Collaborative relationships in general practice projects

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Abstract

This article reports on a national study of collaborative relationships between general practitioners and other health care providers in 20 Division of General Practice projects. It argues that health care organisations will need to collaborate with others in the future and that much can be learnt from the literature on collaborative networks in business and community organisations. Successful collaborations between general practitioners and others were found to be consistent with a model of collaboration in 'under-organised domains', where pre-existing links between organisations are weak. Lessons are identified from the study to assist future collaborative ventures involving general practitioners.

Background

'Collaboration' has become a central tenet of new directions in health care provision. In Britain, the White Paper on health care reform argues strongly for collaboration and the formation of partnerships at a local level. National Health Service bodies are to have a 'new statutory duty of partnership' to work with local government, primary care providers and others for the common good (National Health Service 1997). In Australia, the General Practice Strategy Review argues that collaboration between general practitioners, consumers and other organisations is required to enable the seamless delivery of health care (Commonwealth Department of Health and Family Services 1998, p iv).

Care of patients/clients with multiple needs within a complex service system requires collaboration between the various providers of care. ('Patient/client' is used throughout this article to accommodate the different ways health care professionals refer to the people for whom they care.) This is recognised at a general practice policy level, and Divisions of General Practice are viewed as the

framework through which the collaborative interactions will occur (Commonwealth Department of Health and Family Services 1998, p 53). Health care providers increasingly perceive the need to link with others to provide what they cannot provide alone (Walker, Adam & Lewis 1997).

The establishment of Divisions of General Practice during the early 1990s provided a corporate framework within which it would be possible to explore new ways of linking a number of independent general practitioners in a geographic area to each other, and to other health care providers. Furthermore, divisions had a mandate designed 'to improve health outcomes for patients by encouraging general practitioners to work together and link with other health professionals to upgrade the quality of health service delivery at the local level' (Commonwealth Department of Health and Family Services 1996, p 206).

The study reported in this article was undertaken in 1996. It was based on 20 projects undertaken through the Divisions of General Practice project program, and which involved elements of collaborative activity between general practitioners and other organisations. The other organisations were most commonly hospitals, community health services, mental health services and schools. The study illuminated a number of issues important for organisations wanting to work in collaboration with general practitioners.

Collaboration is an important idea across most industry and service sectors. Since the beginning of the 1980s, a substantial literature has developed on collaborative relationships in business, and the public sector. This literature has been reviewed to identify lessons that are useful for understanding collaboration in the context of general practice.

What is collaboration?

From a three-year study of business partnerships, many of which involved two or more countries and cultures, Kanter (1994, p 105) concluded that:

> *Active collaboration takes place when companies develop mechanisms – structures, processes and skills – for bridging organisational and inter-personal differences and achieving real value from the partnership.*

In order to successfully collaborate, general practitioners and other health care providers need to develop appropriate structures, processes and skills.

Kanter argues that there are eight features that characterise the best collaborative business relationships (Table 1).

Table 1: Features of effective collaborative relationships

Feature	Description
Individual excellence	Partners are good in their field and have something positive to add to the relationship.
Importance	The partners have long-term goals to achieve and the partnership is important in getting there. Partners want to make the relationship work.
Interdependence	The resources of the partners are complementary. They cannot achieve alone what can be accomplished together.
Investment	Commitment is demonstrated through the application of resources (time, equipment, money, facilities) to the relationship.
Information	Partners share information that will help the relationship work.
Integration	Linkages develop between people at multiple levels in large organisations. Shared ways of operating are developed so that work can be accomplished smoothly. Partners learn from and teach each other.
Institutionalisation	The relationship is formalised and responsibilities and decision-making processes are spelt out. It involves additional people to those who started the relationship.
Integrity	The partners behave towards each other in ways that enhance trust. They do not undermine each other or abuse information they gain.

Source: Kanter 1994, p 100.

