

# 'The onus is on me': primary care patient views of Medicare-funded team care in chronic disease management in Australia

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## Abstract

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**Background and objective** This study investigated the views of primary care patients in receipt of Medicare-funded team care for chronic disease management (CDM) in Australia.

**Design** A qualitative study using a repeat in-depth interview design.

**Participants and setting** Twenty-three patients (17 female), aged 32–89, were recruited over a six-month period from two purposively selected general practices: one urban and one regional practice in Queensland, Australia.

**Data collection procedure** Semi-structured interviews were conducted with participants 6 months apart. An interview guide was used to ensure consistency of topics explored. Interviews were recorded and transcribed, and a thematic analysis was conducted.

**Results** Patients in this study viewed the combined contributions of a GP and other health professionals in team care as thorough and reassuring. In this case of Medicare-funded team care, patients also saw obligations within the structured care routine which cultivated a personal ethics of CDM. This was further influenced by how patients viewed their role in the health-care relationship. Aside from personal obligations, Medicare funding got patients engaged in team care by providing financial incentives. Indeed, this was a defining factor in seeing allied health professionals. However, team care was also preferential due to patients' valuations of costs and benefits.

**Conclusion** Patients are likely to engage with a structured team care approach to CDM if there is a sense of personal obligation and sufficient financial incentive. The level of engagement in team care is likely to be optimized if patient expectations and preferences are considered in decisions.

## Background

The increasing prevalence of chronic disease and associated impact on health systems and expenditure has generated major health reform globally. Coronary heart disease, anxiety and depression and Type 2 diabetes are the largest contributors to the overall burden of disease in Australia based on the DALY measure (i.e. years of 'healthy life' lost due to injury or disease).<sup>1</sup> Cardiovascular disease, which includes coronary heart disease and heart failure and stroke, is the most expensive disease group in terms of direct national health-care expenditure, accounting for \$7.9 billion of total health-care expenditure in 2008–09, while the prevalence of diabetes has doubled in the past two decades.<sup>2,3</sup> Approximately 7.5% of the Australian population 25 years and over has a diagnosis of type 2 diabetes, and for every person diagnosed, it is estimated there is likely to be another unaware that they have diabetes.<sup>3</sup>

Strengthening the capacity of the primary care sector to more effectively manage chronic and complex conditions is a key policy strategy.<sup>4</sup> Although there are country-specific policy differences related to the financing and organization of health care, there is nevertheless strong consensus that primary care delivery systems should emphasize continuity of care<sup>5,6</sup> and facilitate access to team care in chronic disease management (CDM).<sup>7,8</sup> In Australia, access to affordable team care in CDM is supported through Medicare, the national health insurance scheme. Medical services, the largest component of primary care, operate on a 'fee-for-service' basis with publicly funded Medicare rebates off-setting the cost to the patient. Importantly, since 1999, the Australian Government has introduced a range of Medicare-funded programmes to encourage General Practitioners (GPs) and allied health professionals (AHPs) to team manage primary care patients with chronic disease. The first wave of policy reforms encompassed a range of financial incentives and payments which were designed to influence GPs to undertake annual health assessments and to collaborate with other non-medical

health professionals, including AHPs and practice nurses, in providing coordinated care for eligible patients diagnosed with chronic disease.

The second wave of reforms, commencing in 2004–05, acknowledged the role of AHPs in an effective team care approach in CDM.<sup>9</sup> Additional Medicare items were introduced to enable more affordable access for patients to individual allied health services provided in the private sector. Funding for allied health services in the primary care sector in Australia has historically been through direct payment by patients, or a combination of private health insurance rebates and patient co-payments. As a result, these services have generally come at a higher cost compared with other health services.<sup>10,11</sup> Further, while publicly funded allied health services are available through hospital outpatient clinics in Australia, increasing pressures on this sector have generated lengthy waiting times. The introduction of Medicare rebates for individual allied health services was significant because direct out-of-pocket payments were likely to be a deterrent to access, particularly among lower socio-economic groups.<sup>12</sup> People in regional and rural areas face greater challenges because they often rely on public hospital outpatient services due to the lack of alternative community options in these areas but are also less able to afford private sector allied health services.<sup>11</sup>

