

Irish general practitioners' perspectives on integrated care and research priorities following health system reform: a mixed-methods study

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Abstract

Purpose – Integrated care aims to improve continuity and coordination across health services. However, the interface between general practice, community services and hospital care remains challenging in many health systems. This study gathered Irish general practitioners' (GPs) perspectives on the current state of integrated care following recent health system reforms and identified priority areas for future research.

Design/methodology/approach – A mixed-methods sequential explanatory study was conducted involving a cross-sectional survey and semi-structured interviews with GPs practising in the Republic of Ireland. The survey captured data on practice characteristics, perceptions of primary–secondary care integration and the research priorities in primary care. Additionally, semi-structured interviews qualitatively explored experiences and suggestions on improving integration.

Findings – Fifty-seven GPs from 17 counties responded, with a median practice size of 5,000 patients; 72% reported a mixed public–private patient population. Most practices were in urban or mixed settings (87%). Nearly all GPs (93%) identified improving primary–secondary care integration as a research priority, though the majority perceived current integration with hospitals and community services as poor. Top research priorities included chronic disease management, population health, mental health, acute care, healthcare access and clinical trials. Qualitative analysis highlighted barriers in digital information exchange, unclear responsibilities, limited time for collaboration and the need for population health–focussed, patient-centred integrated care models.

Originality/value – This study provides the first geographically diverse post-reform examination of Irish GPs' perspectives on integrated care and related research priorities following implementation of major health system



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reforms. The findings identify persistent implementation gaps between national policy objectives and frontline practice, while informing future integrated-care research and service development in Irish primary care.

Keywords Integrated care, General practice, Primary care, Research priorities

Paper type Research article

Introduction

Integrated care seeks to organise services around patient needs so that care is coordinated, continuous, and efficient across clinical, professional, organisational and sectoral boundaries (Valentijn *et al.*, 2013; Busetto, 2016). In this study, integrated care refers broadly to the coordination and continuity of care across general practice, community, and hospital services, including communication, shared decision-making, referral pathways, and collaborative clinical management (Eljiz *et al.*, 2025; Goodwin, 2016; Darker, 2014). As populations age and multimorbidity increases, fragmentation of care across primary, community and secondary services is associated with higher utilisation and costs, poor clinical outcomes, and patient experience, in contrast, well-implemented integrated care models can improve continuity, safety, and access (Busetto, 2016; O'Farrell *et al.*, 2021; OECD, 2023).

While improvements in processes and patient experience are consistent across studies, impacts on utilisation and cost vary by model design, organisational context, and implementation fidelity (Busetto *et al.*, 2016; Murtagh *et al.*, 2021). Consequently, there is increasing recognition that integrated care should be understood not only as a structural reform process, but also as a complex adaptive systems challenge. Complex systems theory conceptualises healthcare systems as dynamic networks of interacting professionals, organisations, technologies, policies, and patient populations, characterised by interdependence, feedback loops, and adaptation (Braithwaite *et al.*, 2018; Greenhalgh and Papoutsis, 2018). From this perspective, integration emerges through relationships, communication pathways, shared norms, and coordination across multiple system levels rather than through policy reform alone. Valentijn's Rainbow Model of Integrated Care further conceptualises integration across clinical, professional, organisational, functional, normative, and system domains, highlighting the importance of both structural and relational components of coordinated care (Valentijn *et al.*, 2013). These frameworks are particularly relevant in national health systems where implementation may vary substantially across regions and organisations.

In Ireland, Sláintecare sets out a ten-year reform programme to shift care to the community and to integrate primary, community, and acute services, with a focus on access, quality, and sustainability (Department of Health, 2017; Department of Health, 2023). In 2024, the Health Service Executive (HSE) implemented six Health Regions focussed on delivering population-based integrated care delivery (Department of Health, 2023; Health Service Executive, 2023). These reforms aim to improve access, continuity, and sustainability while reducing fragmentation between services.

General practice plays a central role in this model as it is the first point of contact for most care episodes and provides longitudinal, relationship-based care that spans conditions and settings, placing them at the interface between community and hospital services. This enables shared-care arrangements, rapid clinical advice, and local monitoring of access and outcomes (O'Farrell *et al.*, 2021; OECD, 2023). Within the Irish healthcare system, general practice refers specifically to GP-led community-based medical care, whereas primary care encompasses a broader multidisciplinary network that may include community nursing, physiotherapy, occupational therapy, social work, and other allied health services organised through primary care teams. In Ireland, many general practices also deliver care under the General Medical Services (GMS) scheme, a state-funded programme providing publicly funded primary care for eligible patients. As such, GPs are uniquely positioned to observe how integrated care reforms are experienced in frontline practice.

