Series title: Towards integrated primary health care
Integration within primary health care and between primary health care and other sectors

Medicare Locals: A model for primary health care integration?
Achieving integration: A study exploring Medicare Locals’ implementation of integrated primary health care policy

Report 4

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Suggested citation

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# Contents

Tables ......................................................................................................................... iii  
List of Abbreviations .................................................................................................... v  
Executive summary ....................................................................................................... 1  
  Context ....................................................................................................................... 1  
  Scope .......................................................................................................................... 1  
  Aims ............................................................................................................................ 1  
  Findings ...................................................................................................................... 1  
  Discussion ................................................................................................................... 2  
Background .................................................................................................................. 3  
  Primary health care in Australia .................................................................................. 3  
  Integration and integrated care .................................................................................... 3  
  Medicare Locals ......................................................................................................... 4  
  Objectives .................................................................................................................. 5  
  Progress ..................................................................................................................... 7  
Approach for this series ............................................................................................... 9  
Scope of the report ...................................................................................................... 11  
Aims of this report ....................................................................................................... 13  
Methods ....................................................................................................................... 15  
Findings ....................................................................................................................... 17  
  Medicare Locals’ place within Australia’s health care system .................................... 17  
  The meaning of ‘integration’ ...................................................................................... 17  
  The stakeholders involved in Medicare Locals’ integration activities ......................... 19  
  Ways Medicare Locals are currently working towards integration ............................ 19  
  Requisites for integration ......................................................................................... 23  
  Challenges to integration .......................................................................................... 24  
Discussion .................................................................................................................. 28  
  Medicare Locals’ interpretation of the principles of integrated health care ................ 28  
  Medicare Locals’ plans to improve integration of local health services .................... 29  
  Medicare Locals’ plans to link with Local Hospital Networks ..................................... 30  
  Challenges and possibilities for MLs as agents for integration ................................. 31  
  ML integration: Key considerations ......................................................................... 31  
  Limitations and future directions for integration research with MLs ......................... 32  
Conclusions ............................................................................................................... 34  
References ................................................................................................................. 36  
Appendix A  Participant Information Sheet ................................................................. 38  
Appendix B  Participant Consent Form ......................................................................... 40  
Appendix C  Interview Schedule .................................................................................. 42
## Tables

<table>
<thead>
<tr>
<th>Table</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Table 1</td>
<td>The nature of Medicare Locals</td>
<td>4</td>
</tr>
<tr>
<td>Table 2</td>
<td>Role of Medicare Locals</td>
<td>6</td>
</tr>
<tr>
<td>Table 3</td>
<td>Medicare Locals’ strategic objectives</td>
<td>7</td>
</tr>
<tr>
<td>Table 4</td>
<td>Medicare Locals’ key areas of work to promote integration in their local area</td>
<td>21</td>
</tr>
</tbody>
</table>
# List of Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AML Alliance</td>
<td>Australian Medicare Local Alliance</td>
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<tr>
<td>CEOs</td>
<td>Chief Executive Officers</td>
</tr>
<tr>
<td>DGP</td>
<td>Divisions of General Practice</td>
</tr>
<tr>
<td>LHNs</td>
<td>Local Hospital Networks</td>
</tr>
<tr>
<td>MLs</td>
<td>Medicare Locals</td>
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<tr>
<td>PCEHR</td>
<td>Personally Controlled Electronic Health Record</td>
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<tr>
<td>PHC</td>
<td>Primary Health Care</td>
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<td>PHCO</td>
<td>Primary Health Care Organisation</td>
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Executive summary

There is a need for a shared vision in which the service user perspective and patient experience is central. This will then shape how, when and where to integrate services in order to improve patient care (Rosen et al., 2011, p 20).

Context

The first tranche of Medicare Locals (MLs) was established in July 2011 as part of the Australian Government’s health care reform agenda. Nineteen proposals were accepted from Divisions of General Practice (DGP) to establish MLs, with an additional 18 established from January 2012, and a further 24 from July 2012. MLs are charged with improving the health care system’s responsiveness to the primary health care (PHC) needs of the population in their area. In order to achieve this, MLs will work in partnership with the Local Hospital Networks (LHNs) being established in each region by State and Territory Governments.

One of the five objectives of MLs is improving the patient journey through developing integrated and coordinated services. Though there are a number of definitions available, integration of health care services typically relates to

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 (WHO, 2008).

In the operational guidelines for MLs there is detail under each strategic objective which provides high-level guidance on how integration may be achieved. For example, there is reference to engaging with patients, clinicians, LHNs and other stakeholders to fill service gaps. However, due to the recency with which MLs have been established, detailed information about how they are currently aiming to accomplish/are addressing integration in their local area is limited.

Scope

This qualitative research explored the role of MLs in the integration of PHC services in Australia. At the time of the study, 19 tranche-one MLs had recently prepared strategic and implementation plans for approval by the Department of Health and Ageing. CEOs were therefore aware of their organisations’ plans to address integration, and had considered the organisational structures required to implement their plans. CEOs of five MLs across Australia were interviewed using a semi-structured questionnaire. This project enabled participants to contribute their knowledge and strategic thinking to an analysis of the health reform agenda, specifically around how to improve integration of local health services. The small number of participants in this convenience sample and the qualitative nature of the study preclude generalising the findings to MLs more broadly. Results from the research may inform future practice as they allow the participants to see where other similar organisations are positioned; while researchers, communities and consumers will benefit through a deeper understanding of the issues relevant to integrated health care from the perspective of MLs. This study may also iteratively inform subsequent policy development within State and Australian Governments.

Aims

The study aimed to gain an appreciation of MLs’ understanding of integration within the PHC sector by examining four main issues:
• the ML Chief Executive Officers (CEOs)’ understandings about the principles of integrated health care;
• how their organisation plans to improve integration of health services;
• how their ML will link with the LHN/s in their region; and the
• strengths, weaknesses, opportunities and threats of MLs as agents for integration.

The aim of this report is to present a brief background around integration and MLs; describe the nature of the study; highlight results using representative quotes from the research participants; and discuss how the CEOs’ perceptions of integration in their MLs can inform future practice and policy.

Findings
Analyses provided operational definitions of integration as connections across service providers and organisations, with emphasis on continuity of care for patients. The requisites for integration identified in the research referred to issues such as service accessibility, availability of change champions, flexible funding, infrastructure and incentives. Results indicated that successful integration was achieved through engaging stakeholders; building relationships and working in partnerships; creating supportive environments; providing brokerage services; prioritising needs; and applying evidence-informed models. In terms of challenges, factors such as geography, funding, performance expectations, workforce deficits and fragmentation require further attention. In addition, there was variability in the progress towards partnerships with LHNs and State/Territory health authorities. Nevertheless, the MLs involved emphasised the value of being ‘local’ and not only embracing e-Health technologies, having the flexibility to be creative, and connecting consumers and stakeholders, but also having the opportunity to apply population health approaches to support patients at a local level.

