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ORIGINAL RESEARCH

# A Qualitative Study on Distributed Leadership in Integrated Care: Exploring the Experiences of Elderly Multimorbid Patients with GP Collaboration

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**Objective:** This study explores how the collaboration between elderly multimorbid patients and general practitioners contributes to the patient's experience of integrated care in the municipality. The research also investigates whether the municipality's integrative mechanisms creating integrated care can be understood as distributed leadership.

**Method:** In this qualitative study, we conducted a thematic analysis of semi-structured interviews with twenty elderly multimorbid patients living at home and their general practitioners.

**Results:** Analysis of patients' and general practitioners' experience of healthcare service characterized by collective efforts identified four themes: 1) an impression of collective processes as difficult for patients to access and influence; 2) that the fluidity and location of leadership is dependent on the individual patient and his or her health condition; 3) that collective implementation of healthcare services is separated in time, geography and between organizations; and 4) that patients experience individual healthcare workers as specialized and unable to support the medical and holistic goals of the collective. The Direction, Alignment, and Commitment or DAC framework, is used to investigate the capabilities of the collective.

**Conclusion:** To promote distributed leadership and create a patient experience of integrated care in the municipality, healthcare organizations must develop collective processes that enhance patient participation to a greater extent. General practitioners and other healthcare personnel should be encouraged to play a more central role in solving elderly multimorbid patients' healthcare needs in the municipality.

**Keywords:** distributed leadership, integrated care, multimorbidity, multidisciplinary healthcare, family practice, qualitative research

## Introduction

The proportion of elderly patients living at home with chronic illnesses is increasing, and management of chronic health conditions is now a major focus in healthcare.[1] In Norway, as elsewhere in Europe, the healthcare government aspires to have these patients remain independent and live at home with the best possible quality of life. To achieve this, patients with chronic health conditions depend on a range of services from numerous primary and specialist healthcare professionals.[2]

We take a patient-centered perspective and define integrated care as a situation where

> I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me.[3]

A patient-centered approach to integrated care in primary care requires that general practitioners (GPs) uncover individual patient needs so that a comprehensive set of healthcare services can be supplied in a coordinated and continuous way by healthcare providers who can monitor the patient's health status, respond to its deterioration, and support and empower the patient and his or her relatives.[4,5]

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According to the literature, demographic changes, longevity, and complexity create leadership challenges in service provision at different levels of healthcare.[6] At lower organizational levels and closer to the patient, distributed leadership has been suggested as one way of gathering "the collective around the table", so that individual patients can benefit the most from the available resources and expertise of the collective.[7]

There is no clear definition of distributed leadership.[8,9] However, most theories describe influence and responsibility as fluid among people who do not necessarily hold traditional leadership positions, focusing on the situation and collective practice, blurring leadership and managerial activities. Consequently, distributed leadership is more concerned with relationships, connectedness, and leadership practices than are traditional leadership theories[10,11] which tend to define leadership strictly as an interindividual process of influence between positional leaders and followers.[12] The idea of distributed leadership in integrated care fits well with recent healthcare reforms focusing on patient participation.[13,14]

It is essential to note that distributed leadership is not a physical entity, but an abstract concept and social phenomenon used to conceptualize leadership as a social process. As a social phenomenon, distributed leadership is hard to observe or measure objectively. However, as researchers, we can infer the existence of distributed leadership by exploring patterns of collaboration and the experience of research participants. The literature suggests that distributed leadership is a relevant concept in health and social care settings where multiple professionals with diverse expertise need to collaborate in service provision.[8,15] This article explores patients' experience of GP collaboration in the municipality to improve our understanding of distributed leadership in integrated care.