Alexander (1995, p 6) argues that when the interactive process of collaboration is successful, the outcome can be coordinated action in regard to particular matters. In other words, successful collaboration can support integration of health care services and assist with the development of a seamless system of care. It should not be assumed that collaborative intentions and actions on the part of health care providers are sufficient to provide a seamless health care system. Many other issues of management and finance also have an effect. Collaboration is, nevertheless, a necessary element.

Gray (1989) outlines a model of collaborative activity development (Table 2). Her model was designed to help understand collaborative activity between a number of stakeholders in 'under-organised systems' in which 'domain level' issues need to be addressed, but which no single individual or organisation can successfully deal with alone. Under-organised systems occur when the networks of relationships between organisations are poorly developed. A 'domain' is the set of individuals or organisations joined to each other by shared concern for a particular problem (Gray 1985, p 912).

Table 2: Stages of collaboration development

Phase 1 Problem setting	Phase 1 Direction setting	Phase 3 Implementing
• identification of stakeholders	• establishment of ground rules	• relationship with constituencies
• commitment to collaborate	• agenda setting	• external support
• shared definition of the problem	• organisation of sub-groups	• consolidation of appropriate structures
• establishment of stakeholder legitimacy	• joint information search	• monitoring the agreement and ensuring compliance
• establishment of convener role	• exploration of options	
• identification of resources	• agreement and decision-making	

Source: Gray 1989.

Gray's model of collaboration requires the organisations and people who might contribute to the solution of problems to be identified and engaged in the process of finding joint solutions. She conceives of collaborative activity as taking place in stages, each of which requires the performance of particular tasks and the development of particular processes and structures.

In Gray's model, the primary basis of the collaborative relationship is stakeholder interest in a problem. Other models focus on reputation and prior relationship as the primary basis of the collaboration. While they may have some relevance for choice of stakeholders, the key element is who has an interest in this issue, or in the care of these patients/clients, and who has the capacity to contribute to solutions?

Gray's model shifts the partnerships beyond the territory where personal links and relationships are strong (the personal networks, which for general practitioners are primarily with medical colleagues) into arenas where personal links and relationships are weak or non-existent, and where interests may appear to be in conflict or competition.

How is collaboration useful?

The research literature from business, public services and the health sector describes common reasons why organisations choose to collaborate. Oliver (1990) argues that there are six contingencies explaining why organisations establish inter-organisational linkages. They are necessity, asymmetry, reciprocity, efficiency, stability and legitimacy. Any one link with another organisation is likely to be based on more than one reason. Furthermore, there are a variety of forms the relationships might take.

Kanter (1994) argues that, in business, successful networks of alliances have three fundamental characteristics. Firstly, the partners gain benefits that are greater than a simple 'deal'. The relationships open up new options for the future and opportunities that were not originally foreseen. Secondly, the relationships involve collaboration, or working together to do things the partners could not do alone. It is more than simply exchanging resources, whether that be facilities or referral of patients/clients. Thirdly, the relationships are not controlled using formal organisational mechanisms, but are negotiated through interpersonal relationships.

The key reasons why health organisations might collaborate can usefully be described under four headings: information sharing, becoming stronger in a competitive world, learning and changing, and impacts on patient/client outcomes.

Information sharing

Sharing of information between partners and across organisational boundaries is frequently experienced as a positive aspect of a collaborative relationship. Powell (1990) argues that, where there is a need for efficient exchange of reliable information, network forms of organisation are particularly useful. Official, bureaucratic communications or market signals from external organisations are rarely the most useful information. Of far more value is the detailed and trustworthy information available from individuals who have provided reliable information in the past. Consequently, information exchanges form patterns that link individuals and organisations who know each other and who have previously related successfully (Larson 1992, p 93).

In highly competitive industries, where knowledge is an important resource, firms form 'networks of learning' through which access to information provides strategic advantages (Powell, Koput & Smith-Doerr 1996). On occasions, the linkages involve contractual arrangements but are more frequently based on less formal agreements or interpersonal relationships. Successful individuals and

organisations develop and nurture networks that include reliable links with key sources of information that are diverse, do not overlap very much and provide links to other, secondary sources of information (Burt 1992). An effective network of linkages for a general practitioner would be broad, including relationships with the range of professions and services required by the practice patient population. The number of contacts with any one profession or service category, however, should be small.