Discussion
This research indicates that CEOs’ language regarding integration centres on a number of themes: variation in the way in which integration is understood; the role of competition versus collaboration; the level at which integration may occur within the health care system; the importance of consumers in service integration; the barriers and enablers to integration; the variation in the scope and nature of relationships; historical factors and their impact on integration; and the assistance that MLs require to enable them to facilitate service integration. Findings illustrate that there is significant variation between MLs regarding their definition of integration, as well as the scope of their responsibility to achieve integration. Stakeholders within the Australian health care system can benefit from a greater understanding of how their MLs understand and hope to operationalise ‘integration’, which is a key platform of Australia’s PHC Strategy.
Background

Primary health care in Australia

As illustrated in previous reports in this series, primary health care (PHC) refers to:

...socially appropriate, universally accessible, scientifically sound first level care provided by health services and systems with a suitably trained workforce comprised of multi-disciplinary teams supported by integrated referral systems in a way that: gives priority to those most in need and addresses health inequalities; maximises community and individual self-reliance, participation and control; and involves collaboration and partnership with other sectors to promote public health. Comprehensive primary health care includes health promotion, illness prevention, treatment and care of the sick, community development, and advocacy and rehabilitation (Commonwealth of Australia, 2009, p 22).

The PHC system in Australia is currently a complex mix of State and Commonwealth funding, offering services through government-managed community health services, publicly and privately funded providers, and government and non-government agencies. The sector operates across macro (system/policy), meso (organisation) and micro (services/patient) levels. In terms of the meso level, for many years the main PHC organisation (PHCO) in Australia has been the Divisions of General Practice (DGP). With emphasis on general practice, these PHCOs aimed to improve access and quality of care based on local community needs (Nicholson et al., 2012). That is, DGP supported initiatives around national practice accreditation, quality improvement, multidisciplinary teams, linkages with practice nurses and allied health, regional integration, information technology, and education and training. DGP offered programs specifically addressing prevention, early intervention, population health, chronic disease and integrated care practices. Viewed by some as “the Australian experiment” (Nicholson et al., 2012), the achievements of these PHCOs have informed recent changes in Australian PHC.

Health system reform is an ongoing process in Australia. This has led to the development of new policies, organisations and goals for PHC. One of the key elements of recent reform has been the introduction of Medicare Locals (MLs), a new PHCO charged with ensuring greater emphasis on PHC as they provide a governance framework and emphasise the need for integration across and within health care providers (Commonwealth of Australia, 2010). In an attempt to enable broader representation, MLs are larger than DGP, with connections across community, health professional groups and business sectors (Nicholson et al., 2012); though it must also be acknowledged that being larger can be a challenge in that trying to represent everyone may result in actions that are not relevant to all parties (Leutz, 1999). Described in more detail in sections below, these PHCOs represent the latest model proposed to encourage an integrated and coordinated Australian PHC health system.

Integration and integrated care

There are a myriad of definitions of the terms ‘integration’ and ‘integrated care’, as highlighted in previous reviews in this series. The WHO offers the following definition which underpins much of the work of MLs:

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 (WHO, 2008).
MLs are involved in both horizontal and vertical integration, reflecting links across health care providers at the same level (e.g., general practice and allied health), and between different levels of the health system (e.g., general practice and acute care). Further to this, the practice of MLs reflects Fulop et al.’s (2005) different dimensions of integration. These include organisational integration (i.e., contracting or strategic alliances between health care institutions), and service integration (i.e., connecting the meso and micro levels of the system to integrate services within and between organisations). In addition, clinical integration, which has relevance at the service delivery/micro level of the PHC system, reflects the MLs’ drive for continuity, cooperation and coherence in the process of care delivery to individual patients. In some cases, MLs will offer initiatives which will represent ‘one-stop-shops’ in that individuals in specific target groups (e.g., people with diabetes) receive all the appropriate information and care they require in a streamlined, coordinated manner. Additionally, continuity of care is a core component of integration, referring to coordination of care over a period of time such as through the course of an illness or across life stages. Improving the patient journey is one of the main aims of MLs. Further, integrated policy-making and management are important as the State and Commonwealth Governments work together to support MLs and the programs they offer in local areas.

**Medicare Locals**

The first tranche of MLs were established in July 2011 as part of the Australian Government’s health care reform agenda. Nineteen proposals were accepted from DGP to establish MLs with an additional 18 established from January 2012, and a further 24 from July 2012. MLs are charged with improving the health care systems’ responsiveness to the PHC needs of the population in their area. As part of their governance, MLs will engage with a range of stakeholders including primarily the Local Hospital Networks (LHNs) being set up in each region, but also consumers, general practitioners, nurses, allied health professionals, and community health service providers (Department of Health and Ageing, 2011). As illustrated in Table 1, MLs are designed to be collaborative, organised, and systems-oriented, ensuring effective infrastructure and a seamless patient experience.

**Table 1 The nature of Medicare Locals**

<table>
<thead>
<tr>
<th>Collaborative</th>
<th>Linking services and sectors for better health care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organised</td>
<td>A planned and coordinated approach to regional health care solutions</td>
</tr>
<tr>
<td>Systems-oriented</td>
<td>Part of a national network for delivering better PHC</td>
</tr>
<tr>
<td>Infrastructure</td>
<td>Ensuring the building blocks for a strong PHC system are in place</td>
</tr>
<tr>
<td>Seamless</td>
<td>Ensuring the path to navigate the PHC system is simplified and easy to use</td>
</tr>
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Source: (adapted from AML Alliance)

Informed by the efforts of the DGP, the MLs have a different role to play (Nicholson et al., 2012). Initially the role is more expansive, with a broad focus on the health and service needs of specific local communities across the entire PHC system. MLs aim to coordinate PHC services beyond general practice, incorporating a range of disciplines and sectors in health practices. There will also be elements of needs assessment and local health planning to ensure that services are appropriately targeted and implemented. An additional difference between the two types of PHCO is that MLs intend to support initiatives designed around prevention and disease management both in general practice and the PHC sector more broadly. In combination with the Australian National Preventive Health Agency, the MLs aim to fill a gap by providing a governance framework for this health
prevention and promotion work (Commonwealth of Australia, 2010). Further, a key aim for MLs is to drive more efficient use of health resources. While funded by the Commonwealth Government, there is the expectation that MLs will be able to use these resources for flexible funding pools as they become more established (Department of Health and Ageing, 2011).