Of particular interest in this article is the introduction of the Allied Health Individual Services for patients with chronic disease and complex care needs, funded under the CDM Medicare items ([www.health.gov.au](http://www.health.gov.au)). This provides publicly funded rebates to be paid to offset the cost of individual allied health services provided in the private sector to patients diagnosed with a chronic disease. To be eligible for the Medicare rebates, a patient's GP must instigate a GP Management Plan with Team Care Arrangements (TCA) ([www.health.gov.au](http://www.health.gov.au)). This is a formal agreement which allows the GP to specify referral to an allied health service, for example, physiotherapy, dietetic or podiatry service, as part of the team care management.<sup>7</sup> There are restrictions however.

The rebates are limited to thirteen allied health services only, and the number of financial rebates is capped. Under the current payment arrangements, patients are eligible to receive five rebated individual allied health visits per calendar year, with eligibility and referral determined by the GP.

Referrals to individual allied health services have increased markedly following introduction of the Allied Health Individual Services under the CDM Medicare items.<sup>13</sup> Although there has been an increase across all eligible provider categories, podiatry, physiotherapy and dietetic services are the most dominant in team care management.<sup>13,14</sup> There is also evidence of a potential positive impact on access. A study examining the experiences of AHPs involved in Medicare-funded team care indicated that the policy was likely to be improving access among lower socio-economic groups.<sup>15</sup> Nonetheless, there is immense variability in the adoption of team care in CDM<sup>15,16</sup> as well as on-going concerns about disparities in access to specific services.<sup>15–17</sup>

Evaluation of the impact of Medicare-funded team care in Australia has focused largely on the views of the health-care professionals. This article reports on the views of patients who are in receipt of this team care for management of chronic disease. The patient perspective requires more empirical attention in the Australian context for three reasons. First, patients may view management regimes very differently from how they are being told to see them by health-care professionals, which in turn may affect their attitudes and choices towards different regimes.<sup>18</sup> There is some evidence, for example, that despite the espoused benefits of coordinated care, patients are reluctant to see GPs unless the problem is acute.<sup>19</sup> Further, some patients might be more open to seeing a range of non-medical providers as part of team care, while others are not. In the latter case, it is possible that personal worldviews may mean a preference to rely on conventional providers such as GPs.<sup>18</sup> This highlights a second reason for understanding the patient perspective. Patients may view some services as more

discretionary than others which in turn may influence their behaviour. For example, patients may view medical services as essential, but allied health services as less important.<sup>16</sup> This could be a factor in explaining poor levels of referral uptake of both first and review appointments by patients referred to Medicare-funded dietetic services.<sup>20</sup> Out-of-pocket expenses could be another factor. At August 2012, the Medicare fee set by the Australian Government for eligible individual allied health services was AU\$61.10 for any visit (Medicare Benefits Schedule [www.mbsonline.gov.au](http://www.mbsonline.gov.au)). The rebate is set at 85% of the scheduled fee, which in this case was \$51.95. Similar to Medicare-funded medical services, AHPs can either accept the rebate amount as full payment or are free to set their own fee level above the rebate, in which case patients will incur an out-of-pocket cost. This raises a third reason for studying patient perspectives. In this case, patients may not view this cost as a priority. Health choices are highly personal and need to be understood in this way.<sup>18</sup> For these reasons, a patient perspective on Medicare-funded team care in CDM has much to offer health-care professionals and policy makers in designing and effectively delivering new care innovations.

This article reports on a qualitative study in Queensland, Australia, on the views of primary care patients who were currently in receipt of Medicare-funded team care for management of chronic disease. Patients receiving team care, which included GPs and individual allied health services, were asked to reflect on their experiences of team care management, and specifically, the involvement of allied health services, their self-management and paying for team care.

