enable and empower Allied Health Professionals as leaders in health reform, they require leadership development and support at local, state and national levels.*

Recommendation 4: *To clearly define the field of Allied Health and articulate the knowledge and value systems of each constituent discipline so their roles and contributions are recognised and their potential realised.*

Recommendation 5: *To acknowledge the contingent nature of the policy process and further interrogate the nexus between systems, structures, culture and change, the influences of power, discourse and identity need to be factored into defining policy problems and developing a reform agenda.*

Concluding statements

This study contributes new insights into primary health care and the legacies of implementing primary health care reform using Medicare Local organisations as a case study. Implementing structural reform as occurred with the mandate to include Allied Health Professionals on governing Boards, represents

a good idea but flawed logic. This one-dimensional approach overlooked the different knowledge systems, values, cultural perspectives and competing interests that key stakeholders brought to the table. It also overlooked the long-standing professional hierarchy in which medical authority was legitimised and imbued with significant power. The ambiguity about primary care and primary health care enshrined within the Medicare Local Operational guidelines and the ways these were operationalised in the respective organisational constitutions, coupled with the competing interests, created tensions between the directives, rhetoric and reality.

This case study provides evidence that integrative, collaborative practice is possible in primary health care. Despite the prevailing medical authority, bringing Allied Health Professionals to the table was instrumental in effecting paradigmatic and cultural shifts. One shift changed the way health professionals were working together and another changed the way health services were beginning to work with communities. The transformation occurring in the health system was not universal and depended on Allied Health Professionals enacting leadership rather than operating as medical assistants. Being at the table enabled Allied Health Professionals to find their voice, share their salutogenic understanding and vision of primary health care and make strategic, innovative contributions to health planning, engaging with communities and working to develop teams to ensure people received the right care, in the right place and at the right time.

The study provides evidence of a range of Allied Health leadership outcomes that could be instrumental to addressing the wicked problems that persist in health care. The future of primary health care in Australia requires evidence-based policy, strategic planning strong transformative leadership, and effective multidisciplinary networks.

Some Allied Health Professionals demonstrated attributes of transformative, inclusive and democratic leadership. With ongoing development and support, Allied Health Professionals are well-placed to lead comprehensive primary health care, the preferred model for improving Australia's health. It is a

concern that the successor organisations, Primary Health Networks have moved away from the vision that valued integrative, multidisciplinary collaborative practice.

Appendix 1. Strategic objectives of Medicare Locals

The Operational Guidelines (2013) specified that Medicare Locals were expected to meet the following five objectives:

Objective 1: Improving the patient journey through developing integrated and coordinated services. To achieve this objective Medicare Locals are expected to:

- work to make the health system function seamlessly for patients, through links with Local Hospital Networks, so that primary health care is a part of an integrated health system;
- establish processes to engage effectively with patients, clinicians, Local Hospital Networks and the National Lead Clinicians Group, and other stakeholders to identify and remedy service gaps and breakdowns in service integration and coordination;
- work with patients and the local clinical community to develop, monitor and maintain high patient care standards and integrated and coordinated clinical pathways to improve access to services, including after-hours services and telehealth services, provided in the most appropriate setting, and connectedness between services in the local area; and
- improve patient awareness of the availability of services by maintaining and ensuring access to relevant and current service directories.

Objective 2: Provide support to clinicians and service providers to improve patient care. To achieve this objective, Medicare Locals are expected to:

- proactively engage with practitioners across the spectrum of primary health care provision;
- provide practice support to improve the uptake of best practice in primary health care;
- integrate varied provider types and models of care to reflect optimal care coordination; and
- assist primary health care providers to meet safety and quality standards of service delivery, including monitoring and providing feedback to providers on their performance.

Objective 3: Identification of the health needs of local areas and development of locally focused and responsive services. To achieve this objective, Medicare Locals are expected to have the appropriate expertise in data collection and analysis, strategies and referral pathways to:

- maintain a population health database including community health and wellbeing measures provide input to population health profiles, and undertake population health needs assessment and planning;
- actively participate in the performance and accountability framework of the Government's health reforms;
- undertake detailed analyses of primary health care service gaps and identify evidence-based strategies to improve health outcomes and the quality of service delivery in local area populations, including for disadvantaged or under-serviced population groups;
- conduct joint service planning with Local Hospital Networks and other appropriate organisations; and
- facilitate a reduction in inappropriate or inefficient service utilisation and avoidable hospitalisations.

Objective 4: Facilitation of the implementation and successful performance of primary health care initiatives and programs. To achieve this objective, Medicare Locals are expected to:

- improve the focus on prevention and early intervention in primary health care;
- improve service delivery, clinical efficiency and efficacy, and drive appropriate service utilisation;
- coordinate the delivery of local area primary health care reform initiatives; and
- ensure the seamless transition of programs and services from existing Divisions of General Practice operating within the local area, including transfer of funding, staffing and corporate knowledge.