**Objectives**

According to the Commonwealth Department of Health and Ageing 2011 establishment guidelines (Department of Health and Ageing, 2011), the work of MLs (Table 2) will be closely aligned with the national health reform priorities. For example, MLs will collaborate with LHNs and the local practices to enable coordinated care and smooth transitions for patients; support the roll-out of e-Health initiatives; improve planning of health services to ensure local needs are appropriately addressed; support the development of infrastructure in PHC including GP Super Clinics; increase and enhance the workforce to ensure that adequate resources are available to support the community’s needs; and develop initiatives to improve health prevention, chronic disease management and access, including promotion of After Hours GP services and access to primary mental health care services (Department of Health and Ageing, 2011, AML Alliance). Further, MLs will provide patients with increased access to information about the services available in their local area.
Table 2 Role of Medicare Locals

<table>
<thead>
<tr>
<th>Health systems planners</th>
<th>Assess the health care needs of local populations, and improve the integration of PHC by addressing service gaps in communities and making it easier for individuals, families and service providers to navigate their local system</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reorient the system</td>
<td>Endeavour to reorient the system away from acute care to a focus on PHC and a PHC system which is stronger, more cost effective, and achieves better health outcomes for individuals and communities</td>
</tr>
<tr>
<td>Improve access</td>
<td>Work towards coordinating more health services locally within the PHC sector and across other sectors of the health care system to reduce visits to hospitals and to enable people to stay closer to home for their health care, where possible</td>
</tr>
<tr>
<td>Target needs of local communities</td>
<td>Work toward building up and establishing the right health care services that are needed for regions to give people, especially the vulnerable and disadvantaged members of the community, greater access to more appropriate services</td>
</tr>
<tr>
<td>Improve navigation</td>
<td>Create a local health system that will be easier for patients to find their way through, ... it’s about seeing the right health professional at the right time, in the right place</td>
</tr>
<tr>
<td>Promote health</td>
<td>Take an interest in promoting healthy lifestyles including working with other health promotion organisations to tackle health risk factors</td>
</tr>
<tr>
<td>Improve health outcomes</td>
<td>Work towards effective and locally relevant preventive health campaigns to help local communities to raise their standard of health</td>
</tr>
<tr>
<td>Reduce duplication</td>
<td>Work towards implementing a personally controlled electronic health record (PCEHR) to make tracking histories and information easier and more efficient</td>
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</table>

Source: (AML Alliance).

Each ML’s role is to better connect health services to meet local needs, encouraging integration across services including general practice, allied health and hospitals. They will also endeavour to improve integration between health and social care or community services. The goal is to make it easier for patients to gain access to the support they need and to identify and resolve gaps in the health service needs of local communities. Further, there will be a responsibility to help shift the focus of PHC to consider population health, addressing the health needs of a particular population in a specific geographic area.

As stipulated by the Commonwealth government, there are five strategic objectives for MLs (Table 3). The first refers to improving the patient journey through developing integrated and coordinated services. In the operational guidelines for MLs there is detail under each strategic objective which provides high-level guidance on how integration may be achieved. For example, there is reference to engaging with patients, clinicians, LHNs, and other stakeholders to fill service gaps; implementing after-hours and telehealth services to improve access; and providing directories of available services in local areas. However, due to the recency with which MLs have been established, detailed information about how they currently aim to accomplish, or are addressing integration in their local area is limited. It was this notion that was the driver behind the current research.
Table 3  Medicare Locals’ strategic objectives

<table>
<thead>
<tr>
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<th>Strategic Objectives</th>
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<tbody>
<tr>
<td>1</td>
<td>Improving the patient journey through developing integrated and coordinated services</td>
</tr>
<tr>
<td>2</td>
<td>Provide support to clinicians and service providers to improve patient care</td>
</tr>
<tr>
<td>3</td>
<td>Identification of the health needs of local areas and development of locally focused and responsive services</td>
</tr>
<tr>
<td>4</td>
<td>Facilitation of the implementation and successful performance of PHC initiatives and programs</td>
</tr>
<tr>
<td>5</td>
<td>Be efficient and accountable with strong governance and effective management</td>
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</table>

Source: (Department of Health and Ageing, 2011)

Progress

There is little evaluative information as to the progress of MLs. At the Australian Medicare Local (AML) Alliance National PHC Conference in November 2012, many MLs reported on a range of initiatives that are being piloted and which are beginning an evaluation phase. A request for tender for a national evaluation of the Medical Locals Program was released in late 2012 and the national evaluator appointed in early 2012. The national evaluation is expected to be completed by early June 2014. Nevertheless, to-date this current research study fills a gap in understanding how the MLs are progressing.
Approach for this series

Given the multiplicity of definitions, dimensions, perspectives, levels and objectives of integrated care, these different aspects have been examined in more detail in other reports (listed below) in this series on integrated care, with a particular focus on the role of PHC. Each report addresses different aspects of integration at one of three levels: macro, meso, micro.

This report is the fourth in the series and provides qualitative data on PHC integration at the meso level via MLs. This report complements Report 3, which provides a comprehensive exploration of meso level integration in Australia and internationally.

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<tr>
<td>1</td>
<td>Macro</td>
<td><em>Integrated care: What policies support and influence integration in health care in Australia?</em></td>
</tr>
<tr>
<td>3</td>
<td>Meso</td>
<td><em>Integrated care: What strategies and other arrangements support and influence integration at the meso/organisational level?</em></td>
</tr>
<tr>
<td>4</td>
<td>Meso</td>
<td><em>Medicare Locals: A model for primary health care integration?</em></td>
</tr>
<tr>
<td>5</td>
<td>Micro</td>
<td><em>Integrated care: What can be done at the micro level to influence integration in primary health care?</em></td>
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Scope of the report

This Rapid Report is based on a qualitative research project exploring the role of MLs in the integration of PHC services in Australia. CEOs of five MLs across Australia were interviewed using a semi-structured questionnaire. The report provides a summary of CEOs’ understanding of integration, their strategies for facilitating integration of health care services including links with LHNs, and their perceptions about the strengths, weaknesses, opportunities and threats for MLs to act as agents for integration.

At the time of recruitment, the 19 MLs that were invited to participate in this study had recently prepared strategic and implementation plans for approval by the Department of Health and Ageing. Therefore, the CEOs were aware of their organisations’ plans to address the integration objective, and had considered the organisational structures required to implement their plans. This project enabled the participants to contribute their knowledge and strategic thinking to an analysis of the health reform agenda. It is anticipated that the outcomes will be useful to the participants and management teams of other MLs who will see where other similar organisations are positioned. Researchers, communities and consumers may well benefit through a deeper understanding of the issues relevant to integrated health care from the perspective of MLs. Additionally, findings may inform subsequent policy development within State and Australian Governments.
Aims of this report

The aim of the qualitative study was to develop an appreciation of the MLs’ understanding of integration within the Australian PHC sector. This was to be achieved by exploring:

- What CEOs understand about the principles of integrated health care
- How the ML plans to improve integration of health services
- How the ML plans to/currently links with the LHN/s in their region
- Strengths, weaknesses, opportunities and threats of MLs as agents for integration.

The aims of this report are to introduce integration and MLs; describe the nature of the study; highlight results using representative quotes from the research participants; and discuss how the CEOs’ perceptions of integration in their MLs can inform future practice. The next (fifth) report in this series examines the strategies and initiatives that influence integrated care at the micro level of service delivery.
Methods

This qualitative research project recruited CEOs from MLs introduced in the first tranche, requesting their participation in a semi-structured telephone interview. CEOs were invited by email to participate, with an information sheet (Appendix A) attachment. Upon replying to the email with an expression of interest, the CEOs were sent a consent form (Appendix B) and asked to nominate a preferred time for the interview. After agreeing to participate in the study the CEOs received a copy of the interview questions (Appendix C) to allow them time to reflect on their answers. Five CEOs (26% of tranche 1) participated in interviews lasting 30-45 minutes, in April-May 2012. The CEOs represented MLs in rural \((n = 2)\) and urban \((n = 3)\) areas, with diverse composition of local populations, across multiple states. All interviews were recorded and transcribed. The interview transcripts were then analysed using a thematic approach (Braun and Clarke, 2006).
Findings

Findings from analysis of the ML CEOs’ interview data centred around perceptions of the role of MLs in the Australian health system; interpretations of the term ‘integration’ in local contexts; key players and activities in integrating PHC; and the requisites and challenges MLs experience in addressing integration. Each of these is described in detail below.