However, implementation of integrated care in Ireland continues to occur within a constrained and evolving healthcare environment characterised by sustained capacity, workforce and infrastructure pressures and ongoing digital fragmentation. General practice faces increasing pressures associated with population ageing, chronic disease prevalence, delayed care following the COVID-19 pandemic, and recruitment and retention difficulties (Irish Medical Council, 2024; Irish Medical Organisation, 2024; OECD, 2023). Limited interoperability between general practice and hospital information systems continues to restrict information sharing, care coordination, and measurement of integrated care (O'Farrell *et al.*, 2021; HSE, 2024; HIQA, 2024; OECD, 2025).

A previous study on integrated care research priorities among general practitioners (GPs) in the Ireland East region highlighted communication failures, unclear responsibilities, and weak liaison structures at the primary–secondary interface (Dunlea *et al.*, 2022). Since that study, several reforms and service developments have been introduced, including Chronic Disease Management programmes, digital-health initiatives, and structural reorganisation through regional health areas (HSE, 2020). These developments create a need to reassess GPs' perspectives on integrated care and to identify current research priorities informed by frontline experience.

This study therefore aimed to explore GPs' views on the current state of integrated care in the Republic of Ireland and to identify priority areas for future research and service development. Using a mixed-methods design (survey and interviews), we sought to inform an updated integrated care research agenda aligned with contemporary general practice experience.

Novelty

This study is the first to examine GPs' integrated care priorities at a national level in the context of ongoing Sláintecare reforms and after the introduction of HSE health regions. It updates and extends earlier regional work by identifying how recent policy and system changes have shifted frontline needs, revealing persistent and newly emerging integration gaps. The results inform a contemporary, evidence-based research agenda for Irish primary care.

Methods

Design and setting

We adopted a mixed-method sequential explanatory design, consisting of an anonymised cross-sectional questionnaire survey followed by in-depth semi-structured interviews. The quantitative phase aimed to describe GPs' perspectives on integrated care and research priorities, while the qualitative phase explored these findings in greater depth and contextual detail (Shorten and Smith, 2017). Integrating both methods enabled a broader understanding of how GPs experienced integrated care within the context of ongoing health-system reform.

Sampling, recruitment and data collection

A total of 2,606 GPs were listed in the Irish Medical Directory (2025) for the Republic of Ireland at the time of the study. A sampling frame of publicly available GP email addresses was compiled by the research team (NR, JB), yielding 764 email addresses, of which 615 were unique and predominantly practice-based. Survey invitations were distributed by email in June 2025, followed by a reminder two weeks later. Approximately 25% of emails were returned because of delivery failures or full inboxes, and some practice-based addresses may not have reached individual GPs directly. Consequently, an accurate response rate could not be calculated (Figure 1). Given the exploratory nature of the study and the challenges associated with surveying busy clinicians nationally, the study aimed to obtain geographically and professionally diverse perspectives rather than statistical representativeness.

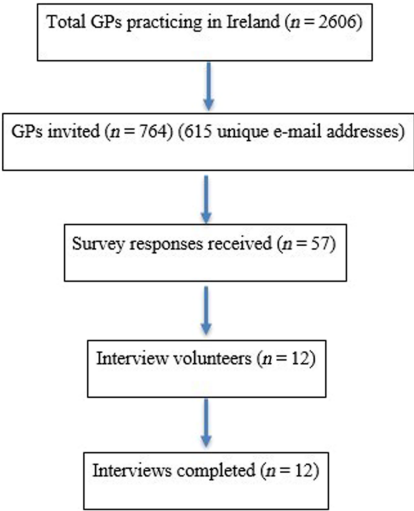


Figure 1. Study recruitment and participation

A total of 57 GPs completed the 18-item online questionnaire. Respondents represented practices across 17 of the 26 counties in the Republic of Ireland, including both urban and rural areas. While Dublin-based practices were somewhat more represented, the sample included a range of practice settings and population profiles. Accordingly, the study is best interpreted as a geographically diverse national study rather than a statistically representative national survey. At the end of the questionnaire, participants were invited to volunteer for follow-up interviews. Twelve GPs consented to participate, and all twelve interviews were conducted between June and August 2025. Interviews continued until sufficient thematic depth and informational richness had been achieved and no substantially new conceptual insights relevant to the study aims were emerging.