Objective 5: Be efficient and accountable with strong governance and effective management. To achieve this objective, Medicare Locals are expected to have:

- appropriate company, Board and senior management structures and processes – to manage risk, ensure compliance with all legal and fiduciary responsibilities, ensure financial viability and accountability, and to attract and retain essential skills across the extent of corporate and primary health care expertise;
- capacity to drive more efficient utilisation of health and administrative resources – including through contract management, resource allocation and acquittal, budget management, and contributing to efficiency and equity across health sectors in the local area;
- sufficient capacity and expertise to effectively and efficiently manage flexible funding to target services to their local community's specific needs;
- mechanisms to appropriately integrate information relating to clinical priorities and governance – including links with Local Hospital Networks and the National Lead Clinicians Group;
- appropriate data collection, performance monitoring and reporting processes – including a commitment to participating within a nationally consistent performance framework and monitoring of definitive outcomes related to Medicare Locals' core business requirements;
- decision making processes that are responsive to local health care needs and accountable across the spectrum of the local community and primary health care providers; and
- capacity to remain flexible and responsive to evolving circumstances.

Appendix 2. Horvath's recommendations for health reform in Australia

In March 2014, a Review of Medicare Locals' structures, operations and functions was conducted by Professor John Horvath, a former Commonwealth Chief Medical Officer. This report contained twelve key findings and ten recommendations to the Government.
Professor Horvath's recommendations were as follows:

Recommendation 1: The government should establish organisations tasked to integrate the care of patients across the entire health system to improve patient outcomes;

Recommendation 2: The government should consider calling these organisations Primary Health Organisations (PHOs);

Recommendation 3: The government should reinforce general practice as the cornerstone of integrated primary health care, to ensure patient care is optimal;

Recommendation 4: The principles for the establishment of PHOs should include:

- contestable processes for their establishment;
- strong skills based regional Boards, each advised by several Clinical Councils, responsible for developing and monitoring clinical care pathways, and Community Advisory Committees;
- flexibility of structure to reflect the differing characteristics of regions;
- engagement with jurisdictions to develop PHO structures most appropriate for each region;
- broad and meaningful engagement across the health system, including public, private, Indigenous, aged care and NGO sectors; and
- clear performance expectations;

Recommendation 5: PHOs must engage with established local and national clinical bodies;

Recommendation 6: Government should not fund a national alliance for PHOs;

Recommendation 7: The government should establish a limited number of high performing regional PHOs whose operational units, comprising pairs of Clinical Councils and Community Advisory Committees, are aligned to LHNs. These organisations would replace and enhance the role of Medicare Locals;

Recommendation 8: Government should review the current Medicare Locals' after-hours programme to determine how it can be effectively administered. The government should also consider how PHOs, once they are fully established, would be best able to administer a range of additional Commonwealth funded programmes;

Recommendation 9: PHOs should only provide services where there is demonstrable market failure, significant economies of scale or absence of services; and

Recommendation 10: PHO performance indicators should reflect outcomes that are aligned with national priorities and contribute to a broader primary health care data strategy.

Key findings of the Review were as follows:

1. Recognition of the need for an organisation to reduce fragmentation;
2. The Medicare Local name is inappropriate and confusing;

3. Local Hospital network boundary alignment and engagement is essential;
4. General practice has a critical role;
5. An absence of a clear purpose for Medicare Locals compounded by variability across the country;
6. One model does not fit all;
7. Selective engagement across sectors;
8. Commonwealth funding for a lead change agent for Medicare Locals;
9. Facilitators and purchasers of health care;
10. Implementation of after-hours incentive payments;
11. Improving financial performance; and
12. Reporting and performance monitoring.

Appendix 3. Results of the international literature review

Table: Evidence for primary care governance attributes making a difference to the performance of health services