Medicare Locals’ place within Australia’s health care system

One clear theme in interviews with ML CEOs was their perception of their roles within the Australian health system. MLs perceived their place within the health care environment as novel and focused on two pivotal areas: leaders of change and population health planners.

MLs perceived one of their key roles within the Australian health care environment as leaders for an improved PHC sector. This leadership was mentioned particularly in relation to change management and integration in the sector. MLs perceived that they were filling a void in the health care system, in that they were providing the mechanism and means for PHC to become a priority where it had not previously existed. For example, one ML CEO described:

*I think the system in a sense is crying out for a stronger primary health care infrastructure and I personally believe that I don’t think we are going to get anywhere on integrated health care if we don’t have strong primary health care organisations like Medicare Locals. I just don’t believe it’s going to happen.* ML3

MLs felt they were in a unique position to be able to pull together the disparate streams of work occurring in the sector.

*... we’re not going to have all of these primary health care services and the acute care services operating under one organisation where there’s a single management structure above them. That’s not going to happen but we can try and put structures in place to replicate that, to try and jointly manage some elements of our health system... this is really where Medicare Locals have to focus their efforts.* ML4

MLs also identified their role as centring on population health planning and priority setting in PHC. The ML CEOs acknowledged the level of fragmentation that exists within the Australian PHC sector, and felt their regionalised perspective allowed them to piece together the puzzle.

*The state funds a lot of stuff, Canberra funds a lot of stuff, but our role at Medicare Local is to sort out the gaps and then fill the gaps in, a bit like having a big jigsaw puzzle...* ML1

*I think the opportunities now we have is that we are taking more of a population approach and down to local populations rather than a higher level which means that we can tailor things in local communities.* ML5

The meaning of ‘integration’

All participating MLs agreed on the importance of integration in an efficient and effective PHC system. However, when asked to describe what this integration might look like in Australia there were varying responses. The majority of the MLs described broad theoretical understandings of the concept of integration, whereby integration was seen to be something that could occur in different
areas and at different levels within the health care system. The areas described ranged from integration as it is experienced by consumers, through to providing infrastructure that promotes integration (such as the GP Super Clinics), integration of funding, and integration of service provision.

Most ML CEOs described and understood that integration could be defined in various ways.

*In the Australian context, I think we’ve defined integrated care in a number of ways. For example, one of the things the government has done is put together GP super clinics and that’s what they call integrated care....Equally I think with Australia we’re very program driven when we talk about integrated care, for example we pick out a disease or a condition, whether it is mental health or diabetes and then apply a whole package around trying to say we want to integrate care in that area and we want that program to do that.* ML4

Some ML CEOs identified that not all forms of integration are equal in terms of how they result in coordinated care for patients. This means MLs should be clear about what they are seeking to integrate, whilst keeping their eye on their long-term goals i.e. improving patient outcomes and their experience.

*There are different ways that you can integrate and different degrees of integration and I think true integration actually requires integration of funding, integration of management and integration of service delivery.* ML5

One CEO felt that ‘true integration’ is unlikely to ever be achieved, though what was possible was a better coordinated system to improve the patient experience.

*The reason that’s [integration] important in the Australian context is because the idea of coordination of care is really important where you haven’t got, which we don’t have in Australia, an integrated health care system, it becomes very important to co-ordinate care as opposed to integrating it.* ML3

Despite the variation in their definitions of integration across different areas, the MLs identified a number of specific areas that were their responsibility. These areas of responsibility focused on the integration of service providers. Whilst there was consensus amongst MLs that integrating services was important, they appeared to vary in the priority placed on the patient experience of the coordination of care. Some ML CEOs felt integration was only important insofar as it improved the consumers’ experiences. Others did not identify the consumer experience as critical to their integration activities.

*...until we can reduce fragmentation then we’re not going to be able to strengthen the primary health care sector so from that perspective, integration to me means increased connectedness across service providers.* ML2

*Integrated health care basically is all the health providers working together in the most efficient and effective way possible to produce the best outcomes for the patients...probably broader than the patients, to the community.* ML4

*... I take an approach that we should be building a system to deal with what the patients’ issues are as opposed to the other way around and I think whether it be when we talk about*
things that might enable better integration being health and better partnerships, all those things enable it but what you’re trying to achieve is the best outcome for the patient in these circumstances. ML3

The stakeholders involved in Medicare Locals’ integration activities

There was a significant degree of variation between ML CEOs regarding who they perceived as the key stakeholders in their work to improve integration, reflecting the composition of their local community and the varied definitions of integration provided by the participants. The stakeholders mentioned ranged from general practitioners, to allied health professionals, State Government community health services, the not-for-profit sector and aged and domiciliary care services. Most MLs acknowledged the importance of expanding their scope to include allied health professionals.

*Within primary health care, then the key stakeholders are general practice, pharmacy, allied health providers...* ML5

*It’s very much about allied health having a vote and shaping the future of the organisation.* ML1

A minority of MLs felt that while the role of allied health was important, they should be required to recognise the general practitioner as the lead coordinator of health care. These MLs indicated that health initiatives were most successful when they placed general practitioners at the centre, and felt that the greatest gains could be made by improving the capacity of other clinicians to integrate into general practice.

*So it’s not about just growing the strengths of general practice. That’s not what I’m about. I’m saying it’s growing the strength of every service within the primary care sector, but linking them to general practice, being aware that there’s a major resource that’s in the primary care sector that we need to be linking with.* ML2

It appeared that ML CEOs’ interpretation of who constituted the ‘key stakeholders’ was largely informed by the way they defined integration, the manner in which the ML was established (e.g. stemmed from a Division), and the ways they saw integration as being achieved in their region. For example, MLs that identified care pathways as a key method for providing integrated PHC tended to describe clinicians (general practitioners and a limited range of allied health personnel) as important actors in a disease management context. However, these MLs did not mention work around risk factors or agencies that may be involved in addressing risk factors for chronic disease, though this may reflect the fact that this responsibility has recently been allocated to MLs. Interestingly, consumers were rarely mentioned as important stakeholders for consideration. However, those who did mention consumers as important stakeholders had a perspective that was strongly informed by a ‘social determinants of health’ approach.