Survey instrument

The study instruments survey questionnaire ([Appendix 1](#)) and interview topic guide ([Appendix 2](#)) were adapted from those previously developed and piloted by Dunlea *et al.* study, which examined GP perspectives on integrated care within the Ireland East region ([Darker, 2014](#); [Dunlea et al., 2022](#)). The revised instruments retained the core structure and domains of the original study to facilitate comparison while reflecting the contemporary Irish healthcare context. The questionnaire contained 18 items covering 3 domains: (1) GP and practice characteristics (e.g. GP age, gender, practice setting, practice size, staffing, IT systems); (2) GPs’ views and perceptions on current integration, especially between primary, community and secondary care; and (3) research priorities relevant to integrated care and primary care development. For the present national study, terminology was updated to reflect recent health-system reforms, including Health Regions and chronic disease management programmes. The interview topic guide was also refined to explore issues relevant to post-Sláintecare implementation, including digital communication, accountability, coordination, population health and GP engagement in research. While the overall structure remained comparable to the earlier study, these revisions enabled exploration of integrated care within the current policy and organisational context.

The interview topic guide explored communication with hospital colleagues, referral processes, shared-care arrangements and required supports. Participants were not provided

with a strict operational definition of integrated care or population health. Instead, the study aimed to explore how GPs themselves understood and experienced these concepts within routine clinical practice and ongoing health-system reform. Additional prompts relating to communication pathways, referral processes, shared-care arrangements, and population health were used consistently across interviews where relevant to further explore participant responses. Qualitative interview recordings were transcribed verbatim and anonymised.

Data analysis

Quantitative data were analysed using descriptive statistical analysis in IBM SPSS Statistics version 29. Qualitative data were analysed using reflexive thematic analysis (Braun and Clarke, 2014) in NVivo 20. An iterative, data-driven approach was used to generate and refine codes and themes considering the study objectives. As per Braun and Clarke's reflexive approach, coding was conducted inductively and iteratively rather than using a predefined framework. The analysis was interpretive in orientation, focussing on how GPs constructed meaning around integration rather than on frequency-based coding or measurement. The data was coded by a primary reviewer MW followed by a secondary reviewer NR. Participant identifiers (e.g. GP1–GP12) were used to demonstrate representation across themes; quotations were selected for conceptual relevance rather than frequency.

Ethical approval

Ethical approval was granted by University College Dublin's Human Research Ethics Committee (Reference:LS-LR-25–048-Broughan-Cullen). All participants received a participant information leaflet outlining the study aims, confidentiality arrangements, and voluntary nature of participation. Informed consent was obtained electronically for survey participation and verbally and in writing prior to interviews.

Results

Respondent characteristics

Of the 57 respondents, 34 respondents (59.6%) were male and 23 (40.4%) were female. Thirty respondents (52.6%) were aged over 49 years, and 33 respondents (57.9%) had more than 16 years' experience as a GP. Overall, 27 (47.4%) practiced in mixed rural/urban settings. In terms of practice types, 41 (72.0%) of GPs described their patient population as "mixed" (neither predominantly private, nor General Medical Service (GMS)) (Table 1).

GP views on integration and current initiatives

Forty-two respondents (73.7%) disagreed or strongly disagreed that general practices and hospitals are well integrated while eleven respondents (19.3%) reported neutral views. This highlights that, despite national reform efforts, the primary–secondary care boundary remains the most problematic point in the patient pathway. Forty-four respondents (77.0%) disagreed or strongly disagreed that local voluntary and community services are well integrated, suggesting that broader social-care partnerships central to person-centred integrated care are under-developed. Thirty-one respondents (54.0%) disagreed or strongly disagreed that general practice and primary care teams (e.g. community nursing, therapists, etc.) are integrated, indicating persistent fragmentation even within community-based services (see Figure 2).

Research priorities identified by the GPs

Nearly all respondents ($n = 53$, 93.0%) agreed that "enhancing integration between primary and secondary care" is a priority area for future research. Additionally, 43 respondents (75.4%) expressed willingness to participate in future integrated care research initiatives. GPs identified several priority areas for future research relevant to general practice, many of which

Table 1. Participant demographics and practice characteristics (*N* = 57)

Characteristics	<i>n</i> (%)
<i>Gender</i>	
Male	34 (59.6)
Female	23 (40.4)
<i>Age</i>	
<34 years	<5*
35–49 years	25 (43.9)
>49 years	30 (52.6)
<i>Experience in Years</i>	
<5 years	9 (15.8)
6–10 years	9 (15.8)
11–15 years	6 (10.5)
16+ years	33 (57.9)
<i>Practice Location Setting</i>	
Urban	23 (40.4)
Rural	7 (12.3)
Mixed	27 (47.4)
<i>Practice Patient Population</i>	
Mixed	41 (72.0)
Private	8 (14.0)
GMS	8 (14.0)
<i>IT System Used</i>	
Socrates	34 (59.6%)
Health One	16 (28.1%)
Other (Helix, E-Clinical, GP Clinic)	7 (12.3%)
<i>Characteristics</i>	
<i>Number of patients</i>	<i>Median (Range)</i> 5000 (1,300–20,000)
<i>Number of GMS patients</i>	2,300 (700–10,000)
<i>Number of GPs</i>	5.0 (1.0–10.0)
<i>Number of general practice nurses (GPNs)</i>	1.5 (0.0–6.0)