Kind of Evidence	Country	Type of health service	Organisational attribute researched	Nature of Intervention used	Kind of organisational performance affected
Comparative study - Mixed	New Zealand (Crampton, 2005)	Community governed non-profit organisations	Community governance	National Primary Medical Care (NatMedCa) survey.	Practice characteristics were different in that community governed non-profits had lower financial and cultural barriers to access and provided a different range of services. They also had larger and more heterogeneous primary care teams and employed more female GP's and more Maori and Pacific staff.
Comparative study - Qualitative	Australia (Donato & Segal, 2010)	Primary care	Nil	Policy analysis	Nil
Comparative study - Qualitative	Netherlands (Hansen, Shafer, Black, and Groenewegen, 2011)	European health care organisations	Four domains of research on health care organisations: • intra-organisational control, focusing primarily on how organisations arrange their work internally, such as by differentiation or specialisation; • inter-organisational relationships; • patient relations; and • governance and accountability.	Comparative research	Research into European health care organisations were categorised into four main domains: intra-organisational control; inter-organisational relations; patient relations; and governance and accountability. Topics that defined governance and accountability were: assessment and improvement of quality and safety; balancing efficiency and quality; regulation of professions; regulation of provider organisations; planning/commissioning/purchasing services; treatment guidelines; treatment effectiveness or outcomes; relationships between managers and clinicians; and other.
Comparative Study - Qualitative	UK (Mickan, Hoffman, & Nasmith, 2010)	Primary health care services in six WHO regions	Describing collaborative practice; shared importance of collaborative practice; and systematising collaborative practice.	Case studies from Canada, Denmark, India, Japan, Nepal, Oman, Slovenia, Sweden, Thailand and the UK.	The findings are that at the broad level of organisational structures, it is recognised that shared governance models and supportive policies are important for collaborative practice. In clinical settings, it is important that policies recognise, support and reward collaborative practice. A team approach is both efficient and effective for health care provision. Health care systems that support effective teamwork can improve the quality of patient care, enhance patient safety and reduce burnout among health workers.

Comparative study - Qualitative	Canada (Seror, 2002)	National health service and a health maintenance organisation.	governance	Comparative analysis	Authors found that there is evidence to validate alternative models of health care governance: the national constitution model, and the enterprise business contract model. The analysis suggests that telecommunications technologies and the Internet may contribute significantly to health care system performance.
Systematic review	Netherlands (Kringos et al., 2010)	Primary care	Structure, process and outcome of primary care systems.	Systematic literature review, development of indicators for the Primary Care Monitoring System (PC Monitor)	Development of the PC Monitor as a standardised instrument for describing and comparing primary care systems. The PC Monitor approached primary care in Europe as a multidimensional concept. It describes the key dimensions of primary care systems at three levels: structure, process and outcome level.
Systematic review	Netherlands (Kringos, Boerma, Hutchinson, van der Zee, & Groenewegen, 2010)	Primary care	Identified ten primary care dimensions and features.	Systematic literature review	Insight into primary care as a multi-dimensional system: the structure of a primary care system consists of governance, economic conditions, and workforce development; the primary care process is determined by access, continuity of care, coordination of care, and comprehensiveness of care; the outcome of a primary care system includes quality of care, efficiency care, and equity in health.
Systematic Review	Australia (Powell Davies et al., 2008)	Primary health care	Care coordination	Systematic review of the literature	Six types of strategy were identified at patient/provider level, falling into two groups: communication and support for providers and patients; and structural arrangements to support coordination.
Systematic Review	UK (Regmi, Naidoo, Greer, & Pilkington, 2010)	Health services in Nepal	Decentralisation	Literature review, data, and assessing the range of choices (management, finance, and governance) using Bossert's "decision-space approach".	The transfer of authority and responsibility in planning, management and decision-making from central government to local authorities suggested increased service access and utilisation and improved service delivery.

Research Protocol

A review of the literature was conducted from 2001 to the period of searching (17-25/7/2012), using the PUBMED/MEDLINE and CINAHL databases. The following table is a list of critical search terms that were used, with filters, article type and the numbers this produced:

PUBMED/MEDLINE MESH Term (title/abstract)	Filters	Article type	Number
1. Primary care organizations	1/1/2001 – 2012, English	Clinical trial, comparative analysis, meta-analysis, RCT, systematic reviews	
2. Primary health care organisations/organizations	1/1/2001 – 2012, English	Clinical trial, comparative analysis, meta-analysis, RCT, systematic reviews	
3. Primary health organisations/organizations	1/1/2001 – 2012, English	Clinical trial, comparative analysis, meta-analysis, RCT, systematic reviews	
4. Medicare Locals	1/1/2001 – 2012, English	Clinical trial, comparative analysis, meta-analysis, RCT, systematic reviews	
5. Primary care trusts	1/1/2001 – 2012, English	Clinical trial, comparative analysis, meta-analysis, RCT, systematic reviews	
6. Primary care network	1/1/2001 – 2012, English	Clinical trial, comparative analysis, meta-analysis, RCT, systematic reviews	
7. Transmural care	1/1/2001 – 2012, English	Clinical trial, comparative analysis, meta-analysis, RCT, systematic reviews	
8. Family health groups	1/1/2001 – 2012, English	Clinical trial, comparative analysis, meta-analysis, RCT, systematic reviews	
9. Health maintenance organization/organisation	1/1/2001 – 2012, English	Clinical trial, comparative analysis, meta-analysis, RCT, systematic reviews	
10. Primary care facility	1/1/2001 – 2012, English	Clinical trial, comparative analysis, meta-analysis, RCT, systematic reviews	