Because access to information is so important, organisations are often willing to forgo some independence and work at sustaining mutually beneficial relationships of interdependence in which reliable information is exchanged between partners (Powell, Koput & Smith-Doerr 1996, p 143). Wiewel and Hunter (1985) show that information sharing with existing organisations is very important for new organisations establishing a niche in a particular context. This is as important for general practitioners as for other organisations, particularly when an environment is competitive.

For health care providers, the flow of information is important in several areas. Information about patients/clients, services available from other providers, new approaches to care, additional resources, and new policies and procedures are all important to the provision of health care. For example, information about treatment their patients/clients have received in hospital or community health services is important to the general practitioner, while hospitals and community health services are dependent on useful and comprehensive information from general practitioners at referral.

Becoming stronger in a competitive world

In a competitive environment, organisations embedded in a network of functional relationships have strategic advantages over organisations without such relationships (Kilmann & Kilmann 1991). For some writers, the development of a network is a source of power that makes the environment a little more stable and controllable (Hakansson 1987, p 11):

> *By building up relationships the company gets control in different ways – through information, through friendship, and through technical and other bonds to counterparts which interlock the variable companies.*

The value of an organisation to a network is determined by what that organisation adds to the functioning and performance of the linked organisations (Kilmann & Kilmann 1991).

Network forms of organisation require participants to forgo some independence in order to develop interdependent relationships based on mutual benefit (Powell, Koput & Smith-Doerr 1996, p 143). It appears that if an organisation wishes to have linkages that pose minimal threat to its own power, then those linkages should be with organisations that are not themselves linked to each other. The benefit is that the partners cannot 'gang up' and exert influence, or divert resources, to each other (Burt 1992).

At a time when hospital patients are being discharged more quickly, a smooth transition to community care is needed if patients are to perceive the hospital's services as acceptable. Establishing collaborative relationships with general practitioners (along with other services) is critical. In times of economic restraint, the opportunities to reduce duplication of services through collaboration – pre-hospital admission assessment, for example – also increases the strength of organisations. At the same time the trend towards specialisation of general practitioners means they can benefit from strong links with other relevant service providers which enable them to offer a comprehensive range of information and services to patients/clients within a chosen area of specialty.

Learning and changing

Not all collaborative arrangements are successful or survive. Limerick and Cunnington (1993, p 86) observe, in regard to strategic alliances in business, that: 'While the modern industrial world is alive with examples of strategic alliances, it is also littered with dead ones.' Kanter (1994) likens the establishment of collaborative arrangements between organisations to the formation of a family. She argues that successful collaborations are founded on the development of successful relationships between people.

Involvement in collaborative ventures can change organisations. The development of collaborative relationships requires the partners to confront a range of issues. They negotiate territorial boundaries; consider and come to terms with points of view common in other organisations (Peck, Sheinberg & Akamatsu 1995); negotiate conflicts over issues such as resources and status (Peck, Sheinberg & Akamatsu 1995); deal with different styles of authority, decision-making and accountability (Kanter 1994); and confront issues of trust and information sharing (Kilmann & Kilmann 1991). In the end, each partner 'discovers it has changed internally as a result of its accommodation to the ongoing collaboration' (Kanter 1994, p 99). There are costs associated with internal change in organisations. However, successful collaborative arrangements deliver benefits that are valued more highly than the costs of change.

Hospitals, community health services and general practice are different forms of organisation with different ways of operating internally and relating to external organisations. Collaboration can offer opportunities for exposure to different ways of thinking, and can necessitate different ways of operating from which each can benefit.

With whom do organisations collaborate?

People in organisations choose their collaborators. Some of the reasons they form relationships with one another include strategic interdependence, position in a social structure and prior relationships.