Ways Medicare Locals are currently working towards integration

MLs were asked to describe the ways they are working towards improving integration in their region. A wide range of activities were being undertaken though a number of themes were clear in
their responses, once again reflecting the variation in definitions of integration embraced by the MLs. The most common ways MLs described working towards integration are shown in Table 4.
### Table 4 Medicare Locals’ key areas of work to promote integration in their local area

<table>
<thead>
<tr>
<th>Method</th>
<th>Details</th>
<th>Example</th>
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<tr>
<td>Acting as a brokerage service</td>
<td>MLs are acting as an impartial facilitator between a diverse range of service providers, programs and organisations in their local areas.</td>
<td>“You’re almost a broker in between the stakeholders and general practice in a way the connecting them up and making sure that connection is facilitated in a way.” ML2  \n“Our model is going into a town into a community and working with the community, so we bring the pharmacist, GP the Physio and the consumers together around the same table and then we look at the planning and the pop health, the burden of disease, the risk taking behaviour” ML1</td>
</tr>
<tr>
<td>Stakeholder engagement and relationship building</td>
<td>Relationship building is taking place with other organisations in the MLs’ catchment area. This relationship building aims to gain increased insight into the MLs’ regional stakeholders. This work is seen as foundational to future work on a programmatic and strategic level.</td>
<td>“That will be the direction that I’ll be trying to take with our engagement with the various other organisations within the primary care sector because I think it’s important. Information” ML2  \n“I just think the focus of our integration work is really going to be trying to improve the working relationship with providers.” ML4</td>
</tr>
<tr>
<td>Improving the coordination of care (including developing care pathways)</td>
<td>Improving the coordination of care was the most commonly mentioned area of focus. This particularly centred on the development of care pathways, and professional development for clinicians and stakeholders.</td>
<td>“I just think the focus of our integration work is really going to be trying to improve the working relationship with providers and we’ll do that through the things like pathways. We’re also strongly involved in the development of multi-disciplinary education for community based providers and other providers...” ML4  \n“There needs will be clear pathways, so there’s criteria to say that if somebody has got these features, then the best environment or the best discipline to respond for those features are these” ML5</td>
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<td>Method</td>
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| Identifying local population needs   | MLs are aware of the gamut of competing needs that exist in their communities, and are tackling this through their needs assessments. These will also inform their community’s needs for improved integration. Needs assessments themselves have been a mechanism to promote integration, however some MLs are struggling with differences of opinion regarding what is needed in their local areas. | “I think having the data and having the planning and everything so we’ve got our population health… and going out in to the communities and really engaging with them to find out what’s going on.” ML2  
“How we are doing it in many respects is using our population health analysis to look at what are our greatest health burdens or concerns that we have and then saying ‘okay, do we have an appropriate model of care that is continuous, that is integrated between the sectors and also within the sectors’ and if not, how do we work with the stakeholders so that we can talk it through.” ML5 |
| Developing shared governance practices | In acknowledging the disjunction between funding mechanisms and policy frameworks within the health care systems, MLs described work that focused on shared governance practices, ranging from Memoranda of Understanding, shared board membership, and organisational management practices which aim to work across organisations. | “We’re going to move there by integrating individual bits, and bringing those bits together and then in our partnership with the LHD, starting to break down the barriers between acute and primary care, I think all of that is a natural evolution.” ML3  
“At each level, from executive level down to the service management level and site level we have sort of interface management processes. That’s a really good example of a properly integrated service.” ML4 |
In addition, MLs also identified other areas of activity which aimed to promote integration. These included:

- Creating environments that support integration by developing e-Health infrastructure
- Enhancing the capacity of organisations and clinicians to use e-Health technologies that already exist
- Contracting or directly delivering services in the absence of appropriate services in their area (particularly in rural areas).

**Requisites for integration**

MLs described a number of requisites that should be present to enable integration to occur. These requisites were beyond their personal sphere of control, and referred to more systemic infrastructure and policy level factors. By far, the most significant requisites that were identified were the need for e-Health and telehealth infrastructure, partnerships with LHNs, and funding models for service providers and organisations that incentivised integration rather than fragmented disparate silos.

MLs most frequently indicated that telehealth, e-Health infrastructure, and related projects (such as the establishment of the PCEHRs) were important requisites for integration. E-Health was identified as critical due to its ability to enable quick access to the consumer’s clinical information. Many of the integration projects that MLs are implementing within their regions (such as the development of regional care pathways) implicitly or explicitly assume the establishment of reliable, robust e-Health infrastructure to progress successfully.

*...information is key to a whole lot of things. ML2*

The necessity of developing e-Health infrastructure becomes apparent in situations where currently even basic telecommunication business services are limited. MLs in rural or remote areas have struggled significantly with establishing their organisation due to difficulties in obtaining reliable phone or internet connections in their rural sites, which may also have ramifications for establishing e-Health processes.

*We’ve got a head office in [regional town] and we’ve struggled to get the technology working just for VOIP and Skype and we’ve wanted to save money and do things innovatively, but it’s a year almost since we started and we’ve only just got our phone system between the branch offices working and that’s because we don’t have the speed for the data. ML1*

Despite the difficulties, MLs in regional and rural areas identified the importance of using telehealth and internet-based service delivery to improve access and fill in the gaps that those outside of metropolitan areas experience.

In both rural and metropolitan areas e-Health technologies have served to integrate different sections of the health care sector, such as the disjuncture that occurs between primary and acute care:

*The area health services are now sending their discharge summaries electronically to all the GPs in their region. We’re working with them to start sending out other communications like letters back from specialists’ clinics electronically and also letters back from community based services. ML3*
A key relationship for MLs is their link to the acute care sector through the LHNs. Despite the importance of this relationship, it appears that each ML is establishing these connections with varying degrees of success. Some MLs are moving forward successfully and rapidly, while others are struggling to establish a clear and formalised relationship.

“We’ve got one member on our board and then equally on their advisory council in South Australia, so we’ve got a member on there as well. ML5

“I’ve got a key deliverable to be working with the LHN, they haven’t actually got it sorted. They advertised for people on the governing council and Canberra told us divisionally there would be a seat at the table for the Medicare Local and we were told ‘no there is not a seat there for you’. ML1

A further requisite for integration that was consistently identified by ML CEOs was a supportive funding model. It was proposed that supportive funding models need to be established at varying levels within the health care system, from provider remuneration through to funding for the MLs themselves.

“And that flexible model of funding, I’m so thrilled to see that recently tailored model that they are talking about in the next budget, but we are really pushing it to Canberra that you need to get flexible fast and the ideal for us in our rural region would be to have flexible funding full stop. ML1

At the provider remuneration level, the potential for funding models to cause fragmentation within the health care system was again identified:

“In my 25 years in health invariably one thing that has always been true and that is the way health is financed is usually means it’s provided in that way. It’s a huge driver. ML3

“It actually quite often requires effort to set up systems that our outside of the clinical service delivery context which is how they generate their revenue. So, one of the things that can really help with integration is if there are a lot of incentives, so if you want GPs to integrate with other providers then you need some incentives in place to encourage them to do that. ML4

Therefore, given their ability to ‘make or break’ an integrated health care system, flexible funding for MLs, and a provider remuneration system that incentivises service delivery organisations working in a coordinated manner are important foundations for an integrated health care system in Australia.