11. Health centre	1/1/2001 – 2012, English	Clinical trial, comparative analysis, meta-analysis, RCT, systematic reviews	
12. Health reform	1/1/2001 – 2012, English	Clinical trial, comparative analysis, meta-analysis, RCT, systematic reviews	
13. Primary health	1/1/2001 – 2012, English	Clinical trial, comparative analysis, meta-analysis, RCT, systematic reviews	
14. Primary healthcare	1/1/2001 – 2012, English	Clinical trial, comparative analysis, meta-analysis, RCT, systematic reviews	
15. Governance (abstract) NOT clinical governance (abstract)	1/1/2001 – 2012, English	Clinical trial, comparative analysis, meta-analysis, RCT, systematic reviews	
(1 or 2 or 3 or 4 or 5 or 6 or 7 or 8 or 9 or 10 or 11 or 12 or 13 or 14) AND 15	1/1/2001 – 2012, English		N=141
CINAHL Term (abstract)	**Filters**	**Article type**	**Number**
1. Primary health, primary care, health reform, primary health care	2002–2012, English	Not specified	
2. Governance NOT clinical governance	2002-2012, English	Not specified	
1 AND 2	2002–2012, English		N=43

Only publications written in English were used. Only clinical trials, comparative analysis, meta-analyses, randomised control trials, or systematic reviews were selected. The final search set in PUBMED/MEDLINE produced 141 articles and the final search set in CINAHL produced 43 articles. Each of these articles were downloaded and analysed. Duplicates were removed through the search. Of significance to the search process, many of the articles

overlapped during the CINAHL search and the PUBMED search which provided confidence that similar types of articles were beings selected. Papers were selected for inclusion that discussed attributes pertaining to governance of primary care health services and were excluded if they did not. After the exclusion process, 9 articles were selected.

References

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Appendix 4. Letter of approval from the Tasmanian Social Sciences Human Research Ethics Committee

Social Science Ethics Officer
Private Bag 01 Hobart
Tasmania 7001 Australia
Tel: (03) 6226 2763
Fax: (03) 6226 7148
Katherine.Shaw@utas.edu.au

HUMAN RESEARCH ETHICS COMMITTEE (TASMANIA) NETWORK

UTAS

07 September 2017

Assoc Prof Tony Barnett
Centre for Rural Health
University of Tasmania

Student Researcher: Deborah Zwolsman

Sent via email

Dear Assoc Prof Barnett

Re: MINIMAL RISK ETHICS APPLICATION APPROVAL
Ethics Ref: **H0016776 - Australian Health Reform: An examination of how Allied Health Professionals are contributing to a more comprehensive view of primary health care**

We are pleased to advise that acting on a mandate from the Tasmania Social Sciences HREC, the Chair of the committee considered and approved the above project on 06 September 2017.

This approval constitutes ethical clearance by the Tasmania Social Sciences Human Research Ethics Committee. The decision and authority to commence the associated research may be dependent on factors beyond the remit of the ethics review process. For example, your research may need ethics clearance from other organisations or review by your research governance coordinator or Head of Department. It is your responsibility to find out if the approval of other bodies or authorities is required. It is recommended that the proposed research should not commence until you have satisfied these requirements.

Please note that this approval is for four years and is conditional upon receipt of an annual Progress Report. Ethics approval for this project will lapse if a Progress Report is not submitted.

The following conditions apply to this approval. Failure to abide by these conditions may result in suspension or discontinuation of approval.

1. It is the responsibility of the Chief Investigator to ensure that all investigators are aware of the terms of approval, to ensure the project is conducted as approved by the Ethics Committee, and to notify the Committee if any investigators are added to, or cease involvement with, the project.

2. Complaints: If any complaints are received or ethical issues arise during the course of the project, investigators should advise the Executive Officer of the Ethics Committee on 03 6226 7479 or human.ethics@utas.edu.au.

3. Incidents or adverse effects: Investigators should notify the Ethics Committee immediately of any serious or unexpected adverse effects on participants or unforeseen events affecting the ethical acceptability of the project.

4. Amendments to Project: Modifications to the project must not proceed until approval is obtained from the Ethics Committee. Please submit an Amendment Form (available on our website) to notify the Ethics Committee of the proposed modifications.

5. Annual Report: Continued approval for this project is dependent on the submission of a Progress Report by the anniversary date of your approval. You will be sent a courtesy reminder closer to this date. **Failure to submit a Progress Report will mean that ethics approval for this project will lapse.**

6. Final Report: A Final Report and a copy of any published material arising from the project, either in full or abstract, must be provided at the end of the project.

