ORIGINAL RESEARCH

Collaboration: developing integration in multi-purpose services in rural New South Wales, Australia

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A B S T R A C T

Introduction: The Multi-purpose Service (MPS) Program was introduced to rural Australia in 1991 as a solution to poor health outcomes in rural compared with metropolitan populations, difficulty in attracting healthcare staff and a lack of viability and range of health services in rural areas. The aim of this study was to describe the main concerns of participants involved in the development of multi-purpose services in rural New South Wales (NSW). This article is abstracted from a larger study and discusses the extent to which collaboration occurred within the new multi-purpose service.
Methods: A constructivist grounded theory methodology was used. Participants were from 13 multi-purpose services in rural NSW and 30 in-depth interviews were conducted with 6 community members, 11 managers and 13 staff members who had been involved in the process of developing a multi-purpose service.
Results: The main concern of all participants was their anticipation of risk. This anticipation of risk manifested itself in either trust or suspicion and explained their progression through a phase of collaborating. Participants who had trust in other stakeholders were more likely to embrace an integrated health service identity. Those participants, who were suspicious that they would lose status or power, maintained that the previous hospital services provided a better health service and described a coexistence of services within the multi-purpose service.

Conclusions: This study provided an insight into the perceptions of community members, staff members and managers involved in the process of developing a multi-purpose service. It revealed that the anticipation of risk was intrinsic to a process of changing from a traditional hospital service to collaborating in a new model of health care provided at a multi-purpose service.

Key words: Australia, collaboration, grounded theory, multi-purpose service, New South Wales.

Introduction

In rural Australia, the Multi-purpose Service (MPS) Program was introduced in 1991, as a solution to poor health outcomes in the rural population compared with their metropolitan counterparts, difficulty attracting healthcare staff and a lack of viability and range of health services in rural areas. Large variations in rural populations create major differences in needs and ability to sustain health services within individual communities[1-3]. For many small rural health services, becoming a multi-purpose service involves the merger of an existing aged care facility with a State-funded entity, such as a hospital[1]. In 2008, there were 117 multi-purpose services in operation in Australia with more under development. Of these, 47 (40%) were in New South Wales (NSW) where this study took place[4].

One major aim of the MPS Program was to improve the coordination of health and aged care services[1,3]. There is little literature available on multi-purpose services and their development. Existing literature indicates that combining health services on a single site leads to some improvement in access to other services, and when the multi-purpose services are able to implement a strategy of sharing staff, coordination of services also improves[3,5-8].

The aim of this study was to gain an understanding of the development of multi-purpose services in rural NSW from the perspectives of the people involved in the process. This article, part of a larger study, discusses the degree of collaboration involved in the resultant multi-purpose service.

Methods

Grounded theory is a research method of generating theoretical frameworks to uncover the meanings and interpretations which participants hold, rather than imposing a framework on them. This approach is useful where little previous research has been undertaken[9-12]. A grounded theory study commonly begins with a broad question and allows participants to identify their area of concern[13]. In this study, a constructivist perspective on grounded theory was taken. Constructivism takes a relativist stance, where differing viewpoints of participants are equally accepted as their reality[14,15].

Following ethics approval, a total of 30 participants were interviewed (6 community members, 11 managers and 13 staff members) who were involved in the development of 13 multi-purpose services across western NSW. All participants were given pseudonyms to protect their identity. The multi-purpose service sites in the study were all small rural communities because the multi-purpose service concept was primarily designed for small communities of up to 4000 people. All multi-purpose services had been commissioned between 2 and 7 years prior to the study taking place.

Data generation and analysis occurred concurrently in accordance with grounded theory. Initially open coding was undertaken with an 'open' frame of mind – without any prior assumptions about what may exist in the data[9]. Open coding involved a line-by-line analysis of each interview transcript which resulted in a large number of codes, with initial labels reflecting the reality for the participants. As data generation and analysis progressed, codes which were conceptually related were grouped forming categories. These categories

were labelled to identify concepts in the developing theory, but were often revised as more data were collected or further analysis took place.

As the clarity of categories improved, relationships between categories emerged from the data, through a process known as theoretical coding[9]. As analysis continued some categories were subsumed into other, larger categories which became the phases of the emerging basic social process. Categories were seen to be theoretically saturated when new data did not reveal any new categories, and at this point data collection ceased.