## Method

A qualitative study using a repeat in-depth interview design was employed. This design is particularly appropriate for research on patient experiences as it allows the experiences to be examined in more depth and detail.<sup>21</sup> Ethical approval was obtained from the Behavioural and Social Sciences Ethical Review Committee

University of Queensland. Patients were recruited over a six-month period from two purposively selected general practices: one urban and one regional practice in south-east Queensland, Australia. Both practices have a commitment to the development of effective and systemic multidisciplinary team models of CDM and to evaluation of these models.<sup>22,23</sup> The practices had similar characteristics, including a patient base with a high proportion of older people. The practices had 17 and eleven GPs, respectively, and each employed several practice nurses. They also had established networks with AHPs. It was reasoned that these practices represented exemplary practice in team-based CDM. Further, any problems with care provided by these practices were likely to be replicated in more standard general practice settings.

The sampling frame for recruitment of patients included patients with a diagnosis of chronic disease who had commenced on a GP-managed care plan with TCA within the last 12 months. Chronic disease was defined by the Allied Health Individual Services policy and the CDM items. In this case, a 'chronic medical condition which has been or is likely to be present for at least 6 months, including but not limited to asthma, cancer, cardiovascular disease, diabetes mellitus, musculoskeletal conditions and stroke' ([www.health.gov.au](http://www.health.gov.au)). GPs and practice nurses within the participating practices assisted with recruitment by identifying eligible patients and sending letters to patients informing them about the research. Patients interested in hearing more about the study were asked to contact the investigators, at which time full written consent was obtained if patients then agreed to participate. The practices were not told which patients agreed to participate or who declined.

#### Data collection

Two interviews were conducted with participants 6 months apart, with 21 participants attending a second interview. In the first interview, patients were asked about how their chronic disease was currently managed, who

was involved and how team care was planned; their expectations and experiences of team care, including allied health services; what they did to self-manage their chronic disease and how they perceived their self-management experiences within the context of team care; and their experiences of paying for care, ways in which out-of-pocket costs influenced decisions about team care, and how they viewed and used Medicare rebates. The purpose of the second interview was to gather more focused information around these topics, but more so, to explore how patient experiences and expectations of team care changed over time. No patients reported any significant change in care arrangements at the second interview. Interviews were conducted by a Research Assistant (RA) and one of the authors (MF). An interview guide was developed to ensure consistency of the broad topics explored. Interviews were audiotaped and transcribed.

The Framework method<sup>24</sup> was used as a guide for a thematic analysis. This involves familiarization with the data to identify key ideas before sorting data according to categories and subcategories and further refining them. This process occurs with reference to the research questions and relevant literature and forms the basis for developing an index of themes. This index is then applied to the raw data so that it can be sorted into thematic sets which are then interrogated further to distil the essential themes, patterns and contradictions.<sup>24</sup> The first- and second-round interviews were analysed separately initially. In the first instance, the aim of the analysis was to develop a description of patient views on team care in CDM. Subsequent analysis, which combined first- and second-round interviews for each patient, aimed to develop an understanding of team care experiences over time. In this article, the description of patient views on team care is reported only. The familiarization process and development and application of the index were conducted initially by the RA and reviewed by one author (MF). Participants were sent a summary of the descriptive analysis. No further comments were received. One author

(MF) then interrogated the thematic data sets to elicit the major analytic themes, patterns and contradictions. A second investigator (GM) then reviewed the themes and examples to ensure representativeness.

