Health service integration: a case study in change management

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Abstract

Health service integration seems a logical and desirable strategy to improve both the efficiency and quality of service delivery. Failure of implementation is common but may not be inevitable. This paper reports on a case study involving structured interviews and focus groups within one health service which has attempted to integrate one area of its acute and community health services. Health service integration was regarded very positively by clinicians and administrators in this case study but the change management process utilised in its implementation was not, suggesting a need for greater planning and transparency.

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What is known about the topic?

While a lot has been written about the potential benefits of health service integration, in practice achieving successful integration among different health services has been difficult.

What does this paper add?

This paper outlines the problems experienced in one integration process, including lack of vision, inconsistent application of resources, and leadership styles that were perceived as too autocratic to achieve the desired integration.

What are the implications for practitioners?

Health service integration needs to be based on sound change management practices.

Health service integration

The benefits

The National Health Strategy[1] likened Australia's health care system to a jigsaw puzzle, comprising an overabundance of relatively autonomous health purchasers (Commonwealth and state governments, insurance companies and individuals) and service providers (public, private and non-profit organisations). The Council of Australian Governments[2] expressed similar sentiments, insisting that there is an urgent need for major systemic change in the way that services are organised and funded to enhance linkages between health and community services and improve the health system as a whole.

Health service integration (HSI) has been embraced by Australia's National Public Health Partnership,[3] and internationally by the World Health Organization as a way of ensuring an abundance of substantial improvements for health care clients, professionals and organisations.[4] HSI involves identifying different services provided for the same group of clients and managing them in a more coordinated manner. It attempts to cut across traditional provider-focused service management arrangements by focusing on the multiple needs of a defined group of service users. It is a strategy aimed firmly at ensuring that service provision is oriented towards clients not providers, and, as such, fits into the public sector approach implemented worldwide since the early 1980s.[5] HSI is believed to offer clients a more coordinated and timely approach to health care delivery, genuine opportunities to participate in their individual health care needs, and consistent information about health education issues and

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Health Service Integration barriers experienced by the National Demonstration Hospitals Program Phase 3 participants

Barrier type	Examples
Structure	Different management philosophies about models of care Lack of best practice guidelines Gaps in service delivery
Resources	Existing workloads and time commitments Sustainability of programs
Communication	Large numbers of stakeholders Difficulty in organising meetings and forums Lack of established links between organisations
Commitment	Lack of leadership Lack of support
Culture	Assumption that hospitals should take the lead and pay Lack of confidence in the competence of others Professional territories/rivalries
Profession	Lack of knowledge of others' roles and responsibilities Lack of understanding of the benefits of integration
Information technology	Lack of strategic direction at local and national levels Duplication of data collection
Legalities	Confidentiality of patient records across organisations Professional medico-legal issues
Consumer participation	Lack of acknowledgement of the value of consumer input Limited/unknown structures for consumer participation
Rural geographical location	Distance for service providers and clients to travel Lack of access to bulk billing (increased costs for clients) Some rural patients delaying medical treatment

Source: Adapted from Alexander A, 2001.[6]

knowledge about how to access appropriate health services.[6] It is anticipated that health professionals would benefit from greatly improved working relationships with other health care providers, an ability to actively reduce existing barriers between health services and an opportunity to help develop best practice guidelines and processes.[6] Finally, health organisations are expected to profit from HSI through reduced fiscal expenditure, more efficient use of limited resources, enhanced client outcomes and diminished client complaints.[6] HSI's potential to improve outcomes for clients, providers and funders seems to have all the makings of a major organisational change movement capable of attaining high levels of support from politicians, managers, health professionals, clients, stakeholders and economists.

Indeed, in 2004, clinicians still considered HSI to be their most important issue and asked the Australian Health Ministers' Advisory Council to consider the integration of community and hospital-based health services as their top priority.[7] In the same year, a meta-analysis of systematic reviews of Australia's health system concluded they unanimously called for the integration of health services so that patients and their carers could more easily steer a path through the complex network of services.[8] There seems no doubt that integration enjoys strong support at all levels.