We consider distributed leadership a collective process among patients and general practitioners (GPs) that enables individuals to work together as a single unit and produce the results the collective of healthcare providers and patients want. We use the DAC framework to study distributed leadership as a social process and as the result that emerges due to the collective's direction, alignment, and commitment.[16] Here, direction refers to the widespread agreement in a collective on overarching goals, purpose, and mission; alignment to the organization and coordination of knowledge in a collective, and commitment to the willingness of members of a collective to subsume their interest and benefit within the collective interest and benefit.[16] Thus, successful DAC outcomes imply agreement on what the collective aims to achieve, that work is coordinated and integrated, and that members make the success of the collective a personal priority. If leadership can arise from anywhere in the organization, this ontological approach allows the researcher to focus on DAC practices, understood as "what has been done" by the collective, and to study DAC outcomes resulting from group leadership practices across "levels of analysis" and independently of whether DAC is created by individuals, a team, or an organization.[16]

We ask the following research questions: How is the collaboration between patients and GPs experienced by patients? And Does the collaboration between patients and GPs contribute to distributed leadership and enhance the patients' experience of integrated care?

# Materials and Methods

## Study Design

This qualitative study uses semi-structured interviews with elderly multimorbid patients and their GPs to explore patients' experience from collaborating with GPs providing integrated care in a primary care setting in Norway. A qualitative approach was chosen since the study was conducted to gain a deeper understanding of interaction and communication between patients and healthcare providers in complex social situations.

## Study Setting and Participants

This study was undertaken in a semi-urban municipality in Norway where the majority of the population is enlisted with a regular GP who provides healthcare services during office hours (about 0800–1500) Monday through Friday. Patients who depend on home care nursing receive these services after application, and after the patient's needs have been reviewed by the municipality in which the patient lives. In this municipality, different healthcare providers digitally communicate their activities and concerns to each other. Patients receive treatment and medical procedures in different locations and only occasionally meet with more than one healthcare provider at a time. The local emergency room is

available 24 hours a day, seven days a week for emergency and semi-acute medical problems outside of GPs' business hours. When more advanced care and medical intervention are needed, patients can be referred to the local municipality acute ward or admitted to the nearby regional university hospital. The Norwegian healthcare system is semi-decentralized, and although the national government is responsible for hospitals and specialist out-patient care operated via regional health enterprises and local hospital trusts, the municipalities are responsible for providing primary healthcare, home care nursing services and preventive care.[17]

Our study was conducted after we contacted the district medical officer and the leader of the municipality's health and social care division. We informed GPs about the project directly through office visits, telephone, and at a meeting between GPs and municipal health authorities to recruit patients. In addition, we approached the director of the municipality acute ward, where two nurses identified patients for inclusion. Potential interview participants received oral and written information on the research project through contacts with their GPs or nurses during stays in the municipality acute ward. We recruited patients from the GPs offices or the municipality acute ward. Once we had recruited a patient, we recruited the patient's GP. This resulted in twenty dyads, or pairs of patients and GPs, who contributed to the study.

Patients were purposely sampled to ensure that all research participants had experienced provision of integrated care. To be eligible for the study, a patient had to have been hospitalized or referred to the local municipality acute ward within the last 12 months, granted home care nursing services from the local municipality and diagnosed with two or more diseases to fulfill the WHO criteria of multimorbidity,[18] treated with four or more medicines and above 65 years of age. Patients with healthcare conditions that impeded their participation (eg, severe hearing loss or moderate to severe dementia) were excluded from the study.

## Data Collection

We recruited 20 patients and their GPs for individual interviews between October 2019 and January 2020. Two researchers who had worked as a GP and a nurse conducted interviews lasting 27–65 minutes. Interviewers and interviewees were not matched by their roles. All interviewers were audio-recorded and conducted with patients and GPs separately. Patient interviews were held in the patient's home or during stays in nursing homes and the local municipality acute ward. GPs were interviewed in their offices. The total dataset consisted of 40 interviews. The average age of patients was 82.5 years, and the majority were female (13). Ten participants were living alone. The average age of GPs was 45.1 years.