Yours sincerely

Katherine Shaw
Executive Officer
Tasmania Social Sciences HREC

Appendix 5. Recruitment email to study participants

UNIVERSITY of TASMANIA

FACULTY OF HEALTH
Centre for Rural Health

Email to participants:
HREC No: H0016776
Investigators: Chief Investigator: Associate Professor Tony Barnett, tony.barnett@utas.edu.au

Secondary Investigators: Dr Lisa Dalton, lisa.dalton@utas.edu.au

Dr Merylin Cross, merylin.cross@utas.edu.au

Student Investigator: Deb Zwolsman, deborahz@utas.edu.au

Dear _____

You are invited to participate in a research project concerned with Australian health reforms, particularly the Medicare Locals and Primary Health Networks.

This research is being undertaken by Deb Zwolsman in partial fulfilment of a PhD degree at the University of Tasmania in the Centre for Rural Health.

Deb Zwolsman will be interviewing Allied Health Professionals who are involved in primary health care and have worked in some capacity with a Medicare Local or Primary Health Network. Your name and contact details have been ascertained from the internet, from your association with a Medicare Local or Primary Health Network.

The attached *Information Sheet* explains the research and the interview process in more detail. From the information provided, you will see that your participation in the study will involve a telephone interview that will take 30-60 minutes. The interview will be recorded so that it can be transcribed as data for the research project.

Confidentiality of all participants will be maintained and all information that could identify you will be de-identified. Please see attached *Information Sheet* that will explain the project further and a *Consent Form* to sign and return as per the details provided.

If you would like further information on the research project, and/or would like to participate, please contact me at deborahz@utas.edu.au or Associate Professor Tony Barnett by telephone on (03) 6324 4011.

Warm regards

Deb Zwolsman, student investigator

Attachment: Information Sheet and *Consent Form*

HREC No: H0016776 04/09/2017

Appendix 6. Participant information sheet

UNIVERSITY of TASMANIA

FACULTY OF HEALTH
Centre for Rural Health

Information Sheet

Australian Health Reform: An exploration of how Allied Health Professionals are contributing to a more comprehensive view of primary health care.

No: H0016776

Investigators:

Chief Investigator: Associate Professor Tony Barnett, tony.barnett@utas.edu.au
Secondary Investigators: Dr Lisa Dalton, lisa.dalton@utas.edu.au
Dr Merylin Cross, merylin.cross@utas.edu.au
Student Investigator: Deb Zwolsman, deborahz@utas.edu.au

1. Invitation

You are invited to participate in this research study focusing on the impact of Australian health reforms that saw a national network of independent organizations form. Medicare Locals were mandated to provide better services, improve access to care and facilitate multidisciplinary integration and primary health care services.

Medicare Locals emerged from an existing network of Local Hospital Networks and Divisions of General Practice that were formed in 1992 as the architectural basis of the Australian Government's National Health and Hospitals Network. This Network was established to set up activities focused on improving the health of the Australian community, including health promotion, early intervention and prevention strategies, health service development, chronic disease management, medical education and workforce support. Medicare Locals were tasked to extend this mission through the introduction of service coordination and population health planning priorities at the local level.

The study is being conducted by Deb Zwolsman a Student Investigator in partial fulfilment of a PhD Degree at the University of Tasmania.

2. What is the purpose of this study?

The aim of this research is to investigate changes to the governance structures in primary health care that occurred under the national health reforms and the introduction of Medicare Locals into the Australian health landscape. This follows changes that occurred with the Divisions of General Practice that flowed into the structures of Medicare Locals that have since been replaced with Primary Health Networks.

An in-depth analysis of each of the Medicare Locals constitutions, board structure, and membership will be undertaken to identify the techniques of power used in the language of these documents and to explore their implicit and explicit mechanisms of governance. Further to this, interviews will be undertaken with Allied Health Professionals who have had contact with Medicare Locals through the health reforms in Australia in 2007, with a view to examining how Allied Health Professionals have contributed to a more comprehensive view of primary health care.

3. Why have I been invited to participate?

You have been invited to participate in this study as you are a registered Allied Health Professional involved in primary health care and have worked in some capacity with Medicare Locals. We have identified that you work in the catchment area of a Medicare Local or Primary Health Network. Your details have been obtained from the internet as having a past association with one of these organisations.
Your participation in this study is voluntary, and there will be no consequences to you if you decide not to participate, nor will it affect your relationship with the University of Tasmania.

4. What will I be asked to do?

You will be required to participate in an audio taped interview that will take approximately 30- 60 minutes. This interview will be undertaken over the telephone at a time suitable to you.

You will be asked about your views on various aspects of the health reforms in Australia, such as the introduction of Medicare Local's, and the newly formed Primary Health Networks. The interview will be recorded so that it can be transcribed as data for the research project. After the interview has been transcribed, you will be sent a copy to check and provide any additions or amendments.