The difficulties

Research so far, however, suggests that health services often experience serious implementation impediments. The WHO[4] has argued that integrating health services can be adversely affected

by an absence of political commitment and financial support and professional resistance to sustainable, client-centred health promotion practices. Alexander's[6] analysis of the third phase of Australia's National Demonstration Hospitals Program (NDHP) led to the development of the comprehensive list of localised HSI barriers summarised in the Box.

Australia's Centre for General Practice Integration Studies,[9] in a national study of GP and hospital integration, found that stakeholder involvement, leadership and change agent characteristics, time and flexibility, resources and incentives and communication were critical integration success factors. Leutz[10] devised five "laws of integration" from his extensive experiences with integrated health services in the United Kingdom and United States:

1. Seek to assist the neediest clients without disadvantaging any other groups;
2. Acknowledge that HSI is bound to cause additional financial expenses, which may not be offset by potential savings in the future;
3. Be mindful that HSI will inevitably burden already overworked employees with new philosophies, practices, routines, more than they may be willing (or able) to absorb;
4. Understand that some fundamental differences between services (including a lack of shared understanding about the purpose of integration) will ultimately prevent any attempts to integrate particular types of health services; and
5. Appreciate that an integrated service will essentially be shaped by those persons who already wield the most power in an organisation, unless specific steps are taken to actively involve clients, employees and other stakeholders throughout all stages of the developmental process.

The benefits of HSI may be difficult to realise, even if major integration barriers are minimised. Weil's meta-study of global integration initiatives[11] indicated that there was limited evidence that integration actually worked in either a financial or an operational sense. Over the last 30 years, many American studies have indicated that HSI generally resulted in either modest economic savings[12-14] or actual increases in health care costs[15,16] and insurance premiums.[17,18] European studies[19] also showed that integration produced negligible improvements in efficiency or profitability. Moreover, a Canadian study[20] indicated that HSI may not improve clinical effectiveness. An earlier study into integrated organisations indicated that declining service quality may be caused, in part, by particular leadership styles that delay problem-solving capabilities, deplete resources and sap management morale.[21]

According to the WHO any plan to integrate health services will not be sufficient unless it is viewed as a learning process by all relevant stakeholders. There is a need to critically examine integration initiatives in order to understand the forces that drive or restrain the integration process.[4]

The case study

The study critically examined one medium-sized urban Australian health district's attempt to integrate the community and acute services designed to serve a target population. The organisation was subject to both external and internal pressures for change. It had a defined population of service users and was facing strong internal resource constraints which made the increased flexibility implied by integration attractive.

The aim of the integration was to provide better access for the defined population through both clinical and organisational integration, as outlined by Shortell et al,[22] with one point of entry to the system. It would enable clinicians from both community and acute areas to share the medical record, reducing the capacity for error.[23] Referrals could be managed by providers, reducing the need for patients to have a comprehensive knowledge of the system through which they had to navigate. Most of all, it would enable families to be supported at the most vulnerable points in their journey by providers who had knowledge of the social and economic factors involved in the health of their patients rather than just the medical issues.

An interpretative case study was conducted to analyse the process used to integrate the state-funded primary and secondary health services. Before integration, primary health services staff reported through their team leaders to the Director of Community Health and Nursing Services. Hospital services staff reported through their line managers to senior medical and nursing directors. Staff of both of these services now report through their team leaders to a single Director, who is supported by a two-person Executive Committee, all of whom were previously part of the hospital (as opposed to the community service) management group.