## Results

Twenty-three patients were recruited across the two sites. All patients had a diagnosis of a chronic health condition and routinely attended one of the two practices. Although the intention was to include equal numbers of male and female participants, of the 23 patients recruited, 17 were female. Diabetes was the most common diagnosis, followed by heart problems and chronic respiratory disease and asthma. Fifteen participants were diagnosed with multiple chronic conditions. Participants were between 32 and 89 years of age. The majority was born in Australia, and no participants identified as an Aboriginal or Torres Strait Islander person. As ethical approval for the study did not include access to patient clinical records, patients in this study were asked to give a general overview of their care arrangements. Patients were all seeing a GP regularly and in most cases, a range of specialist medical and other non-medical health professionals, including practice nurses and AHPs. Some were also accessing domestic help services and hydrotherapy from non-government agencies. In relation to Medicare-funded team care, which is of central interest in this article, patients across both sites typically saw a GP and two other non-medical health professionals, mainly physiotherapists, diabetes educators, dietitians and podiatrists. Information on the number and frequency of visits with AHPs was not recorded.

Three overarching main themes characterized Medicare-funded team care from the patient perspective: (i) networked surveillance, (ii) personal ethics and (iii) preferential team care. All participating patients were positive about Medicare-funded team care in CDM. A small number of participants voiced some specific negative comments, but were otherwise positive overall about team care. The negative comments were in

relation to the frequency of visits, the cost of services and perceptions about lack of benefits. The three main themes are presented and discussed below. Representative extracts are shown in the text, and these are uniquely coded to indicate participants (P1-P23). No obvious differences were evident in the accounts of female and male participants or in the accounts of participants from the two different sites.

### Networked surveillance

Participants' experiences of Medicare-funded team care, across both sites, resembled a type of networked surveillance which on the whole was highly appreciated. Less positive comments were quite specific, for example, the frustration of having to see multiple professionals. Medicare-funded team care incorporated regular reviews with their GP and a structured process of appointments, which included referral to specific AHPs. As indicated in the first extract below from a woman diagnosed with diabetes, the process often involved an assessment initially by the practice nurse, or diabetes educator where appropriate, before seeing the GP, and this was followed by visits to AHPs. Moreover, participants from both sites also spoke as if this was a highly routinized and 'taken-for-granted' procedure, which depended on their willing participation. The second extract below taken from an interview with a male participant diagnosed with diabetes captures this sentiment.

It was the nurse who did it and then I went back to see the doctor after the nurse interviewed me and processed me... Well she just told me that I would be getting a letter every so often. I have to go and have a blood test and then go and have this again, this process again, to see how I'm going. (P4)

What they like particularly at [name of clinic] is that you line up with the nurse, the dietitian and your doctor on the same day...that's the three monthly regular check... I understand that my willing participation is part of the overall machine that makes it functional...it is something of a procedure that I have to follow. (P1)

Participants appreciated the combined contribution of a network of providers. The general view was that this was more thorough and reassuring. However, participants explained this in different ways. For example, as illustrated in the first extract below, some participants perceived that more providers meant early diagnosis and intervention. Others perceived that the extended network of providers, including AHPs, compensated for pressures on GPs which could potentially compromise the quality of their interactions. As illustrated in the second extract below, the perception was that the combined contributions of different health-care professionals meant more dedicated time and information.

Knowing that everything is okay. You know they are the ones that are going to pick up on anything straight away if anything goes wrong...so it's going to be on the spot sort of thing. The same as with the podiatrist. If anything is going to be wrong there, they are going to be there straight away. (P3)

It has taken a load off GPs. Time is something that GPs don't have. They'll talk to you while they think it is necessary but they will shut you out as quickly as they can because they have got ten patients waiting to come and see them whereas if it is broken up into other individuals they can devote more time to what they are doing...you are learning a lot more and being told more by the different people involved. (P5)

Most patients were aware of the availability of Medicare rebates for up to five individual allied health sessions permitted under the policy. However, as the extracts below show, there was a strong element of provider-induced influence. For example, participants talked about how health-care professionals directed when and how often to see AHPs. It is possible this was a way of managing restrictions on rebates, as the second extract seems to indicate.