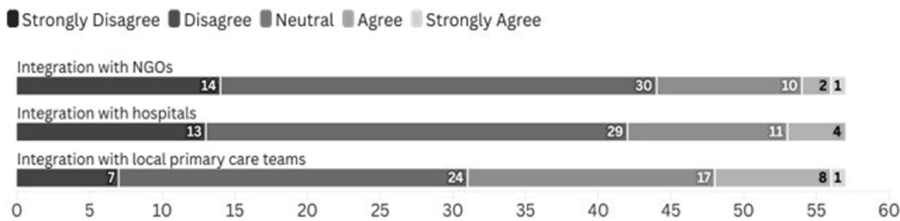


Figure 2. GPs' agreement on integration between general practices and other health services

have implications for integrated care development (Table 2). The highest-rated areas on the 5-point Likert scale were chronic care (mean 4.12), population health (4.04), mental health (4.04), healthcare access and integration (3.96), acute or unscheduled care (3.96) and clinical trials in general practice (3.96). Free-text responses further highlighted priorities relating to obesity and weight management, care-transition pathways, funding models, workforce sustainability, and evaluation of chronic disease management programmes. Respondents also emphasised the importance of research examining how integrated care initiatives could support both patient outcomes and health-system sustainability.

Table 2. GP research priorities in integrated care and general practice

Research priority	Likert mean (sd)
Chronic care	4.12 (0.8)
Mental health	4.04 (0.8)
Population health	4.04 (0.8)
Healthcare access and integration	3.96 (0.9)
Acute or Unscheduled care	3.96 (0.9)
Clinical trials	3.96 (1.2)
Knowledge transfer	3.89 (1.0)
Women's health	3.88 (0.9)
Paediatric health	3.75 (1.0)
Medical education	3.68 (1.0)

Qualitative findings

The qualitative analysis identified three key themes relating to GPs' experiences of integrated care and perspectives on future service and research priorities: (1) digital infrastructure and clinical accountability (2) enabling integrated care in practice, (3) population health and equity

Across themes, participants described integration as a complex systems issue shaped by communication pathways, organisational structures, feedback mechanisms, workforce capacity, and relationships across services.

1. Digital infrastructure and clinical accountability

Participants consistently described fragmented communication systems and unclear accountability structures as major barriers to integrated care. GPs frequently referred to missing feedback loops between hospital and community services, particularly around referrals, discharge planning, and test-result ownership (Dunlea *et al.*, 2022; Murtagh *et al.*, 2021).

One participant noted that HealthLink was valued because it provided confirmation that referrals had been received, illustrating how even simple feedback mechanisms could improve accountability, as explained "*HealthLink provides accountability-a receipt to confirm the referral was received and accepted*". However, many participants described current referral systems as incomplete and one-directional, often lacking acknowledgement, tracking, or timely updates.

a. Referrals, shared records and interoperability

Referral systems were often one-directional and lacked confirmation or progress updates, leaving GPs uncertain about whether referrals were received or actioned. This created inefficiencies, avoidable delays, and extra follow-up work.

The absence of a shared electronic health record was viewed as a fundamental barrier to integration. The data highlighted difficulty accessing hospital results, imaging, and clinical notes in real time by GPs, increasing duplication and risk. As one participant noted "*We need a single patient record so both general practice and hospital can access results and relevant notes. Without that, you are only moving the physical location of care, not actually integrating it.*"

b. Discharge information

Delays and omissions in discharge summaries, particularly regarding medication changes, pending results, and follow-up plans, undermined continuity of care and increased safety risks. Participants recommended standardised discharge templates and minimum content and timeliness requirements. A participant stated, "*Discharge letters can take months, and patients may be readmitted before we get them*".

c. *One-way task shifting to general practice and ownership of tests and results*

The data highlighted that hospitals often transferred tasks such as arranging follow-up tests or prescribing without consultation or resourcing, creating additional workload and gaps in care. This unstructured transfer created workload pressures and risked gaps in care. When hospital clinicians requested investigations to be ordered through general practice, GPs were often unsure who held responsibility for reviewing results or managing findings. This created confusion and potential medico-legal uncertainty. As one participant observed “*If everyone assumes someone else is responsible, it ends up being no one and the patient suffers*”.

d. *Safety risks and access to diagnostics*

Inconsistent handover and unclear task allocation contributed to conflicting medication instructions, omissions and delays, with some participants describing instances of avoidable harm. Limited access to community diagnostics such as echocardiography or spirometry made it difficult for GPs to manage chronic disease, often resulting in unnecessary hospital referrals. Together, these findings point to the need for shared-care protocols with explicit definitions of responsibility, escalation routes, and feedback loops between general practice and hospital services (see Table 3).