Patients' recollections and experiences of collaborating with their GP and home care nurses in day-to-day practice and during health deterioration were key themes of interviews.[19] Additionally, interviews focused on the patient's efforts, actions, and thoughts on how to regain health and live as well as possible. Similarly, GP interviews focused on GPs' experience from collaborating with other healthcare providers and the GPs' recollections of the patient's most recent hospitalization.

## Data Analysis

All interviews were anonymized. All contextual identifiers, such as names of patients and healthcare institutions, were removed during transcription. After transcribing, the analysis consisted of open coding and thematic analysis.[20] Codes were identified based on units of analysis, consisting of sentences describing and illustrating the patient's experiences from his or her routine interactions with healthcare providers during critical events like hospitalizations and referrals to the municipality acute ward. After patient data were analyzed, GP interviews were analyzed to identify GPs' experiences or critical events identified in patient interviews. Interview findings and emerging themes were discussed in detail during meetings in the research group (HB, AM, MS).

Finally, an aggregate approach was taken to explore the relationship between themes and to identify patterns of DAC practices at the group level. This synthesis of themes allowed for exploration of the collective process involved in the provision of integrated care from the perspective of patients, however, with sensitivity to the wider collective represented by the experiences and voices of GPs with whom the patients were enrolled.[20]

## Ethical Considerations

The study is part of a research project, "Leadership and Technology for Integrated Health Care Services", which was conducted following the Helsinki Declaration and discussed with the Norwegian Centre for Research Data (Project No. 228630). The research project was considered health service research without the intent of generating new knowledge of health and disease and exempted from formal review by the Regional Committee for Medical and Health Research Ethics (ref. no. 2019/1138). All participants provided written informed consent before participation in interviews. Participants informed consent included statements that their anonymized responses could be published. In addition, written patient consent for disclosure of the GP's confidentiality was obtained before GPs provided informed consent and participated in interviews.

# Results

This study's results describe the experience of patients participating in collective processes with GPs. Four themes emerged from the interviews with patients: (i) the collective process is difficult to access and influence; (ii) the fluidity and location of leadership is dependent on the individual patient and his or her health condition; (iii) the collective implementation of healthcare services is commonly separated in time, geography and among organizations; and (iv) individual healthcare workers are specialized and unable to support all of the collective's medical and holistic goals.

## Patients Experience the Collective Process as Difficult to Access and Influence

Healthcare personnel play a central role in elderly multimorbid patients' life, and the collective is bound by patient follow-up in GPs' offices, the interaction between patients and home care nurses in patients' homes and the digital correspondence between home care nurses and the GPs. GPs' and nurses' access to digital communication makes implementation and changes in medical treatment more efficient. However, interviews show that patients and GPs rarely participate together in collaborative meetings with other healthcare professionals. GP interviews also reveal that healthcare professionals typically share information or discuss concerns regarding a patient's situation in a professional language and style. Patients are often excluded from these communications.

> **P6**: I think digital solutions are good. At least when it comes to communicating with me. I can also write messages digitally (to them), but I have never done that.

> **GP of P6**: The majority of digital communication with home care nurses is good, I was about to say that it is "to the point". Depending on personnel, communication may be a bit loosely or too much. In such cases a meeting may be more appropriate.

The barriers to multidirectional influence that patients experience can result from the communication tools that they use, personnel changes when services are available around the clock, opening hours and schedules when personnel is regular and organizational fragmentation when the collective group expands. Due to their busy schedules, GPs explain that they are not usually involved in managing acutely sick patients. These patients are frequently managed by the acute care chain or hospitalized when their GP's office is closed.

> **P4**: That's the way it has been happening recently. I have been pressing the alarm button so that home care nurses come here and contact the ambulance services for me. That's the way it goes (…) No, they don't answer the phone in that office. I get help from my daughter to use the mobile and send SMS because they don't answer regular fixed phone calls down there.