[the nurse] told me that I could get five sessions...five sessions for the first year and then five sessions for the second year. (P12)

[the podiatrist]...she comes and visits the clinic... the GP made the suggestion... I've had more

than five but...she tries to make them like every 10 weeks. It sort of carries on. (P7)

Although positive overall about team care, two male participants and one female participant expressed some reservations about the regularity of visits to health-care professionals. In each case, this was linked to highly personal reasons, including: views about not seeing a doctor until absolutely necessary; frustration with the regularity of visits to a number of different professionals; and an aversion to being 'a professional sick person'.

I don't like doctors at all. I'll be half dead before they get me to a GP so that's how bad my leg was. It was really bad. (P17)

The most important thing to me, that feeling of being supported...Up to now I have been seeing my doctor in an intermittent fashion... I said 'I don't want to be a professional sick person' and [my doctor] looked at me and she was quite forthright and she said 'you are sick'... I need the doctor to tell me that...she's monitoring me that way. (P8)

#### Personal ethics of team care

Medicare-funded team care had cultivated and reinforced an ethics of CDM among participants around their personal obligations and financial investment in team care. Personal obligation was continually reinforced by the structured team care routine and centred on self-management responsibilities in relation to daily routines. Participants perceived a reciprocal obligation to help themselves in return for the efforts of health professionals involved in the team care. In the first extract below from a woman with diabetes, this was about *doing more* to be a good example for others; whereas in the second extract from a woman with chronic pain, it was an obligation to push yourself to get the most benefit from the helping relationship.

I should be doing more so that it benefits them to know how to help people with diabetes and to keep it at bay. (P16)

I know that even sometimes when you get a real lot of pain and think, 'oh god I can't go on with

this' but you have got to push yourself past it and so if I keep myself active and say to yourself 'well don't throw it in and just lie on the bed', just keep going well then you know that your body is loosening up and you are benefiting from the help that between [the physio] and myself are doing. (P21)

The other aspect of personal ethics was the perception of personal responsibility in return for entitlement to publicly funded rebates and services. For some participants, knowing they were able to access publicly funded services evoked a sense of duty to comply and co-operate with treatment. Even more, for others, it was about using this access to health-care professionals as best as possible to maximize independence. This is illustrated in the second extract below from a woman diagnosed with a long-term neurological condition.

I'm not paying the taxpayers are paying...and I have to have a reasonable level of understanding of compliance and co-operation. (P10)

It's allowing people who have chronic disease to access health professionals and I think we get about five or six free times a year which is quite useful because the financial side of things is not insignificant. If you can help even to the extent of five or six times, well that is probably plenty. For example, the physio I'm hoping that after say three or four visits I'll be able to be independent... and I won't have to keep going back to see her. I won't be tied to her is what I am saying. (P13)

Interestingly, there were subtle variations in personal ethics depending on how participants perceived the patient role in team care. For example, those with a more traditional perspective felt obligated to comply with expert advice and to do their best to assist the experts in their role. This meant demonstrating personal discipline and the right attitude about lifestyle and self-management routines. Regularity of contact with health-care professionals assisted them with this.

Why should they look after me if I won't look after myself? You know that's how I look at it. (P5)

I have expectations of being helped... I don't have a particular goal but I realize that I need

the assistance and I certainly in this case need the exercise, mainly for the heart condition and the arteries. (P22)

I just feel the onus is probably on me now because the information has been provided and a lot of written material has been provided and outcomes have been provided so...I guess I'm the focus of all of their skills which is good and they seem to be very directive with each other. (P20)

In contrast, participants who talked about their role in a more partnership or consumer-oriented way felt obligated to be proactive in seeking information, or in some cases, actively directive in their care. This meant not simply complying with recommendations but being influential in decisions about their care, gathering information and research on their disease and seeking different opinions. Implicit in this was a more active and discerning consumer.