The study was conducted approximately 3 years into the integration process to examine the organisation's success in managing the change process. One third of the staff participated in one of seven focus groups or seven semi-structured interviews. In total, 64 staff drawn from both the community and acute services were asked about their experience of the integration process and their perceptions of its successes and failures. Approximately forty percent of the sample were acute care staff with the remainder from community health. The Directors, both past and present, and the original project manager and project officer were interviewed. All interviews and focus group sessions were tape recorded with participant consent. Ethics approval was obtained from both the organisation and study institutions. A triangulated data collection approach was adopted using four qualitative data collection techniques: semi-structured interviews, focus groups, reflexive participant observation and a critical review of relevant organisational material. In addition, the results of the study were presented to the Executive Committee of the District, and several recommendations were discussed. The data generated from all of these encounters was subsequently examined using a three-stage thematic analysis procedure, comprising open, axial and selective coding techniques.

Findings

The organisation developed a new structure, changed some of the roles of staff and moved resources more easily across the whole service. But overall, it appeared that there were more shortfalls than successes. Several difficulties in the change management process occurred which ultimately resulted in negative consequences. These have been summarised and discussed under the broad categories of vision, leadership and structure, resources and culture.

Vision

Most models of organisational change stress the importance of formal and informal philosophies used to guide the strategic direction of the organisation.[24,25] The findings suggested that this organisation was not working towards a cohesive vision as there seemed to be lack of agreement on what integration meant in practice. The service's philosophical objective of better client service through HSI may have been impeded by an underlying focus on increasing centralised control. Many participants openly acknowledged this incongruence between explicit and implicit service goals. For instance, one participant stated:

> I think it was to do with the cultural differences in what integration was. Community Health Services work in an integrated way with everybody, going back 30 years. So integration is about people working together for a common purpose … as a collaborative way of working, not an amalgamated service or one centred on ownership. I think that they [the Executive] honestly believed that they had been given a Christmas parcel that was now theirs to do with what they wanted. They only worked from an ownership point of view in that these teams [from Community Health Services] now belonged to the Hospital and they would tell them how to work. It was as if they had signed a contract and from that date [Community Health] was theirs.

Some participants perceived a distinction between "clinical integration" (where services work together to improve client services) and "organisational integration" (where services are amalgamated to centralise control) and felt that more emphasis was being placed on organisational integration at the expense of clinical integration.

Leadership and structure

Leadership refers to the way that the service is governed by its most senior employees. Successful change management requires people who have the skills to address the human factors involved in change.[26]

Several participants stated that executives seemed unwilling to share power with employees in order to enhance service functionality. A number of participants felt that executives dismissed the value that the community health employees added to the integrated model, which caused strong feelings of powerlessness, dissatisfaction and alienation. These participants felt that the executives lacked understanding of the primary health care paradigm, which resulted in their perception of community health staff roles as not as important as acute ones. Many participants stated that community health needed greater representation at the leadership level to ensure that the primary health care approach was viewed as a valid professional paradigm within the integrated service. This point concurs with Leutz's fourth rule of integration, viz. "You can't integrate a square peg and a round hole."[10] (p. 93).

Several participants also felt that one of the most serious problems with the service was the perceived dictatorial, top-down approach. A survey conducted by the organisation just before this study indicated that only 7% of employees felt that they were able to contribute to executive decisions. Some participants thought that there was no collaboration with staff, that everything was generally on a need-to-know basis, and that team leaders were not given access to important documents, including evaluation reports. Others contended that the leadership styles had encouraged an "us and them" mentality that had resulted in exclusion-based decision making. Most participants advocated for a more inclusive, bottom-up-based leadership style. It appeared from the data that leaders may not have adopted an organisational development approach, using the skills of education and communication, participation and involvement, and facilitation and support, in leading change.[26]

Structure refers to the way that the organisation fulfils its day-to-day functions. Structural factors have been acknowledged as important success factors in the HSI literature. Alexander[6] noted eleven strategic/structural barriers including boundaries or authority and delegation, gaps in service delivery, and internal fragmentation of services. Before integration there were three executives: the Assistant Director of Nursing, and two medical Directors. After integration, one of the original medical executives was appointed as the sole Director, while the Assistant Director of Nursing was away on secondment. Subsequently, the single executive was supported by an executive committee comprising the other two former directors of the service.