> **GP of P4**: It happens that I hospitalize patients. However, quite a few times, they are hospitalized by the emergency care services. Sometimes the ambulance services come here to transport patients or bring patients when it is not that urgent.

Patients are frustrated when healthcare personnel are not regular. While some patients included in this study had established long-lasting relationships with their GP, some had difficulties achieving this with temporary GPs, as well as other healthcare personnel in hospitals and home care nursing services. Lacking relationships makes it hard to achieve continuity and to accommodate healthcare services to individual needs.

GPs prefer digital communication, even though they are aware that most elderly patients do not use them. Patients report that communication is commonly experienced as one way: from the GP to the patient. It is not always easy for

patients to contact their GPs. While GPs say that patients need to contact them for acute care, patients often lack the digital skills, or have functional impairments that make this difficult. They must also contend with designated times for phone calls and having to wait for care.

Patients who take action across organizational borders sometimes enlist their home care nurses to initiate contact with GPs or to refer them to the local emergency room. When the collective includes an increasing number of healthcare specialists, organizational fragmentation and borders make it difficult for patients to influence in multiple directions across the system. Both GPs and patients see GPs as the coordinator of larger collectives. However, some patients suggested the introduction of coordinators to remedy the exclusion of patients from professional discussions.

## The Fluidity and Location of Leadership is Dependent on the Individual Patient and His or Her Health Condition

GPs and patients involve in routine tasks during stable health but set up more advanced adaptive functions when needed. The roles of individuals within the collective are not always fixed, however, patients hold opinions concerning who is to take leadership, where, and when. The patients frequently associate leadership with responsibility and physical meetings and delegate leadership responsibility to the individual healthcare provider they interact with when it happens.

> **P12**: No, I don't have any knowledge concerning what is best for me. It is the GP who suggests this or that solution, and I follow the advice and do not think more about it. I trust in their assessment.

Leadership is not easily transferred or decentralized; treatment and task ownership have become associated with one or more healthcare providers. This is most easily observed when new medical treatments are initiated, invasive procedures are performed, or the patient's medical history is complex. In complex patient cases, leadership can become tied to individual GPs, thereby hindering fluidity.

> **P5**: My GP is in the office only some days of the week. The other GPs in the office say it's too special and that they do not want to involve in my GP's plan. I'm not sure, but it's OK for me.

> **GP of P5**: I spend most of the time in my office, and he visits me about once a month. We spend about 20–25 minutes on conversations, perhaps investigations.

Furthermore, interviews show that patients can be too incapacitated to participate in the collective process when sick or hospitalized. Patients do not usually remember the details of their hospital stays and prefer followership in acute disease and sometimes also during stable health conditions when they lack the knowledge or energy to assert their agency in the collective process. After hospital discharge, some patients experience illness, fatigue and hardship initiating follow-up with GPs or other healthcare providers.

> **P7**: No, that's the problem. You can't do anything yourself. Need help for everything, just moving from one chair to another.

At other times, patients find it hard to "let go" and relinquish control to their healthcare providers. Several patients struggle to balance their own needs for control and trusting the system because they have experienced medical mistakes, some irreversible. Thus, patients express that they are obliged to pay attention and insist that they are the final authority on their health as long as they are "up and running". Patients say they avoid visiting GPs when healthy, and GPs state that patients should take care of their health and treatment as much as possible.

> **P19**: I just need to do as they say and trust them. I cannot be in complete control and keep fussing back and forth. I'm sure it's going to be OK.

## The Collective Implementation of Healthcare Services is Commonly Separated in Time, Geography, and Among Healthcare Organizations

Individual patient leadership and collective actions are local and primarily played out at home, where patients take measures to solve their medical and non-medical problems. However, such measures are highly individualized and initiated only after discussion with or input from family or peers.

> **P4**: I was better after I arrived back home. Because after quitting medicines, appetite improved, and food stopped coming back up again.