2. **Operational supports for integrated care and research participation**

This theme concerned the practical and organisational conditions required to support integrated care implementation and GP engagement in research. Participants repeatedly highlighted that integrated care requires dedicated infrastructure, protected time, and sustained communication between services rather than relying solely on professional goodwill. Participants also discussed the organisational conditions required to support GP engagement in integrated care research and service-development initiatives.

a. *Time constraints and protected time*

Coordination activities, such as case reviews and joint planning, were often displaced by clinical workload. Participants underscored that meaningful integration requires protected

Table 3. Additional excerpts on the theme “Digital infrastructure and clinical accountability”

Theme 1 - digital infrastructure and clinical accountability	
Referrals and tracking	“It would help to have a liaison officer for GPs and hospitals.” [GP1]
Unified record and interoperability	“We are still getting a lot of physical post. A unified record using the same system would let us share notes and discharge summaries easily.” [GP11]
Discharge information	“Discharge notes often focus on hospital care, not what needs to happen next — a quick call from a discharge nurse would help.” [GP12]
One-way task shifting to general practice and ownership of tests and results	“We’re often asked to take on tasks from secondary care.” [GP2] “If I’m asked to order tests or prescribe by hospital doctors, who’s ultimately responsible? Technically me, but I didn’t request it” [GP7]
Safety risks and medication errors	“Medications are being changed without communication, leading to errors and harm” [GP1]
Access to diagnostics	“Older patients need tests like ECHOs or spirometry, which we can’t easily access in general practice.” [GP5] “It can take 10 days just to get a chest x-ray; we need faster, one-stop facilities.” [GP11]

time explicitly funded within GP contracts. A participant stated *“In primary care, resources always mean time and there isn’t enough”*

b. Research participation

Most participants reported willingness by GPs to participate in research when communication pathways were clear and administrative burden was minimised. Dedicated research leads or coordinators were seen as essential to enabling participation.

c. Digital tools to support integrated care

GPs valued tools that could automate data extraction, support consent processes, and summarise information such as discharge letters. However, they emphasised that these tools must integrate with existing systems and maintain data governance standards. They also mentioned AI to summarise discharge letters, prioritise referrals and route results, contingent on integration with existing systems and governance.

d. Community-based integrated care models

Virtual specialist clinics and shared-care arrangements were seen as successful when advice was timely and follow-up responsibilities were clear. These models reduced unnecessary hospital attendance and supported continuity in general practice. Multidisciplinary hubs were effective when inclusion criteria, referral mechanisms, and feedback systems were well defined. Without clear processes, co-location alone failed to overcome siloed working. The data reported limited involvement of GPs in service design and decision-making, emphasising the need for consistent two-way communication and general practice representation in governance structures to ensure that integrated care models are practical and sustainable as explained by a participant *“GP voices aren’t always heard — we need more say in how integrated hubs are set up”* (see [Table 4](#)).

3. Population health and equity

Participants highlighted the importance of prevention, equity, and patient empowerment within integrated care development. Participants reported that integrated care strategies should extend beyond service coordination to address unmet need, prevention, and the social determinants of health.

a. Prevention and public health

Participants noted limited alignment between service provision and population needs, calling for preventive interventions to be embedded in everyday general practice rather than added reactively after hospital events. A GP stated, *“We need better research on what populations actually need”*.

Table 4. Additional excerpts on the theme “Operational supports for integrated care and research participation”

Theme 2 - operational supports for integrated care and research participation

Supporting roles in research	“There should be a named lead researcher we can contact directly.” [GP5]
Technology to support integrated care	“Digital tools for data and consent would help, as long as they don’t burden practices.” [GP8]
Bringing services into the community	“Virtual clinics work well — they keep patients in the community.” [GP1] “CDM is positive, but it still feels one-way; communication needs to be two-way- incorporating patients perspectives and feedback.” [GP2]
Primary care hubs	“People still work in silos; pressure and structure make it hard to collaborate fully.” [GP8]

b. *Underserved groups and social determinants*

Social disadvantage, housing instability, and substance use were described as major barriers to continuity and coordination. Integration strategies were seen as incomplete unless they also addressed social determinants of health. As one participant explained “*Social issues like housing and drug use affect continuity and wellbeing in deprived areas*”.

c. *Patient empowerment and self-management*

Participants advocated for models that strengthen patients’ capacity to manage chronic conditions through education and digital tools, within realistic limits of healthcare resources as explained by a GP “*patients should be supported to manage conditions themselves, .care should be a partnership, not just the traditional paternalistic model*”.