In addition to funding, partnerships and e-Health infrastructure, MLs mentioned a number of additional factors which can promote integrated systems. These include the need for leadership; clear advocates or change champions to encourage movement towards an integrated system; a clear reason for integration that providers can relate to and understand, and a model to allow integration to happen. In Australia, this model has now been provided by MLs, who are responsible for facilitating integration in their local areas.

Challenges to integration

MLs were asked to identify the challenges to health service integration in their regions. There was a clear theme in response to this question, with MLs identifying the political environment as a key
challenge to health service integration. MLs described multiple ways that the political environment affected their work, particularly in the area of state-federal disjunctions. Further challenges were associated with time pressures and community attitudes.

we are just getting on with it because you know, we are here for the customers, and okay yes, there is all the politics going on but what saddens me is I suppose that there is not more recognition of Medicare Locals coming out of the state. ML1

The local hospital networks aren’t up and running in Queensland yet. The election has put all of that back... ML2

Many MLs felt that the question mark over the likely outcome of the next election was putting significant pressure on their work. The MLs commented that the Opposition have promised to move back to a DGP-style arrangement if they win the next election, and this seems to have led State Governments and other health organisations to simply sit and ‘wait out the storm’, concerned that MLs may revert back to DGP in the near future.

The [senior health bureaucrat] who I used to work with in a previous life said ‘Well look Medicare Local is not terribly relevant, I don’t know how long they’re going to be around for and through COAG and everything there has been this lack of cooperation and you really are not relevant to us’. ML1

The political environment was also linked to the community’s perception of their need for health care. Some MLs identified that despite their efforts to put PHC ‘on the map’, many politicians continue to equate health care with hospital beds. This obscures the message to the public about the advantages and need for preventive care or early intervention models, which are more cost effective and efficient.

I think if you would say let’s invest more in patient care pathway, and more into coordinated patient care around diabetes for example, it wouldn’t have the same sexy appeal.

You don’t have politicians advocating that because people in their community wouldn’t necessarily see that and understand that as building more hospital beds. I think there is a need for a change in how we look at these things and how effectively we debate them. ML3

MLs also reported that this political environment made them feel that they need to achieve ‘quick runs’ in their activities to demonstrate the value of their work and approach. These quick runs have been described as affecting the opportunities to focus on larger, more important work.

I think Medicare locals are pragmatic enough to know we’ve got to demonstrate a value and demonstrate some outcomes in a short period of time. I think that the undermining part of the process is where you might try to do that more quickly than otherwise is appropriate. ML3

MLs described concerns with the expectations placed upon them more generally. They described anxiety about what can be achieved realistically in short periods of time; and identified that reaching significant goals (such as improving integration) takes a significant amount of time and energy.
There is an expectation that Medicare Locals will suddenly, in this case, have fully integrate healthcare networks up in place in a really short period of time. In reality, that isn’t possible, it does take time. ML5

The MLs interviewed also reported struggling to access evidence to inform and support program and policy development in their regions. They were having difficulty identifying best practice models for the new and expanded scope of work they are undertaking.

But that evidence base…. if we could be told ‘here is an evidence based program say the stop smoking’ instead of having 10 different things. ML1

ML CEOs also mentioned challenges based on different priorities and directions compared to other key stakeholders in their areas. The relationship with these organisations is variable, and MLs appeared to depend on relationships to gain support given the lack of other leverage tools they have at their disposal.

One of the challenges is working with the health district. They’re a much bigger organisation. They obviously want to work with us but they have some other priorities as well. They’re a bit like a container ship; it’s a bit hard to change direction. It can be quite hard to get them to do something a bit differently. ML4

Despite the significant collective efforts to produce a reformed health care system, it appears that different priorities are having significant impacts on the MLs’ ability to create integration within their areas. ML CEOs suggested that this fragmentation in policy frameworks serves to maintain the silos that exist at the service delivery level.

We often don’t connect the various parts of those programs to other programs, or connect policy together. We don’t then necessarily have integration across those various silos. ML3

This was an issue that we kind of had to grapple with which was how do you get the public and the private and then the continuity of care in that when there are competing sort of policy frameworks within each of those. ML5

MLs are also experiencing challenges in establishing collaborative relationships with stakeholders in a health care environment that is becoming increasingly fiscally constrained. Some organisations with which MLs are trying to develop partnerships perceive that the MLs are ‘taking away’ money from other health organisations. This has been a particular issue with the DGP.

But if they could have known what their money was then they would have been our friend. The issue is they don’t know what their money is, they don’t I know if they are going to be able to have their staff on 30 June, and they don’t know if they have to make staff redundant and they still don’t know and it’s now the 17 April. ML1

This perception of competition sometimes extended to the providers themselves.

There used to be GPs in the same street, different practices in the same street but they didn’t talk to each other and were sort of seeing each other as competitors, which is a ridiculous thing to do when you’ve got more work than you can poke a stick at. ML4
Additionally, as MLs approach communities to engage or consult about the direction of reforms in their catchment areas, they describe community attitudes that do not support a move to a preventive PHC system.

*What we want is for Primary Health Care to really get on the map, and it’s made me realise that Primary Health Care is just not on the map. When you talk to people about their health, they say ‘oh yes, we are having a new hospital in [the town]’.* ML1

Some MLs feel that they are fighting an uphill battle in their efforts to change the attitudes within their regional areas. As mentioned previously, they describe encountering a social, cultural and political environment in Australia that promotes and prioritises the acute care sector; and suggest that this attitude is also internalised by the local communities they are working with.

*It’s a cultural change and it’s a counter to the way most of the system is funded at the moment, so there needs to be levels in there and advocacy in there in using what we’ve got to change bits of it and hopefully change some parts of the system as well... I think the problem is I think the political agenda is still very much about ‘if we build more beds and hospital beds we’ve done the right thing’ we’re still facing the perception in the community that investing more hospitals and hospital beds is a good thing.* ML3

Most MLs identified that there is a critical role for culture change in local communities. This change needs to be pervasive, and move beyond consumers to include all stakeholders and service providers. In some regions, this change is beginning with service providers, though the change is slow and variable across different professional groups. Nevertheless, there is definitely a drive and will that was not present during the days of the DGP.

*I wasn’t expecting all of a sudden all these extra people would be wanting to work with us but that’s what happened and the local health district became more serious about working with us. And a whole bunch of other providers and players have approached us wanting to work with us and so that surprised me.* ML4
Discussion

Preliminary findings suggest that CEOs’ discourse regarding health service integration centres on a number of themes:

- some variation in the way in which integration is understood and operationalised between MLs
- the role of competition versus collaboration in service delivery
- the level at which integration may occur within the health care system
- the relative importance of patient-centredness as a principle in service integration
- the barriers and enablers to integration
- the variation in the scope and nature of relationships
- historical factors and their impact on integration
- the assistance MLs require to enable them to facilitate service integration.

These findings show that there was variation between the five MLs involved in the research regarding their definition of integration, as well as the scope of their responsibility to achieve integration. Stakeholders within the Australian health care system may benefit from a greater understanding of how MLs understand and hope to operationalise ‘integration’ in their local area, which is a key platform of Australia’s PHC Strategy.