According to the patients and GPs, home care nurses are responsible for collective continuity as they frequently meet and monitor patients, are available around the clock, and are better connected to GPs. Patients complain that asking for extra home care services is pointless as services are limited, needs-based and governed by organizational rules. Similarly, patients experience hospital stays as burdensome due to high efficiency and a lack of regular healthcare personnel. However, patients support the way of organizing hospitals and admit that home care nurses are fast responders and "great at medical matters". We interpret that the system conformity among patients relates to patient compliance and acknowledgment of some greater good resulting from this way of care provision.

Where hospitals are associated with acute and severe disease, GPs are associated with milder illnesses and debility. In stable health, home care nurses play a central role in patients' everyday lives, while GPs are the primary point of contact for patients in the healthcare system. Patients describe the services offered by GPs as less regulated and more flexible compared to other healthcare services, appreciates the GPs' ability to provide continuity and individual modification of medical measures, and prefer physical meetings with their GPs. Patients can be frustrated by short appointments and hard-to-reach GPs, who can become bottlenecks in this organizational system where patients depend on GPs both before and after specialist healthcare visits. Healthcare services that are continuous from the GPs point of view can be experienced as non-continues from a patient perspective.

> **P3**: I think that when I arrived back home that the GP could have … The office is just in my neighborhood. The GP could have come for a visit or telephoned me. The GP's office is on the corner over there. It's just 50 meters.

> **GP of P3**: S/he was in the hospital from (date) to (date), then in a rehabilitation stay in (name of town) before s/he came back home on the (date). Interviewer: Was there any contact with you for the period s/he stayed in the hospital or the nursing home? GP: No, I received a discharge report from the nursing home explaining what had been done, what had been discussed with the hospital, and what was considered the correct way forward.

Findings show that GPs cannot address or solve all health issues patients present with and that complex health problems frequently necessitate specialist referral or hospitalization. GP interviews confirm that the patient group is complex and that specialist healthcare providers often initiate more advanced treatment. GPs solve many of the patient's minor medical problems and assist home care nurses but are only occasionally involved in more advanced medical treatment of patients in the municipality. While management of common diseases traditionally is considered the responsibility of GPs, multimorbidity may require the involvement of multiple professions to ensure correct disease treatment, prevent side effects, and guarantee safe administration of the treatment.

> **P3**: This was addressed properly first when I was in the hospital because of (disease 1). It was at that time that they suggested the treatment for (disease 2), something they hadn't mentioned before.

> **GP of P3**: Now, s/he has been to the hospital and had (treatment of disease 2) in connection with the hospital admission for (disease 1) where (disease 2) was addressed. S/he went to a follow-up in the hospital in (month).

### Patients Experience Individual Healthcare Workers as Specialized and Unable to Support the Medical and Holistic Goals Residing in the Collective

Findings show that the elderly, multimorbid patients participating in this study seem focused on accepting and managing their chronic health conditions as best as possible. Patients occasionally act more proactively, wanting more medical examinations to clarify the cause of long-standing symptoms or to rule out that nothing more can be done to improve their situation. In several interviews, patients say that they avoid hospitals and prefer to stay home and live the best life they can. However, interviews have revealed that the collectives of patients, GPs and other healthcare personnel are not equipped to achieve their aim of optimal functioning in everyday life. The quality of life, according to almost all patients participating in this study, depended on having family members to make things run smoothly. Patients depend on family members to assist with running the household, doing the shopping, and offering companionship.

**P3**: I have family who lives close by. In addition, I have relatives who work in healthcare. So, I have many helpers.

### "Leadership of the Collective" – Identified DAC Practices

By applying an aggregate approach to the results of the thematic analysis of study findings, this study identifies three collective processes that create functional DAC outcomes in this municipality. First, in everyday life, the collective of patients and GPs focuses on everyday tasks. Here, a strong focus on medical treatment and assistance of the home care nursing services ensure quality in implementing healthcare services in the patient home. However, the holistic and non-medical aspect of healthcare services required to create a patient experience of integrated care needs to be improved. Concerning the more complex activities of daily living, patients depend on next-of-kin activities that are better aligned with and more sensitive to their needs.