Discussion*Key findings and comparison with existing evidence*

Accountability failures. A major finding was the persistent ambiguity surrounding responsibility across primary and secondary care. GPs described routinely assuming responsibility for investigations, medication management, and follow-up tasks initiated in hospital settings without formal shared-care arrangements or adequate communication. Participants perceived this as creating both workload pressures and patient-safety risks, particularly for patients with multimorbidity and chronic disease. These findings are consistent with previous Irish work identifying unclear role boundaries and weak liaison structures at the primary–secondary care interface (Dunlea *et al.*, 2022), while also extending this literature by identifying the operational mechanisms through which fragmentation occurs. In particular, participants highlighted the absence of clearly defined escalation pathways, structured feedback mechanisms, and agreed governance arrangements. International evidence similarly demonstrates that integrated care models are most effective where accountability structures, shared-care protocols, and professional continuity are clearly established (Valentijn *et al.*, 2013; Busetto *et al.*, 2016). Within complex adaptive systems, unclear responsibility can generate cascading inefficiencies and safety risks across organisational boundaries, particularly where coordination depends heavily on informal professional relationships (Plesk and Wilson, 2001).

Information and communication failures. Fragmented digital infrastructure and poor information exchange emerged as another major barrier to integration. Participants described unreliable referral tracking, delayed discharge summaries, limited visibility of inpatient investigations, and continued dependence on paper-based communication despite ongoing digital-health reforms (Department of Health, 2024). These findings align with Irish and international evidence demonstrating that weak interoperability undermines continuity, coordination, and patient safety (Alderwick *et al.*, 2024; Li *et al.*, 2021). However, the present study provides additional insight into where communication failures occur operationally, particularly at transition points such as referral, admission, discharge, and follow-up.

Participants viewed interoperable shared records, real-time communication pathways, and automated tracking systems as essential components of effective integration. This reflects broader evidence that digital integration is not solely a technological issue, but also a governance and workflow issue requiring agreed standards, accountability structures, and shared clinical processes (True *et al.*, 2022; Tran *et al.*, 2024). Restricted access to community diagnostics, including echocardiography and spirometry, was also perceived as limiting GPs’ ability to manage chronic disease effectively within primary care, often resulting in avoidable hospital referrals. This suggests that integrated care depends not only on communication infrastructure but also on equitable access to diagnostic and specialist supports within community settings.

Capacity, workforce and organisational constraints. Participants consistently described limited time, staffing pressures, and insufficient operational supports as barriers to integrated care implementation. Activities central to integration, including multidisciplinary

coordination, case discussions, and participation in research or service development, were frequently displaced by routine clinical workload. These findings reflect broader international concerns regarding workforce sustainability in primary care and the implementation burden associated with integrated care reform (Shabbir *et al.*, 2025). While Sláintecare and the establishment of Health Regions aim to strengthen community-based care delivery, participants perceived a continuing gap between policy ambition and operational capacity at practice level.

Importantly, GPs emphasised that integration cannot rely solely on professional goodwill or informal collaboration. Instead, sustainable integration requires protected time, funded liaison structures, interoperable systems, and workflow-integrated supports. This aligns with systems-based approaches to healthcare reform, which emphasise that successful integration depends on aligning incentives, infrastructure, workforce capacity, and organisational culture rather than implementing isolated structural changes (Braithwaite *et al.*, 2018).

Governance and implementation challenges. The findings also point to broader governance and implementation challenges within the Irish healthcare system. Participants described inconsistent referral pathways, opaque triage processes, and limited GP involvement in service planning and decision-making. Many perceived integrated care reforms as insufficiently connected to frontline operational realities. These findings are particularly relevant within the context of Ireland's transition to regional health structures under Sláintecare (Schulmann *et al.*, 2024). While Health Regions aim to support population-based integrated care, participants suggested that integration remains unevenly operationalised across services and locations.

From a systems perspective, these findings highlight the importance of two-way communication, distributed leadership, and shared governance structures in enabling integration across organisational boundaries. Participants repeatedly emphasised the need for greater general practice involvement in regional planning, pathway development, and service governance to ensure that integrated care initiatives are both feasible and sustainable in practice consistent with existing literature (Barry *et al.*, 2021).