In the same respect as a developer... I'm the client who is instructing and I want the architect to do this and this party to do that... I still coordinate where my investments go. (P1)

All participants identified the costs of care as a significant issue, irrespective of Medicare-funded team care. However, for some participants, their personal ethics meant accepting that sometimes you had to pay for services to get your needs met. This included paying for more allied health services after receiving the five eligible services under Medicare funding. As the extracts below indicate, some participants were either pragmatic about out-of-pocket costs or prepared to pay personally for additional allied health services beyond the Medicare-funded sessions to maximize the benefits. As the second extract below indicates, this could also mean making lifestyle sacrifices.

I'm paying a lot more money than you would otherwise pay...I put a huge amount of energy into getting those needs met as best as I can. (P13)

I think to myself \$45, divide that by four and it's not all that much a week. I'm not one to go and put my money on the pokies and do silly things with it and I think well if that's going to be valuable to my livelihood then I'm happy to pay it. (P21)

It seemed that participants had different preferences when it came to allied health services in team care, particularly when cost was a factor. This is addressed in the final major theme: preferential team care.

#### Preferential team care

It was clear that participants appraised the different elements of Medicare-funded team care. In this case, allied health services were viewed and valued differently both in terms of priority compared with GP services and value for money. As a result, participants expressed different preferences for engaging with allied health services and how much allied health services they were prepared to access, particularly if paying out-of-pocket. Some participants perceived the GP as 'non-negotiable', even if it involved financial hardship. By comparison, decisions about allied health services, such as physiotherapy, were seen by some participants as a lower health and financial priority. This valuation of allied health services is illustrated in the extracts below. As the second extract indicates, decisions about allied health services as part of team care could vary either way depending on the out-of-pocket costs.

If we are sick we go to the doctor we would never hold back. But for a physio which is something that is not life-threatening, I would hesitate if I had to pay the lot. (P22)

I simply couldn't access them if I had to pay for them. It would be a non-event. You know I'm flat out going to the doctors with \$40 in my hand left over from my pension to pay that fee in advance, albeit that I get the \$30 back. You know you are really stringing it out and going to the dentist and things. I mean you know that's really expensive. I wouldn't do any of this. I would go to my GP but I wouldn't do any of it. (P8)

Participants needed to be convinced about the benefits of team care which included allied health services. As the first extract indicates, some participants weighed up the cost and priorities and considered value for money. Moreover, as the second extract implies, patient perceptions about the benefits, or lack

of, could be highly influential in their decision making.

I've got to look at it in so far as what I consider that I'm getting out of it for what I'm putting into it. Depend on what it was and what it was for... But in so far as going there having to pay that and not getting a result, it would come to a halt very quickly. (P10)

I don't know what is going to come of this physio business, because personally I don't have any faith in exercise fixing arthritis pain and I do wonder whether there is going to be a charge on it because it's money down the drain as far as I'm concerned. (P10)

A defining factor in participants' co-operation with team care was the Medicare rebate. Most participants indicated that they would not have contemplated going to an AHP unless it was recommended by their GP. The rebates clearly facilitated access to team care by making allied health services more affordable. This is illustrated in the extract below concerning a man diagnosed with heart failure. In his case, reliance on a government pension meant team care with allied health services was not affordable without the Medicare rebate. Moreover, this case also highlights the significance of a rebate in facilitating more timely access and early intervention for health problems.

I think if I went to a podiatrist he would have discovered and come up with solutions three months ago, four months ago, even five months ago but the cost. I can't afford it...so I've got to sit in the system you know and this is, I would say this is why a thing like allied health is coming into its own being more these last few years because we are going further backwards on the pension and you just can't afford private practitioners to get treatment. (P2)

However, while Medicare rebates might have succeeded in providing an incentive for participants to engage with allied health services, the reasons around on-going engagement, or conversely, intolerance to team care were more complex. As the first extract shows, disengagement could be due simply to the out-of-pocket costs which resulted over and above the rebate. Alternatively, as the second extract shows, it

could be due to a combination of out-of-pocket costs and a perception of lack of benefit.