Second, in the case of minor medical problems, the direction of the collective is instructed by GPs, who can be either controlling or open to influence from patients and other healthcare personnel. In such cases, where medical problems can be solved in the municipality, GPs rarely involve or commit strongly and depend on home care nurses to show commitment and do nursing tasks that GPs rarely do. Furthermore, patients, their next of kin, GPs and home care nurses may all contribute to aligning the collective in the case of minor medical problems in the municipality. Lastly, patients contribute less to direction and alignment in more severe and complex medical problems as the process involves advanced medical assessments and investigations in specialist healthcare. GPs in such situations play a role in alignment, primarily as medical and holistic "knowledge brokers". However, GPs lack the necessary tools or competence and depend on the expertise and advanced procedures of healthcare specialists' services or home care nurses to ensure organizational alignment and commitment to implementation when such collective processes span organizations.

## Discussion

This study shows that when patients in this municipality view their healthcare services as coherent and connected, this is due to the efforts of healthcare professionals and help from the immediate family of patients. In general, patients express that they are satisfied with their service offerings. However, results from the study identified room for improvement in the collaboration between patients and GPs which is central in the provision of integrated care in this municipality.

First, the study shows that if patients' access to and influence over the collective is limited, the contribution from the collective process in achieving a patient experience of integrated care will also be limited. Findings from interviews show that patients are sometimes unaware of collaborations between GPs and other healthcare personnel and that patients generally struggle with accessing GPs offices and influencing the primarily digital collective processes. More often, patients are frustrated over weak relationships with healthcare professionals, specifically GPs, who are hard to reach when needed most and a lack of regular relationships with other healthcare personnel. Consequently, the collective direction-setting and subsequent DAC outcomes are not optimized as patients and healthcare professionals find themselves at odds when it comes to an individual patient's goals, aims, and possibilities. Additionally, study findings show that delivering more holistic healthcare services will require digital correspondence that does not narrow the focus to the selected topics healthcare professionals consider relevant to each other.[19] In reference to the literature on

distributed leadership, this finding is consistent with research suggesting that pluralized leadership has both collective and individual elements, and that collective leadership may need the support of both infrastructure and individual agency.[21–23]

In addition, the study shows that if GPs limit their efforts to direction setting or only function as coordinators or implementors of medical tasks and interventions in isolation from the rest of the collective, this will limit the contribution the collective process has in creating a patient experience of integrated care. In this study, where GPs focus on implementation and follow-up of medical investigations and treatments, and frequently depend on assessment by other specialist physicians and implementation by home care nurses, the result is a hybrid leadership practice that is more coordinated and aggregated than collaborative and holistic.[24] From the theoretical perspective of DAC outcomes, characterized by healthcare providers who are more dependent and independent than interdependent.[25] A stronger commitment to collaboration and implementation in hands-on work and a broader set of service offerings is required from GPs if patients in this municipality are to experience collective efforts that contribute to a patient-centered experience of integrated care. Findings correspond to previous research showing that the practice of distributed leadership depends on the competence and skills residing in and transferring within the collective;[26–28] that unleashing the full potential of distributed leadership may require organizational intervention in the form of both resources and support from senior leaders in organizations.[15,29]