Compared with the earlier regional study by Dunlea *et al.* (2022), the present findings suggest that many of the previously identified barriers to integration, including communication failures, unclear accountability, and weak coordination structures, remain persistent despite ongoing reform initiatives. However, participants in the current study also placed greater emphasis on digital interoperability, operational governance, protected coordination time, and population-health approaches, reflecting evolving system priorities following Sláintecare implementation and the establishment of Health Regions.

Implications for policy, practice and research

This study demonstrates that integration across general practice, hospital services, and community care in Ireland remains limited despite substantial national reform efforts. While policy commitments to integrated care are well established, participants described continuing fragmentation in communication, accountability, workflow coordination, and operational capacity. The findings indicate that moving from strategic ambition to practical implementation requires interventions at practice, organisational, policy and research levels. Consistent with international evidence, successful integrated care depends not only on structural reform but also on clear governance arrangements, interoperable digital infrastructure, multidisciplinary collaboration and sustained investment in workforce capacity (Alderwick *et al.*, 2024; Matos *et al.*, 2025; van Rensburg *et al.*, 2016; Qian *et al.*, 2017).

Practice-level implications

At the practice level, the findings highlighted the need for clearer, more operational shared-care arrangements. Ambiguity around who is responsible for initiating and monitoring follow-up,

prescribing changes, and responding to outstanding investigations has been commonly reported. To strengthen integration, shared-care protocols must be standardised to define responsibilities for initiation, monitoring, escalation, and discharge in a way that aligns with everyday clinical workflows. Improving communication is equally essential. Real-time channels for resolving queries, timely access to inpatient results, and structured discharge information would help GPs manage patients more safely and efficiently. Importantly, these activities require time; integrated care will not be achievable without protected time for case discussions, coordination activities, and participation in clinical pathways. Technology also needs to support, rather than burden, general practice. Tools that assist with referral tracking, discharge summarisation, and results routing, preferably integrated into existing general practice systems could help to streamline care. AI-supported tools may play a role, but only where interoperable systems exist and only where they reduce administrative workload rather than add to it.

Organisation-level implications

At the organisational level, the new Health Regions have a direct opportunity to operationalise integration. The findings point to the need for standardised regional processes, including routine referral acknowledgement, timely discharge communication, and shared access to inpatient investigations. Health Regions should establish dedicated general practice liaison roles to support rapid problem-solving around referrals, results and follow-up responsibilities, reducing the one-way transfer of tasks to general practice. They can also strengthen multidisciplinary working by ensuring clear entry criteria, feedback loops and consistent pathways across primary, community and acute services. Practical examples include same-week community diagnostics, transparent rapid-access pathways, and agreed timelines for specialist advice. These recommendations align with international evidence emphasising that successful integrated care requires coordinated governance structures, collaborative leadership and clearly defined organisational processes ([van Rensburg et al., 2016](#)).

Policy-level implications

At the policy level, the system must shift from strategic ambitions to enforceable operational standards. National policy should set measurable expectations for communication flow across the referral, inpatient and discharge pathway, with compliance monitored through Health Region performance frameworks. Integrated care will not be possible without properly resourcing the frontline; therefore, protected time for coordination and integration activities must be explicitly funded within GP contracts, alongside support for liaison functions and digital interoperability. Addressing unresourced task shifting from hospitals to general practice is essential for safety, workload sustainability and effective implementation of shared care. These findings are consistent with international experience demonstrating that integrated care reforms are most successful when supported by sustained investment in workforce capacity, digital interoperability and organisational infrastructure ([Matos et al., 2025](#)).

Research implications

The findings suggest several priorities for future research relevant to integrated care and general practice. These included evaluating shared-care models, improving digital interoperability and communication between primary and secondary care, supporting population health approaches, strengthening healthcare access and assessing interventions that improve coordination, continuity of care and patient outcomes. Participants also highlighted the importance of developing interoperable data systems capable of supporting population health monitoring, practice-based audit and collaborative research within general practice. Building on these participant-identified priorities, our study also highlights methodological priorities for future research. Studies should evaluate the implementation of integrated care models across different regional and organisational contexts following

Sláintecare reform and examine whether interventions such as protected coordination time, shared-care protocols, expanded community diagnostics and interoperable digital systems improve continuity of care, workforce sustainability and patient outcomes. Future research should also include the perspectives of hospital clinicians, allied health professionals, community organisations and patients to provide a more comprehensive understanding of integrated care across the healthcare system.