I have been to the physio... I went back because the pain was so bad but it used to cost \$40...\$60 for the first visit then \$40 and I wasn't getting any results from it so I pulled out of that and I was going to a doctor acupuncturist and I used to get a lot of relief from that but I used to go say every 3 days out of every week and it was \$100 for the first visit and \$60 for each following visit and you got some back from Medicare but after a while it just come back and so I thought oh it's just such a lot of money. (P11)

[the physiotherapist] charged me \$110. Apparently there was some talk that these services were reduced in price...but she charged me full price. We did claim on Medicare I suppose but I wasn't very impressed... I didn't feel she had done anything because all I was doing was some silly exercises.... I put it down to not a very pleasant experience. I felt it was a waste of time and a lot of money for nothing. (P22)

For some participants, the value and benefit of allied health services outweighed concerns about costs. These participants were willing to pay personally for more service because they perceived potential for more benefit and did so after completion of the five rebated sessions. As the second extract below indicates, this capacity to pay privately for more services beyond the rebated services could provide a health advantage by increasing the frequency of care.

I'll try it three times and then see where I am. I think that's what I'd do. I'd go three times and see where I am and if it was good enough I'd probably find the money for two or three extra times. I might have a bit of trouble finding the money but I would find the money. (P13)

I said to [the physiotherapist] if I was to have more frequent visits and can't get the five visits I'd be prepared to pay if I'm going to benefit. (P21)

The personal valuations of allied health services are interesting in view of the lack of evidence about how much allied health services are required to achieve specific health benefits. The differences in how participants valued

allied health services, despite the Medicare rebates, raises interesting questions about how the benefits of a combined team care approach are framed for patients.

## Discussion

Integration of the patient perspective into the design of service delivery is critical to developing effective patient-centred health-care systems. This study shows that patients are likely to engage with a structured approach to team care in CDM. However, personal obligations and financial incentives can be discerning factors in their level of engagement. In relation to these points, the study raises three main considerations for policy and practice. First, although questions have been raised in the Australian context about the extent to which team care actually improves the management of chronic disease in primary care,<sup>25</sup> the findings of this study indicate that from a patient perspective there is value in team care, but also highly personal dilemmas and preferences. Participants valued the combined but distinct contributions of multiple health-care professionals which overall amounted to enhanced quality of care with a thorough focus on the management of their condition. Participants saw team care as compensating for the pressures on GPs' time as contact with other health-care professionals gave them information and reassurance about their management. This is consistent with previous research with patients with type 2 diabetes in Australia. This research indicates that good communication, described as having time to ask questions, and education about diet and exercise, were indicators of service quality.<sup>26</sup> Interestingly, GPs and AHPs in Australia seem to have a similar view about the value-added aspect of team care. In a recent study on the role of allied health in comprehensive primary health-care settings, GPs and AHPs agreed that team care provides a broader treatment approach, but the value of allied health, when compared to GPs, was flexibility of time to provide education and support for self-management.<sup>27</sup>

The second consideration is that although participants valued team care, they also saw different personal obligations in CDM. These influenced the extent to which they were prepared to engage with the recommended team care. Participants were influenced to act in ways of compliance, co-operation or in some cases, as more of a consumer of services. The discourse of obligation evident in participants' experiences is perhaps not surprising. The notion of health moralities which includes the link between personal responsibility and health is well recognized.<sup>28</sup> Moreover, the notion of responsibility is increasingly part of policies and practices relating to the prevention and management of chronic disease.<sup>29</sup> In this study, participants adhered to a personal ethic that was linked to expectations of self and what they could do to reciprocate the commitment shown by health-care professionals. In other cases, it was linked to entitlement that engendered expectations about using public resources responsibly. These findings are consistent with the patient study conducted by McDonald and colleagues<sup>30</sup> and similarly indicate the possible influence of government policy in promoting responsible citizens and preferred actions around health and health care. A sense of personal responsibility can be a strong motivating factor in changing individual behaviour and in determining how a patient constructs his or her role in the primary care relationship,<sup>30</sup> although it is not the only factor. Health-care professionals play a central role in influencing how a patient views his or her role in the overall management. Indeed, choices about health care are subject to framing effects.<sup>31</sup> For example, it is argued that framing the benefits of diabetes self-management from the patient's worldview can be more successful in influencing their choices than using a biomedical frame.<sup>32</sup> To that end, health-care professionals need to ensure that the mutual obligations and the benefits of team care are framed in a way that is both personally relevant and confidence building for the patient.<sup>32</sup> This study highlights the uniquely personal dimensions of responsibility which may assist health-care profession-