At any time in the interview you can say that you do not wish to answer a question. You will also be asked to sign and return the attached **Consent Form**. The return address is located on the Consent Form. Participation in this research is completely voluntary.

5. Are there any possible benefits from participation in this study?

This research will benefit the wider community, by exploring historical health reform measures and the changing primary health care landscape.

6. Are there any possible risks from participation in this study?

There are no risks to participating in this study. Confidentiality of participants will be maintained and all information that could identify you will be de-identified prior to reporting any results.

7. What if I change my mind during or after the study?

You are free to withdraw from the study during the interview or at any time for up to 3 months following the interview, and can do so without providing an explanation. If you choose to withdraw, please notify the Chief Investigator or student researcher and your data will not be used for this study.

8. What will happen to the information when this study is over?

All of the recorded interviews and transcribed data will be securely stored for 5 years from the date of first publication of the study. Electronic data will be stored securely on the UTAS server in a

password protected folder, accessible only to the researchers, and deleted after five years of the first publication. Hard data will be stored at the University of Tasmania in a secured storage unit, and shredded and destroyed at the end of 5 years.

9. How will the results of the study be published?

The findings of this study will be used in partial fulfilment of a PhD degree by the Student Investigator and will be published in accordance with the requirements of that degree. The data may also be used in journal articles and at conferences.

10. Who are the researchers?

The Chief Investigator is Associate Professor Tony Barnett, Director, Centre for Rural Health. The secondary researchers are Dr Lisa Dalton, Associate Head Learning & Teaching (School of Health Sciences) and Dr Merylin Cross Senior Lecturer (CRH). Ms Deb Zwolsman is the student investigator who is conducting this research in partial fulfilment of a PhD degree from the University of Tasmania.

Ms Deb Zwolsman, the student investigator for this study is a PhD student at the University of Tasmania, and a registered psychologist working for the Tasmanian Health Service.

11. What if I have questions about this study?

If at any time you have a question about this study, or your participation in this study, the following contact details are provided:
Associate Professor Tony Barnett, Chief Investigator: Ph: 03 6324 4011
E: Tony.Barnett@utas.edu.au
Dr Lisa Dalton, Secondary Investigator: Ph: 03 6324 3734 E: Lisa.dalton@utas.edu.au

Dr Merylin Cross, Secondary Investigator, Ph: 03 6324 4032 E: merylin.cross@utas.edu.au

Ms Deb Zwolsman, Student Investigator E: Deborahz@utas.edu.au

This study has been approved by the Tasmanian Social Sciences Human Research Ethics Committee.

If you have concerns or complaints about the conduct of this study, please contact the Executive Officer of the HREC (Tasmania) Network on (03) 6226 7479 or email human.ethics@utas.edu.au. The Executive Officer is the person nominated to receive complaints from research participants. Please quote ethics reference number **H0016776**.

This information sheet is for you to keep. If you would like to participate in this research study, please fill out the attached *Participant Consent Form*.

Thank you for your time.

Appendix 7. Participant consent form

UNIVERSITY of TASMANIA

FACULTY OF HEALTH
Centre for Rural Health

Consent Form

Australian Health Reform: An examination of how Allied Health Professionals are contributing to a more comprehensive view of primary health care. No: H0016776

This consent form is for the use of participants in a research study on Medicare Locals and Primary Health Networks:

1. I agree to take part in the research study named above.
2. I have read and understood the Information Sheet for this study.
3. The nature and possible risks and effects of the study have been explained to me.
4. I understand that the study involves a 30-60 minute telephone interview and that the interview will be recorded for analysis purposes. I understand that the findings of this study will be used as part of a doctoral thesis and will be published. The data may also be used in journal articles and at conferences.
5. I understand that all research data will be securely stored on the University of Tasmania's server and premises for five years from the publication of the study results, and will then be destroyed.
6. Any questions that I have asked have been answered to my satisfaction.
7. I understand that the researcher will maintain confidentiality and that any information I supply to the researcher will be de-identified and used only for the purposes of the research.
8. I understand that my participation is voluntary and that I may withdraw at any time without any effect. If I so wish, I may request that any data I have supplied be withdrawn from the research up to 3 months following the interview.
9. I will be provided with an opportunity to review the transcript of interview and provide amendments/additions or modifications to my interview.
10. Please sign this form and return it to the Chief Investigator at tony.barnett@utas.edu.au or post to the **Centre for Rural Health, Locked Bag 1322 Launceston Tasmania 7250**

Participant's name: _____

Participant's signature: _____

Date: _____

Statement by Investigator

☐ I have explained the project and the implications of participation in it to this volunteer and I believe that the consent is informed and that he/she understands the implications of participation.