Medicare Locals’ interpretation of the principles of integrated health care

The ML CEOs’ perceptions around both integration and the role of MLs in the health system reflected an inherent understanding of the fundamental aims of these PHCOs. The participants described how they are well-placed to set priorities and pull disparate streams together, operationalising the Government’s guidelines around coordinating different sectors. Further, the themes of having a regionalised focus and reducing fragmentation were common throughout the findings. Once again, this provides support for both the need for this service in Australia and the way in which the MLs have been able to take the Commonwealth Government’s instructions and embrace the strategic objectives (Department of Health and Ageing, 2011).

The breadth of the definition of integration across the MLs reflects the widespread challenge of pinpointing one clear definition and subsequent operationalisation of ‘integration’ which fits all circumstances/situations. For some MLs, the interpretation was at a theoretical level and referred to the potential for coordination and partnerships in different areas and different levels within the health system. For other MLs, there were different concepts at the core of their understanding of integration with discussion around integration for consumers’ benefits, or integrating infrastructure, funding and services. This reflects the very nature of this series of reports on Integrated Care; that is, the fact that the CEOs view integration at such a range of levels illustrates the importance (and challenge) of a health system integrating across and within macro, meso and micro levels. The complexity of the construct was also evident in the diversity present in the discussion around identifying key stakeholders relevant to integration. Combinations of general practitioners, allied health professionals, not-for-profit organisations and community services were mentioned; yet there were differing opinions about which of these should be involved and what role they should play. There was also much debate about whether general practitioners should be at the helm. This most likely stems from the GP-centric DGP model and reiterates the current transition phase that Australia is experiencing. Additionally, the diversity of definitions of integration may reflect what is important to the community in each ML’s local area.
As discussed in Report 1 (Integrated care: What policies support and influence integration in health care in Australia?), national health reform is driven by the need for patient-centred care and improved outcomes for Australians (Commonwealth of Australia, 2012). It is interesting to note that among the ML CEOs there were few occasions in which consumers were mentioned as key stakeholders in the drive for integration. Nevertheless, the activities of MLs were often centred on chronic disease management and promoting communication to improve the patient journey. However, there needs to be a change to start including consumers as consultants in activities (Yen et al., 2010), particularly with the MLs’ emphasis on tackling the needs of the local people.

**Medicare Locals’ plans to improve integration of local health services**

There were a range of mechanisms employed by the MLs to promote integration in their local areas. These included acting as a brokerage service, stakeholder engagement, building relationships, improving coordination of care, identifying local needs and shared governance. Many of these mechanisms are described in Report 3 (meso-level integration) as some of the common factors employed by PHCOs around the world to encourage integrated health services and high quality communication.

The MLs identified specific requisites for integration around infrastructure, policy, governance, e-Health and funding. These represent some of the core priorities and building blocks emphasised in the National PHC Strategy (Commonwealth of Australia, 2010). In particular, e-Health and assessing needs consistently emerged as key steps in integrating local health services. e-Health seemed to represent the future of improved communication between and within the different health sectors. Further, assessing the needs of the local community reinforces the value of MLs’ position in regional zones and highlights a shift in focus from the individual patient to consideration of population health. These issues were also described by Nicholson et al. (2012) in their discussion of how the DGP informed the MLs. That is, the authors highlight the transition in recent decades as “moving from focus on individual practitioners to a professional collective local voice” (p S18).

It was interesting to note that one CEO did not believe integration was achievable but that aiming for a better coordinated system was a more realistic goal, reflecting the notion that integration is the process rather than the destination (Armitage et al., 2009). That is, it has been suggested that the key outcomes are not achieving ‘integration’ but rather the benefits that will occur once services are well integrated. This echoes the concerns commonly cited by the participants around the high expectations for MLs’ output yet the short timeframe they face to achieve such objectives. Thus, more time is an additional requisite for integration, as reducing the pressure of expectations and the need to achieve long-term tasks in short-term periods may improve the likelihood of successfully integrated outcomes.

In ensuring equitable access and an adequate workforce, Nicholson et al. (2012) encourage learning from international models and Australia’s previous practices. That is, recommendations are provided around promoting fiscal mechanisms such as the use of incentives to encourage coordinated care; ensuring high-quality communication; developing an effective governance arrangement to promote better primary/secondary care integration; continued investment in infrastructure; and sharing of resources. In the current research, these same ideas consistently emerged from the MLs interviewed. Funding was a common theme in terms of challenges to the MLs’ integration plans. In line with the recommendations of Nicholson et al. (2012), it seems that financial incentives for
integration and supportive funding models for coordinated care are the next desirable steps for MLs. Coordinating flexible funding opportunities and a system of incentives for providers would improve the likelihood of organisations forming linkages, and provide motivation for this integration. While MLs are the new ‘model’ for integration, the CEOs noted that there is a need to develop a logical argument for integration (reflecting the challenges of different priorities across stakeholders), and also the value of advocates/change champions. Furthermore, there was mention of the need for evidence to inform initiatives and best practice. This has been the driver for many of the peak bodies mentioned in Report 3 (Integrated care: What policies support and influence integration in health care in Australia?) and forms part of the macro policies which promote capacity building for knowledge translation and exchange.

Medicare Locals’ plans to link with Local Hospital Networks

The varied relationships between MLs and LHNs that were described may be due to a range of issues. One, the LHNs have been established for even less time than the MLs, hence are still carving out their roles and may not be ready to explore partnership opportunities yet. It may also be a reflection of differing priorities between the acute and PHC sectors and the lack of shared governance currently in place; an issue these partnerships will directly address once firmly established. Generally it seemed that this linkage was a work in progress and that both MLs and LHNs were in varying stages of readiness to collaborate. There was much hope emerging from the CEOs about the future of the relationships with the LHNs with much value placed on the partnership and the potential it offered in terms of improving the patient journey and practitioner communication.
Challenges and possibilities for MLs as agents for integration

ML integration: Key considerations

Strengths (Current performance)
- Fill a gap in the health care system
- Well-positioned to make sure PHC becomes a priority
- The ‘local’ in Medicare Local i.e. the focus on local population and local needs
- Multidisciplinary, intersectoral approach
- Funding from one source i.e. Commonwealth Government
- Pre-existing relationships with stakeholders.

Weaknesses (Current performance)
- Limited availability of technology in rural and remote settings restricting telehealth opportunities
- Complexities in funding
- Competitive environment
- Lack of evidence to inform best practice models and initiatives
- Too many tasks, insufficient implementation time
- Poor communication.

Opportunities (Factors in external environment)
- Playing a role as leaders of change
- Well-positioned as population health planners
- Shared governance with LHNs promotes possibility of improving links between acute and PHC sector
- Improving linkages and promoting partnerships between health sectors
- Encouraging improved communication across health professionals
- Giving consumers and communities a voice
- Embracing and promoting the roll out of e-Health
- Increased flexibility to be creative.