Methodological considerations

The sample size was modest and may have been biased toward research-engaged GPs. In addition, because recruitment relied primarily on publicly available practice email addresses, it was not possible to calculate an accurate response rate. Although participants represented practices across 17 counties and diverse practice settings, the findings should therefore be interpreted as reflecting geographically diverse GP perspectives rather than statistically representative national estimates (Templeton *et al.*, 1997). The study also reflects the perspectives of GPs only. Hospital clinicians, community organisations, allied health professionals, and patients were not included, limiting triangulation across the wider integrated care system. As a cross-sectional study, the findings provide a snapshot of perspectives at a single time point and cannot assess changes over time or causal relationships. The mixed-methods sequential explanatory design enabled quantitative findings to be explored in greater depth through qualitative interviews, strengthening interpretive richness and contextual understanding. The study also builds directly on the earlier work of Dunlea *et al.* (2022), providing conceptual continuity while examining integrated care perspectives within a substantially changed post-reform context. The qualitative analysis followed a reflexive thematic approach supported by iterative coding, analytic memos, and an audit trail within NVivo, enhancing transparency and rigour.

Conclusion

This study suggests that many GPs across diverse Irish practice settings continue to experience substantial barriers to integrated care despite ongoing health-system reform. Participants described persistent fragmentation in communication, accountability, digital interoperability, and operational coordination between general practice, hospital services, and community care. The findings indicate that integrated care will require more than structural reorganisation alone. From the perspective of frontline general practice, effective integration depends on interoperable infrastructure, clear accountability arrangements, funded collaboration time, and stronger communication pathways across services. GPs prioritised chronic disease, mental health, urgent care, and healthcare access and coordination as key areas for future research relevant to integrated care development. Future work should focus on evaluating practical implementation strategies and include perspectives from patients, hospital clinicians, and community organisations to support more coordinated and sustainable healthcare reform in Ireland.

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(The Appendix follows overleaf)

Appendix 1 Semi structured interviews – topic guide

1. Integrated care

- (1) Do you consider enhancing links between primary and secondary care a priority for future development? Why or why not?
- (2) Can you suggest one specific initiative that could improve integration between primary and secondary care?
- (3) How do you think the following areas could strengthen GP-hospital links?
 - Communication
 - Coordination, collaboration, and cooperation
 - Responsibility and accountability
 - A population health approach

2. Research priorities and enablers

- (4) What do you consider the key research priorities in integrated care?
- (5) Would you be interested in collaborating on future research in this area?
- (6) What support or resources would help your practice engage in research on integrated care? On research in general?
- (7) Beyond integrated care, what do you think should be the priority research themes in General Practice?

3. Population health management

- (8) What are your thoughts on Population Health?
- (9) Do you have any other feedback or comments to add on integrated care?

Appendix 2 Survey questionnaire

1. Age
 - < 34
 - 35–49
 - > 49
 2. Gender
 - Man
 - Woman
 - Non-binary
 - Prefer not to say
 - Other: _____
 3. County of practice
-
4. Type of practice
 - Mixed

- Rural
 - Urban
 - Other: _____
5. Type of practice
- Mostly GMS
 - Mixed
 - Mostly Private
6. Approximately how many patients are registered with your practice?
- _____
7. Approximately how many GMS patients are registered with your practice?
- _____
8. Approximately how many doctors currently work in your practice?
- _____
9. Approximately how many full time equivalent doctors currently work in your practice?
- _____
10. Approximately how many nurses currently work in your practice?
- _____
11. Approximately how many full time equivalent nurses currently work in your practice?
- _____
12. How long have you been working as a GP?
- < 5 years
 - 6–10 years
 - 11–15 years
 - 16+ years
13. What IT system does your practice currently use?
- GP Clinical
 - Health One
 - Helix Practice Manager
 - Socrates
 - Other: _____
14. Is enhancing integration between primary and secondary care a priority area for future research?
- Yes
 - No
15. Are you interested in being involved in research that aims to enhance links between GP and hospital care?
- Yes
 - No

16. For these statements, please rate from 1 to 5, where 1 = strongly disagree and 5 = strongly agree
 - General practices and local hospitals are well integrated
 - General practices and local primary care teams are well integrated
 - General practices and local NGOs involved in health and social care delivery are well integrated
17. Lastly, we want to know how important these areas are for future research. Please score from 1 (least important) to 5 (very important)
 - Acute/unscheduled care
 - Chronic care
 - Clinical trials
 - Healthcare access and integration
 - Knowledge transfer
 - Medical Education
 - Mental Health
 - Paediatric Health
 - Population Health
 - Women's health
18. Any other important areas for research that you consider apart from the areas mentioned above. Please specify

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