If the Investigator has not had an opportunity to talk to participants prior to them participating, the following must be ticked.

☐ The participant has received the Information Sheet where my details have been provided so participants have had the opportunity to contact me prior to consenting to participate in this project.

Investigator's name: _____

Investigator's signature: _____

Date: _____

Appendix 8. List of Medicare Local constitutions reviewed

Year	Name of Text	Author Comments
2014	Constitution	ACT MEDICARE LOCAL
2013	Constitution	Central Adelaide and Hills MEDICARE LOCAL
2014	Constitution	Central Coast NSW MEDICARE LOCAL
2014	Constitution	Central North West QLD MEDICARE LOCAL
2013	Constitution	Central QLD MEDICARE LOCAL
2013	Constitution	Country North SA MEDICARE LOCAL
2013	Constitution	Central Sydney Allied Health Network Ltd (Central Sydney MEDICARE LOCAL)
2013	Constitution	Central Sydney GP Network Ltd (Central Sydney MEDICARE LOCAL)
2013	Constitution	Country South SA MEDICARE LOCAL
2013	Constitution	Darling Downs South West QLD MEDICARE LOCAL
2012	Constitution	Eastern Melbourne MEDICARE LOCAL
2014	Constitution	Eastern Sydney MEDICARE LOCAL
2014	Constitution	Far North QLD MEDICARE LOCAL
2012	Constitution	Gippsland MEDICARE LOCAL
2013	Constitution	Frankston Mornington Peninsula MEDICARE LOCAL
2012	Constitution	Far West MEDICARE LOCAL
2012	Constitution	Greater WA Health Partnership Ltd. (Goldfields Midwest MEDICARE LOCAL)
2012	Constitution	Goulburn MEDICARE LOCAL
2013	Constitution	Grand Pacific Health MEDICARE LOCAL (Illawarra Shoalhaven MEDICARE LOCAL)
2013	Constitution	Great South Coast MEDICARE LOCAL
2013	Constitution	Hume MEDICARE LOCAL
2012	Constitution	Hunter MEDICARE LOCAL
2012	Constitution	Inner East Melbourne MEDICARE LOCAL
2012	Constitution	Inner North West Melbourne MEDICARE LOCAL
2013	Constitution	Kimberley Pilbara MEDICARE LOCAL
2013	Constitution	Lower Murray MEDICARE LOCAL
2012	Constitution	Loddon Mallee Murray MEDICARE LOCAL
2012	Constitution	Metro North Brisbane MEDICARE LOCAL
2012	Constitution	Murrumbidgee MEDICARE LOCAL
2012	Constitution	Northern Adelaide MEDICARE LOCAL
2014	Constitution	New England MEDICARE LOCAL
2012	Constitution	North Coast MEDICARE LOCAL
2012	Constitution	North Melbourne MEDICARE LOCAL
2012	Constitution	Northern Sydney MEDICARE LOCAL
2013	Constitution	Northern Territory MEDICARE LOCAL
2012	Constitution	Perth Central & East Metro MEDICARE LOCAL
2012	Constitution	Perth North Metro MEDICARE LOCAL
2012	Constitution	South Eastern Melbourne MEDICARE LOCAL
2012	Constitution	Southern NSW MEDICARE LOCAL
2013	Constitution	Sydney North Shore & Beaches MEDICARE LOCAL
2013	Constitution	Southern Adelaide Fleurieu Kangaroo Island MEDICARE LOCAL
2012	Constitution	Sunshine Coast MEDICARE LOCAL
2014	Constitution	South East Sydney MEDICARE LOCAL
2013	Constitution	South West Health Alliance (South West WA MEDICARE LOCAL)
2012	Constitution	South West Sydney MEDICARE LOCAL
2013	Constitution	Tasmania MEDICARE LOCAL
2013	Constitution	Townsville-Mackay MEDICARE LOCAL
2012	Constitution	West Moreton Oxley MEDICARE LOCAL
2014	Constitution	Western NSW MEDICARE LOCAL

Appendix 9. Interview guide

UNIVERSITY of TASMANIA

FACULTY OF HEALTH
Centre for Rural Health

H0016776

Interview Questions

This interview is for Allied Health Professionals who have worked with a Medicare Local.

Preamble: Hi, my name is Deb Zwolsman. I am undertaking a PhD with the University of Tasmania at the Centre for Rural Health. As I have explained in the Information Sheet and the Consent Form, I am conducting a research study on the health reforms in Australia associated with the introduction of Medicare Locals in 2009, the subsequent introduction of the Primary Health Networks in 2015 and the way that Allied Health Professionals work in primary health care.