Threats (Factors in external environment)
- Fragmented ‘silo’ system and the need for a culture change, encouraging different organisations and sectors to work together
- Different priorities across stakeholders and sectors
- Community expectations/attitudes which see the acute sector as the core component of the health system
- Fragmented policy frameworks
- The political context
- The perceptions that MLs are receiving more funding than other PHCOs in a money-poor environment
- Geography
- Insufficient funding
- Unclear terms of reference and performance expectations
- Workforce deficits.
Limitations and future directions for integration research with MLs

The main limitation in the current research was the small sample size. The small number of participants in this convenience sample and the qualitative nature of the study preclude generalising the findings to MLs more broadly. However, the study provided some preliminary insights into ML CEOs’ perspectives on integrated care. The available data offer details related to the experiences and positions of CEOs from across Australia, both in remote and urban areas with diverse composition of local populations; and the results highlight the experience of a select number of CEOs rather than describing the experiences of all MLs across Australia.

Future research may consider exploring barriers to participation in this type of research to understand whether there may have been specific factors (e.g. time commitment, willingness to disclose, etc.) influencing recruitment in the current study. Nevertheless, in qualitative research small samples are both common and acceptable; the validity is not in the number of participants but rather the likelihood of achieving saturation (Ambert et al., 1995). As indicated in the findings, intensive analysis indicated consistent themes from the interviews. However, expanding on these results in future research would require recruitment of a larger sample representing the diversity of MLs.

This project provided information about perceptions of integration from CEOs of MLs established in the first tranche as they were developing the plans for their local areas. Future research directions include exploring the MLs’ experiences of implementing their integration plans and comparing the journey for MLs based on the different tranches in which they were established, and their development, locations and population compositions.
Conclusions

This project enabled the CEOs of five tranche-one MLs to contribute their knowledge and strategic thinking to an analysis of the health reform agenda. MLs have hopes/plans/belief in the value of integration but currently face challenges as they cement their role in both the health system and the local community. Driven by the needs of local populations, aiming to improve the patient experience and the overall seamlessness of the health system, the MLs have a number of important roles and responsibilities ahead of them.

The diversity in experience across MLs was reflected in the CEOs’ different interpretations of integration, and organisational cultures. Issues of partnerships in competitive environments which commonly emerge in discussions on integration challenges (Ham, 2012, Hawkins, 2011) and the emphasis on patient-centred practice were common themes, along with e-Health and the complexity of funding arrangements. Identifying barriers and enablers to integration has the potential to inform future policy/practice across the macro, meso and micro levels of the health system. The findings emerging from this research will be useful to CEOs of other tranches of MLs, demonstrating where other similar organisations are positioned and the kinds of successes and challenges they faced. Researchers, communities and consumers may use this evidence for a deeper understanding of some of the issues relevant to integrated health care from the perspective of MLs and their implementation experience. It is hoped that this information will also help to inform subsequent policy development within State and Commonwealth Governments.
References


AML ALLIANCE The Medicare Local brand. ACT: Australian Medicare Local Alliance.


Appendix A  Participant Information Sheet

INFORMATION SHEET

Title: The role of Medicare Locals in Primary Health Care integration

Investigators:
Dr Petra Bywood & Ms Rachel Katterl, Primary Health Care Research & Information Service
Dr Tracy Cheffins, James Cook University

Description of the study:
This research project will explore the role of Medicare Locals in the integration of the Australian health care system. Chief Executive Officers (CEOs) of 19 Medicare Locals across all states and territories are invited to be interviewed.

Purpose of the study:
This examines Medicare Locals understanding of integration and how it might be achieved in their regions, including:
- What CEOs understand about the principles of integrated health care.
- How CEOs expect their organisations will improve the integration of health services in their regions.
- How their Medicare Local will collaborate with the Local Hospital Network/s and other organisations in their region.
- Strengths, weaknesses, opportunities and threats of Medicare Locals as agents for primary health care service integration

What will I be asked to do?
You are invited to participate in a one-on-one telephone interview with a researcher. You will be asked to answer questions on the role of your organisation in promoting health service and systems integration. The interview should take about 30 minutes, and will be recorded using a digital voice recorder. You are free to stop the interview and withdraw from the study at any time.

What benefit will I gain from being involved in this study?
The sharing of your experience and knowledge as a Chief Executive Officer will improve the planning and delivery of future health reform programs. The research will capture the opinions of recognised leaders in primary health care and the resulting reports, publications, and policy suggestions will be a useful resource for all involved.

Will I be identifiable by being involved in this study?
All your responses will be treated confidentially. Any identifying information will be removed from the paper based versions of your interviews, and the recordings of your interviews will be stored on a password protected computer. Your comments will not be linked directly to you.

Are there any risks to my involvement in this study?
There are no foreseeable risks to your involvement.
How do I agree to participate?
Participation is voluntary. You may answer ‘no comment’ or refuse to answer any questions and you are free to withdraw from the interview at any time without effect or consequences. A consent form accompanies this information sheet. If you agree to participate please read and sign the form.

How will I receive feedback?
Outcomes from the project will be summarised and given to you by the investigator if you would like to see them.

If you have any questions of concerns about this project, feel free to contact Dr Petra Bywood on (08) 7221 8544 or petra.bywood@flinders.edu.au.

*This research project has been approved by the Flinders University Social and Behavioural Research Ethics Committee.*

Thank you for taking the time to read this information sheet and we hope that you will accept our invitation to be involved.
Appendix B  Participant Consent Form

CONSENT FORM FOR PARTICIPATION IN RESEARCH:

The role of Medicare Locals in improving Primary Health Care integration

Dr Petra Bywood, Ms Rachel Katterl & Dr Tracy Cheffins

I ....................................................................................................................................................

being over the age of 18 years hereby consent to participate as requested in the interview for the research project on integration on health care.

1. I have read the information provided.

2. Details of procedures and any risks have been explained to my satisfaction.

3. I agree to audio recording of my information and participation.

4. I am aware that I should retain a copy of the Information Sheet and Consent Form for future reference.

5. I understand that:
   • I may not directly benefit from taking part in this research.
   • I am free to withdraw from the project at any time and am free to decline to answer particular questions.
   • While the information gained in this study will be published as explained, I will not be identified, and individual information will remain confidential.
   • I may ask that the recording/observation be stopped at any time, and that I may withdraw at any time from the session or the research without disadvantage.

Participant’s signature........................................Date........................

Researcher’s name.................................................................

Researcher’s signature........................................Date.......................
Appendix C    Interview Schedule

1. What do you understand to be the meaning of “integrated health care”?

2. What do you think integration means when we’re talking about Australian primary health care?

3. What are the key elements that support integrated health care?
   3.1 Which of these are present in your area?
   3.2 What is missing in your area?

4. What kind of activities is (or will) your Medicare Local implement that specifically focus on integration of care?

5. How does/will your Medicare Local link with the Local Hospital Networks in the region?

6. What are the methods by which this integration will be achieved in your region?

7. Can we please now discuss your views on the strengths, weaknesses, opportunities and threats facing Medicare Locals in addressing health care integration?
   7.1 Strengths
   7.2 Weaknesses
   7.3 Opportunities
   7.4 Threats

8. Can you suggest any supports that might facilitate your work in facilitating health service integration?