als in their communications with patients and to individually tailor CDM approaches.

A third consideration for policy and service system development emanating from this study is that payment systems can determine not only how patients will view the benefits of different elements of team care, but the extent to which they will engage with it. In this case, although participants prioritized GP services, they had mixed views about the utility of team care involving allied health services. This was evident when costs were incurred and/or when participants perceived they were under financial pressure. Accordingly, although Medicare rebates facilitated participants' contacts with allied health services, the absence of rebates or equally, the likelihood of out-of-pocket costs led to variations in how participants viewed their value and necessity. Previous research indicates that although recommendation by a medical professional is influential in using allied health services, the particular features of a health plan will also have significant influence.<sup>33</sup> Patient preference for services can also be influenced by the types of services already received,<sup>23</sup> while willingness to use non-medical or complementary services is often influenced by the expectations patients hold about the benefits.<sup>33</sup> These themes are evident in the findings in this study. In some cases, contact with allied health services seemed to alter personal views such that participants were willing to pay for additional services as part of team care; whereas in other examples, contact with allied health services did not seem to meet expectations of utility, which in turn impacted personal preferences about these services. In Australia's market-based primary care system with a mix of private/public financing, the central question raised by these findings is whether the standard fee-for-service model, with publicly funded rebates, provides the appropriate incentives for effective and equitable team care management of chronic disease.<sup>34</sup>

The lack of transferability of findings is always a limitation with qualitative research. However, this study has provided a unique description of the patient view about Medicare-

funded team care in Australia. Moreover, the findings raise some particular issues that have relevance to team care more broadly; for example, the importance of communicating the benefits and the types of incentives likely to engage patients in team care. The study is limited by the small sample of patients which was drawn from two general practices. As such the participants might not necessarily be representative of the broader patient group. Nonetheless, the study does offer a glimpse into how patients might view team care and indicates areas for further enquiry, such as expectations and motivations around use of allied health services.

## Conclusion

Successful management of chronic disease ultimately depends on close collaboration between patients and health-care providers,<sup>35</sup> to develop a shared and integrated understanding of both the expert and clinical evidence, and patient experience and preference.<sup>36</sup> Without knowing how patients perceive their care, it is difficult to plan health-care innovations that are acceptable and cost-effective. Patient views convey important messages about what elements they see in different management regimes and what factors might influence decisions about care. More needs to be known about the patient view of team care in the Australian context, the expectations about different aspects of team care and whether these differ among patient groups. This will assist GPs and other health-care professionals in their interactions with patients, particularly in relation to information and decision making about on-going care. However, by indicating the types of incentives that are likely to engage patients in team care, as well as the areas where there could be more resistance, this study has highlighted issues of relevance to team care more broadly.

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## Ethics approval

Ethical approval has been obtained from the Behavioural and Social Sciences Ethical Review Committee, University of Queensland.

## Author contributions

Both authors read and approve the final manuscript. MF designed the study and participated in the collection and analysis of data, and conceptualized and completed the first draft of the manuscript. GM contributed to recruitment of participants and the analysis of data, read and commented on the draft manuscript and approved the final manuscript.

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## Conflicts of interest

The authors declare they have no competing interests.

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