Date/Time:
Name:
Profession:
Name of Medicare Local associated with:

1. Tell me a little about what you do as an Allied Health Professional?

2. Can you tell me a little more about your involvement in Primary Health Care?

   Prompt: that's interesting, tell me more.
   Prompt: Can you give me an example of that? Prompt:
   Why is it that you think about it that way?

3. Can you tell me about how you think the reforms associated with the introduction of Medicare Locals, and now, the Primary Health Care Networks, have impacted on primary care?

   Are you familiar with the goals of the Medicare Local/Primary Health Network?

   Prompt: Did you read their Constitution or anything?

   Prompt: How did you know about the direction in the Medicare Local/Primary Health Network?

4. How does that marry up with your practice?

   [*Depending on the participant's description ask either a) or b)]*

   a). That sounds like primary care. Can you tell me a little more of how you understand primary care?

   b). That sounds like primary health care. Can you tell me a little more of how you understand primary health care?

5. How do you use these different approaches to shape your own practice?

6. I'm interested in how you see these two approaches when you are involved in primary health care? How do these approaches work in primary health care?

   Prompt: Do they clash? Do they support each other?
   Prompt: Are there other ways we should be working?

7. The whole notion of Allied Health is interesting. What does Allied Health mean to you?

   Prompt: What does that mean to you as a clinician and what does that mean to you working in a Medicare Local?

8. How does those understandings influence how you work in Primary Health Care?

9. Have you taken any action to ensure you are visible, or included in primary Health Care activities?

10. Can you tell me what has led you to think and act this way?

Thank you for participating in this interview.

Appendix 10. Medicare Local geographic location codes

Medicare Local Code	State	Name	Metro/Rural
101	NSW	Eastern Sydney	Metro 1
102	NSW	Inner West Sydney	Metro 1
103	NSW	South Eastern Sydney	Metro 2
104	NSW	South Western Sydney	Metro 3
105	NSW	Western Sydney	Metro 3
106	NSW	Nepean-Blue Mountains	Regional 1
107	NSW	Northern Sydney	Metro 1
108	NSW	Sydney North Shore and Beaches	Metro 1
109	NSW	Central Coast NSW	Regional 1
110	NSW	Illawarra-Shoalhaven	Regional 1
111	NSW	Hunter	Regional 1
113	NSW	North Coast NSW	Regional 2
114	NSW	New England	Regional 2
115	NSW	Western NSW	Regional 2
116	NSW	Murrumbidgee	Regional 2
117	NSW	Southern NSW	Regional 2
118	NSW	Far West NSW	Rural 1
201	VIC	Bayside	Metro 1
201	VIC	Inner North West Melbourne	Metro 1
203	VIC	South Western Melbourne	Metro 2
204	VIC	Macedon Ranges and North Western Melbourne	Metro 3
205	VIC	Northern Melbourne	Metro 3
206	VIC	Inner East Melbourne	Metro 1
207	VIC	Eastern Melbourne	Metro 2
208	VIC	South Eastern Melbourne	Metro 3
209	VIC	Frankston-Mornington Peninsula	Regional 1
210	VIC	Barwon	Regional 1
211	VIC	Grampians	Regional 2
212	VIC	Great South Coast	Regional 2
213	VIC	Lower Murray	Rural 1
214	VIC	Loddon-Mallee-Murray	Regional 2
215	VIC	Goulburn Valley	Regional 2
216	VIC	Hume	Regional 2
217	VIC	Gippsland	Regional 2
301	QLD	Metro North Brisbane	Metro 2
302	QLD	Greater Metro South Brisbane	Metro 2
303	QLD	Gold Coast	Metro 2
304	QLD	Sunshine Coast	Regional 1
305	QLD	West Moreton-Oxley	Metro 3
306	QLD	Darling Downs-South West Queensland	Regional 2
307	QLD	Wide Bay	Regional 2

308	QLD	Central Queensland	Rural 1
309	QLD	Central and North West Queensland	Rural 2
310	QLD	Townsville-Mackay	Rural 1
311	QLD	Far North Queensland	Rural 2
401	SA	Northern Adelaide	Metro 3
402	SA	Central Adelaide and Hills	Metro 2
403	SA	Southern Adelaide-Fleurieu-KI	Metro 2
404	SA	Country South SA	Regional 2
405	SA	Country North SA	Rural 1
501	WA	Perth Central and East Metro	Metro 2
502	WA	Perth North Metro	Metro 2
503	WA	Fremantle	Metro 2
504	WA	Bentley-Armadale	Metro 2
505	WA	Perth South Coastal	Regional 1
506	WA	South West WA	Regional 2
507	WA	Goldfields-Midwest	Rural 2
508	WA	Kimberley-Pilbara	Rural 2
601	TAS	Tasmania	Regional 2
701	NT	Northern Territory	Rural 2
801	ACT	Australian Capital Territory	Metro 1

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