Results

The basic social process which emerged from the data was 'Developing an Integrated Rural Health Service'. It was conceptualised to have three phases: (i) driving change; (ii) engaging with stakeholders; and (iii) collaborating. The findings presented in this article are related to the final phase of *collaborating*.

The phase of collaborating conceptualised the end product: the multi-purpose service. The multi-purpose service combined pre-existing health services under a single organisational structure. Participants described differences in the degree of collaboration which occurred in the resultant multi-purpose services. Although some functioned as relatively well integrated health services, others were better described as coexisting within the same building. The core category of *anticipation of risk* which was identified throughout the basic social process appeared to be significant in determining the degree of collaboration which took place in the resultant multi-purpose service.

Anticipation of risk

In this study all participants anticipated the degree of risk involved in their interactions with each other during the development of a multi-purpose service. *Anticipation of risk* involved judging the motives of other people who were involved in developing the multi-purpose service and created *trust* or *suspicion*. Participants would judge each other's motives to determine the degree of collaboration they wished to engage in and would attempt to control the risks they perceived.

The dimensions of this phase existed as a continuum with two extremes: 'integration' (which resulted from *trust*) where participants embraced the change to a multi-purpose service and 'coexistence' (which resulted from *suspicion*) where participants accepted the change superficially, suspicious of the motive behind the development. Few, if any, multi-purpose services existed at either extreme of the continuum, but rather displayed a greater or lesser degree of collaboration. The sites which adopted a more integrated identity relinquished their acute care focus and developed multi-skilled staff. Sites where participants demonstrated greater *suspicion* of the multi-purpose service concept and of each other did not make a great deal of change, as they maintained their 'hospital' identity, coexisting with the additional services now being provided on site.

Integration

Participants stated that the desired outcome of the multi-purpose service was integration of services. Integration occurred when the pre-existing services which were now part of the multi-purpose service functioned as a single coordinated health service. Features of integration reported by participants included: shared staff among pre-existing services, staff meeting spontaneously to discuss service provision, and participants identifying with the new health service delivery model. Integration demonstrated a degree of *trust* in other service providers, particularly from those services that handed over their funding and ability to make decisions. Danielle stated:

> *We would really push…for integration. So people bump into one another in the corridors and have a common dining room and that sort of stuff.* (Danielle, Manager)

In some multi-purpose services integration was effective and enhanced the communication between staff members who would not otherwise have had a great deal of contact, as Jenny said:

> You'd go to morning tea in the same area and everything, so you'd get lots of inadvertent communication about patients and questions and answers between both sides, because you were just seeing each other; more so that convenience factor improved communication. (Jenny, Staff member)

Multi-purpose services could also function over more than one site and still manage to benefit from integration. Helen describes the improved services aged care residents received in one multi-purpose service:

> Oh, it's great; I don't have to worry about dragging residents up to the doctor's or up to the hospital to have bloods taken. [The community nurse] comes down and does all that. If I have a problem she comes down. Dressings we need assessed she'll come and do that, so whereas before it was just, because we have no hostel car, so before I had to drag residents to the doctor's and up to the hospital and all over the place…I [now] have access to a hospital car…The doctor comes here once a week. Oh, it's wonderful. (Helen, Manager)

Participants working in integrated sites described improved communication and improved services for their clients. For those participants who continued to be suspicious about *collaborating* with each other, coexistence was the outcome.

Coexistence

All pre-existing health services which became part of the multi-purpose service collaborated to a greater extent than they had done previously. Coexistence was conceptualised as being at the opposite end of the continuum to integration, requiring the least amount of collaboration between previously single health services. In some cases moving services on to the same site but not under the same management structure gave the impression of integration without a great deal of change and some participants were unable to identify any change (other than a new building) from their previous health service. Other services 'cashed out' to give the new multi-purpose service control of their funding. This often led to the devolution of a community committee and a subsequent loss of status for those members within their community. Ruth describes one situation where:

> The committee that used to run the HACC [Home and Community Care] service there still want to be involved. Still want to be able to manage it and have told the employee, 'If [area health service] aren't paying their bills, we want to know about it because we'll be writing letters'…They just can't grasp that cashing out means giving management to somebody else. (Ruth, Manager)

Despite a coexisting multi-purpose service not meeting the stated objective of becoming an integrated health service, increased collaboration had many benefits. As Bev described:

> The MPS did all their cooking…they subcontracted the meals for the hostel. And we had a gate that went through to the hostel, so if they wanted to come in to the doctor, [they] could just do that easily and we also had a multi-purpose room, which was sort of like a big shed, but it was a proper big meeting room that they could access from both sides. (Bev, Staff member)

Coexistence allowed pre-existing services to maintain their individual identities. One multi-purpose service had the ambulance service come on site, into the same building; however, they maintained their ability to separate themselves from other services. As Mary stated:

> We can make ourselves private by just shutting the door…Oh, we're very parochial [laughs]. The mindset of we don't tread on their toes, they don't tread on ours and it's because we have two distinct…employers and two distinct cultures. It is very important to respect the other…sometimes the best way to do that is to stay separate. Good fences build good neighbours [laughs]. (Mary, Manager)

While integration was identified as the more desirable option, Danielle pointed out the need to develop a unique solution which was suitable for each community. In some communities coexistence was a good outcome and helped avoid the feeling of participants in some organisations that they had been forced to participate in the development:

> …there's lots of scope for all sorts, different sorts of arrangements…You know the scope of the model is really up to us and the community and the other stakeholders to work out. It doesn't always have to be the standard sort of MPS takes over a low care facility. (Danielle, Manager)

Coexistence was generally at the 'suspicious' end of the dimension. In order to embrace the ideal of the multi-purpose service model stakeholders needed to *trust* each other sufficiently to integrate their organisational identity.

Discussion

Anticipation of risk was a core concern of participants. When participants described stakeholders as trusting one another, they were more likely to develop a new *integrated health service* than if they were described as being suspicious of one another, which was more likely to lead them to develop a *coexisting relationship*. In literature related to organisational mergers, integration is usually described as being most beneficial when long-term relationships are being formed[16-18]; however, the present study confirmed that low levels of integration (ie coexistence) could also be viewed in a positive light by participants[19].

When merging, coexistence does not entail as great a risk for pre-existing organisations as integration[20]. Parkhe indicates that small companies are more vulnerable when merging with larger companies which requires a greater degree of *trust* from members of the smaller company if integration is to occur[21]. It should not be overlooked that in some cases such *trust* can be misplaced, making a coexisting identity a better solution than an integrated one[21]. The size of the State-funded area health service which assumed management of the multi-purpose service was much larger than any community-managed services which were given the opportunity to 'come on board' with the proposed model of health service delivery. The term 'come on board' reflected the size of the area health service; interestingly, the term 'merger', which may have indicated a more equal partnership, was never used by participants in this study. Participants frequently described community-managed services as hesitant to hand over management and funding of 'their' services due to a lack of *trust* in the area health service. Many negotiated arrangements of coexistence which were beneficial to both services but did not require the same levels of *trust* to be invested.

Regardless of whether a participant was a manager, staff or community member, all participants revealed that their understanding of what a multi-purpose service entailed was poor. Clearly senior staff in health departments could improve strategies that lead to better understanding of processes for the management of change. This could improve *trust* in the end result, and lead to greater integration between services. Further research is also warranted to determine how trust can be measured prior to initiating projects, how the level of integration can be measured as a component of outcome evaluation and how much integration of services is desirable for a multi-purpose service to be effective.

Limitations

This study was exploratory because there has been little previous research undertaken into the development of multi-purpose services. Contextually this was an appropriate time for this study as further multi-purpose services are planned throughout Australia. Nevertheless there are several limitations to this study. First interviews are designed to provide an in-depth understanding of the perspectives of participants rather than sample large numbers. Second this study was limited to the development of multi-purpose services located in one area health service in NSW and this may limit the generalisability of these findings to other rural areas.

Conclusion

This study contributes to the literature related to multi-purpose services by acknowledging that integration is not the only successful outcome of a multi-purpose service development. It is possible to negotiate an improved health service which involves coexisting entities rather than a single integrated entity.

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