This modest alteration to the managerial structure was perceived by many participants to be an attempt to enable the executives to be seen to be doing something:

> I don't believe that it's made any difference whatsoever. Basically, the three of us still do business very much the same. But that person is the figurehead now.

The structure did not appear to support the formal philosophical objective of the service to achieve both clinical and organisational integration. The data suggested that the structure remained problematic for both executives and employees, causing confusion and stress through duplication in accountabilities, roles, responsibilities and reporting lines, and lack of executive community health representation.

Resources

Resources refers to financial or non-financial capital that is invested at any stage during the integration process. Extra funding was allocated and spent on visits to other integrated services, physical changes to the acute hospital which enabled relevant acute services to be located on the same floor, the temporary provision of a Project Manager then a Project Officer and additional administrative support. However, shortage in ongoing financial support caused heated dispute as to where financial resources should be

utilised within the service. Some participants were keen to alleviate hospital costs through shifting funds from community to acute care. One participant suggested:

> There is a very strong concern that we will alienate community health by shifting money from community to acute. Whereas, in a truly integrated service you'd shift the funds wherever it's needed.

The analysis of internal documentation suggested that some movement of funds from community to acute services had occurred. In addition, several participants stated that financial restrictions had resulted in nursing staff being used as a general labour pool for other areas of the hospital. They said that this had led on occasion to their own clients being attended to by nursing staff from other areas of the hospital, who did not have the training to deal with the specific needs of the target population. They felt that having the wrong people filling these positions could result in errors and omissions, which could ultimately lead to additional service expenditure and increased risk of litigation: "When you catch a plane you don't expect a bus driver to be flying it."

It seems that participants' perceptions of resource shortages were not limited to financial areas. Lack of time was consistently cited as a major problem throughout the development process. Participants thought that the change process was too sudden and that the project officer's ability to consult with staff and consolidate the integration was hindered by the short timeframe. Shortage of time often appeared to participants to be used as an excuse to ignore service problems. One participant stated that that the change process was:

> . . . the most confused process I have been through in my entire life. It was just an ongoing whinge about issues with no solutions. They just kept on talking and talking and waiting for issues to go away.

The change process was described by a manager as:

> So what we are doing I guess is trying to get people to appreciate that health is actually across the continuum. It's wellness and sickness and promotion and prevention, as well as healing and treatment . . . better relationships between the business units, and that only develops over time . . . Look what happens when you take a diverse group and throw them in a room together. It'll all be hunky dory for a little while and then it will all start to come out. So we're going through that in a more protracted way I suppose. But we are now at that stage where people have all had their heads banged together and realised that this isn't going to go away, and they're all going to have to live with each other in a better way.

The perceived inability to prepare for a new integrated health service delivery model left this participant feeling frustrated at the prospect of having to lead a major change process by essentially "winging it". Participants suggested that time-related problems should be rectified by using a more incremental change process and allowing a longer period of time to consolidate changes. They felt that communication and ongoing feedback loops should be a priority. More sharing of information about integrated health service models and experiences could help.

On a similar note, many participants were concerned about an absence of information and training pertaining to the organisation's integrated service model. One group of participants said that the single biggest hindering factor was the lack of orientation for new staff about the model. Some participants also felt that there was not enough education or understanding of the different approaches taken by acute and community staff and that this was causing confusion among employees and could potentially lead to future organisational hostilities. They suggested that employees should work together to create a suitable orientation for new staff (backdated to include existing staff), which was specific to the new business unit rather than to the acute hospital. They felt that this could help employees gain a better understanding of how the integrated model

works in practice and enable more staff members to get to know each other. There was a general consensus in this focus group that this would solve a lot of problems.