Finally, this study identifies that organizational structures and service offerings affect the way in which patients experience and envision collective processes contributing to integrated care. As most identified collective practices run sequentially between healthcare providers in different organizations separated in time and geography, and other healthcare professionals are successively involved when tasks become too complex for the GPs as first-line responders, patients frequently experience healthcare services as units of services that are not interdependent.[25] Patients' experience of healthcare services is closely associated with the setting and their interaction with healthcare professionals.[30] If aiming for patients to experience organizational boundaries as floating and health workers as boundary spanners, this will require a more open and collective organizational system. From the perspective of patients, geographical distance[31] is the most readily apparent boundary to distributed leadership in this municipality. However, co-locating services would probably not remedy this, as moving to a less hierarchical, open, and collective system would require patients and peers to attend to new ways of working across professions. Previous research on distributed leadership suggests that such cultural changes will be hard to achieve in a healthcare organizational environment.[8,32] Considering these findings in the context of the study's ontological approach to distributed leadership, the DAC framework includes assumptions that DAC practices make up the leadership culture and that DAC practices are the result of underlying individually and collectively held beliefs about how to produce DAC.[16] In line with this, patients frequently state that they do not see themselves as part of a continuous process but distinguish stable health from illness, see the healthcare provider they meet as responsible for task implementation, and give away leadership when a lack of knowledge or health deterioration demands it. However, patients supervise and monitor healthcare providers' doings to their bodies if able. The list is not exhaustive but identifies underlying leadership beliefs that are suggested to affect the collective practices observed in this municipality.[16] Whether patients participate in distributed leadership or not, such underlying beliefs must be expected to affect the implementation of distributed leadership at clinical levels in integrated care.

## Strengths and Limitations

A key strength of our study is the sample of participants, as interviews with both patients and GPs who have regular contact with each other provide a realistic understanding of patients' experience of integrated care. As some patients were relational and close to their GPs, sometimes entered the study through their GP's invitation, and were aware that GPs and other healthcare personnel participated in the larger research project that this study originates from, the risk of selection bias and response bias is emphasized. Using two interviewers and discussing study findings during meetings within the multidisciplinary research team helps to limit researcher and insider bias. As patients' experience of critical events was

chaotic, and patients and GPs only occasionally experienced critical events together in this municipality, we suggest observational case studies to investigate the subject of distributed leadership in integrated care from a patient perspective.

## Conclusion and Implication

This study shows active collaboration among patients and GPs in this municipality that contributes to a patient experience of integrated care and that the collective processes identified can be understood as distributed leadership from the perspective of the DAC framework. To deliver healthcare services that are sensitive and responsive to the needs of individual patients, and that can support and empower patients, collective processes in this municipality need additional development to support patient involvement. When patients, for whatever reasons, cannot participate in digital communication, healthcare workers and organizations must commit to ways that enable patient participation in and influence over collective processes. The study clearly shows that GPs and other healthcare personnel should be stimulated and encouraged to play a more central role in solving patients' healthcare needs in the municipality. Together with the municipality and other healthcare personnel, GPs should aim to provide flexible healthcare services that are more holistic and better adjusted to the needs of the individual patient.

## Abbreviation

GP, General practitioner.

## Data Sharing Statement

Due to ethical and privacy restrictions, only limited extracts of the data can be provided upon reasonable request to the first author (HB).

## Ethics Approval and Informed Consent

The study adhered to the principles outlined in the Helsinki Declaration and was discussed with the Norwegian Centre for Research Data (reference number 228630). As the study was classified as health service research and did not aim to produce new findings about health and disease, it was deemed exempt from formal review by the Regional Committee for Medical and Health Research Ethics in Norway (REK) (reference number 2019/1138). All research protocols were carried out in compliance with ethical guidelines and regulations. The study was authorized by the municipality's Health and Social Care Services Divisions, and all participants provided written informed consent. Participants were informed that they could withdraw from the study at any time. Disclosures of confidentiality were obtained from patients before data collection.

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## Author Contributions

All authors made a significant contribution to the work reported, whether that is in the conception, study design, execution, acquisition of data, analysis and interpretation, or in all these areas; took part in drafting, revising or critically reviewing the article; gave final approval of the version to be published; have agreed on the journal to which the article has been submitted; and agree to be accountable for all aspects of the work.

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## Disclosure

Dr Harald Braut has experience working as a GP. The authors report no other conflicts of interest in this work.

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