Culture

Culture refers to the explicit and implicit customs, norms and rules of an organisation. The organisation encountered problems concerning the perceived clashing of two organisational cultures. Acute and community health care were seen to have very different organisational cultures which did not easily mesh. Some participants said that the cultural differences were exacerbated by executives' "lack of recognition of the value of community health services" and their perceived desire to own and control the integrated health service. Other participants maintained that the differences were "not unique to this organisation, it's unique to the whole of health". Of those that believed the latter, some participants implied that these cultural differences were mainly due to simple things, while others insisted that they were caused by fundamental differences between acute care's biomedical paradigm and community care's primary health care approach.

Participants explained that they found the integration process "very traumatic" and "confusing", and stated that they had often felt "angry", "annoyed", "powerless", "frustrated" and "lacking in motivation" as a direct result of the process of integration. A number of people believed that the service should minimise these negative consequences by altering its leadership structure to provide balanced strategic direction to the service, recognising the qualities that both acute and community cultures bring to an integrated service model.

Discussion

Without adequate measures of health outcomes or patient satisfaction with the service, it is difficult to objectively assess whether this organisation's integration was successful. Canvassing the views of consumers was outside the scope of this project. It is clear from the data gathered from managers and staff that the service integration was seen as largely unsuccessful. Three years after the process was first initiated, divisions and conflict and lack of knowledge seemed to be continuing, and the implementation was perceived as having largely reached a plateau which few considered acceptable. Little other than the organisational structure was found to have changed.

Health service integration requires an explicit change management focus which this organisation did not seem to have adequately planned or resourced. The cultural and operational divide between acute and primary care is a well known characteristic of the Australian health care industry. It is clear from this study that leadership structure and practice is critical. The intensity of health care provides temptation to continue business as usual — who the leaders are and the decisions they make must be seen to be based on a commitment to the changed model of service delivery.

Community health services were predictably perceived as losing out to the more pressing demands of acute services. Health service integration should be about leaving the sector approach behind, but too often the dominance of the acute sector is difficult to overcome. Appropriate use of organisational resources may overcome the sector approach. If an integrated service model is to be achieved, the budget allocation process must be transparent and clearly aligned with service objectives.

The other important resource highlighted by this study is staff skills and knowledge. Lack of knowledge of integrated service models or of the roles of primary and acute carers requires continuing training and development. Achieving an integrated service without this shared knowledge may be impossible. Investment in knowledge acquisition by both managers and staff is critical.

It is suggested that the leadership style of the executive was inappropriate for the successful implementation of change. There appeared to be little planning, education and communication, involvement and participation, transparency of evaluation and willingness to admit mistakes. The research on health service integration demon-

strates convincingly that HSI is difficult, costly and with mixed benefits. Research on managing change points to the importance of "confronting the brutal facts"[25] and reflecting upon the process of change management[27] rather than ploughing on without regard for either reality or reflexivity. All of these factors, but especially trust and transparency, are critical for the success of any change process.[16,24]

Conclusion

This study suggested the need for a cohesive vision of the outcome the organisation wants to achieve from the change process. People resist change for many reasons[26] and leaders need to be able to articulate the vision. Staff roles need to be directly linked to the vision to minimise confusion.

In achieving the vision, leaders need to foster participation and involvement through developing trust. Being transparent about difficulties and failures is part of the trust-building process. Resources need to be allocated consistent with the vision. Leutz's[10] second law of integration is perhaps the most important for any change process: it costs before it pays. Leaders need to employ a rigorous project management approach to implementing change which clearly identifies the costs and risks, as well as the benefits.

Health service integration has the potential to address issues of access, patient satisfaction, better use of the diminishing health labour force and more effective use of financial resources. This case study demonstrated that managers and clinicians agree on its desirability. The issue is implementation through effective change management, not just good intentions.

Competing interests

The authors declare that they have no competing interests.

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