Strategic interdependence

Strategic interdependence occurs when one organisation has resources or capacities that are desirable for, but not possessed by, another organisation. These resources and capacities include facilities, money, skills and access to markets. By combining forces and sharing strengths, both organisations can benefit. Clarification of the strategic interdependencies can form a basis for collaborative ventures. For health service providers, for example, relationships of strategic interdependence can arise where services offered by two or more providers can be combined to improve the capacity of each. One area where relationships are poorly developed, but interdependence is obvious, is between general practitioners and the allied health capacity of community health services (Commonwealth Department of Health and Family Services 1998).

Position in a social structure

When looking for partners with whom to form collaborative relationships, it is important to know who has the capacities for strategic interdependence *and* to know who is likely to be a reliable partner. Because collaborative relationships can pose risks for the partners, it is important to obtain information about potential partners' behaviour in earlier relationships. Through social networks, organisations 'learn about each other's existence and also about each other's needs, capabilities, and alliance requirements at a given time' (Gulati 1995, p 622), and about potential partners' performance in prior collaborations. Much of the information gained from social networks is reputational, based on other people's experience of the organisation and the judgement they choose to make. Once the significance of reputation becomes understood in a network, it becomes important for organisations to behave in ways that do not jeopardise their

reputation (Larson 1992). In this way the social network also becomes a mechanism for social control.

For reputable organisations, membership of social networks increases the likelihood that collaborative relationships will be formed for mutually advantageous purposes. In some respects this is a chicken and egg situation for general practitioners. Establishing networks takes time, and maintaining reputations takes care. If a general practitioner has a small network, limited primarily to other medical practitioners, it is difficult to find out who are reputable providers to whom patients may be referred for non-medical services. Identifying non-medical providers for specific patients/clients will take time if it is to be done at all. It is also likely that referral to the general practitioner, from other providers, will be limited. However, if a general practitioner invests time in establishing and maintaining a broad network, referring to non-medical providers is easy and quick, reputation is more likely to be sustained, and the general practitioner is more likely to receive referrals.

Prior relationships

When organisations have a direct and positive experience of working with each other, they are more likely to collaborate in the future. They are likely to know about each other's needs and capacities and to see opportunities for collaboration in the future, and are more likely to have reliable relationships upon which to build another partnership (Larson 1992; Gulati 1995). Podolny (1994) observed in the finance industry that, under conditions of environmental uncertainty, organisations were more likely to establish relationships with organisations with which they had previously worked. In Podolny's view, prior experience of working with another organisation is the 'first best' method of selecting future partners. The 'second best' method is by reference to status.

General practitioners who already have successful collaborative relationships with other health care providers are more likely to be invited to participate in joint ventures in the future. This is particularly relevant to the relationship between general practitioners and hospitals. Pirkis and Montalto (1995, p 1027), describing a survey of hospital administrators, noted that 61% of the administrators claimed that the most important influence on their decision to engage general practitioners was a history of prior involvement of general practitioners in the hospital.

Research methods

A national sample of projects was selected from projects funded through the Divisions of General Practice program. This was a qualitative study and its purpose was to provide insights into the structures and processes of collaboration. Therefore the process of project selection was purposive, and focused on identifying a group of projects which would provide breadth and depth of experience of collaborative efforts.

Twenty projects were selected from those funded during 1994 to reflect a range in type of project and geographic (urban/rural) distribution. Approximately half the projects were located in Victoria, and the others were in New South Wales, Western Australia and South Australia. It has been argued by general practitioners that collaboration was new in 1994 and that later projects would offer a more sophisticated set of relationships. The research team considered this criticism but concluded that informants needed to be able to reflect on the collaborative relationships over the duration of a project in order to capture change processes and to identify learning. The 1994 projects were the most recent which would permit this.

Seventy-six interviews were conducted between June and October 1996 with a total of 78 respondents engaged in 20 separate projects. Twenty-one interviews were with general practitioners. Other interviewees included division-based project officers, managers/coordinators of community health services and other agencies, nurses, allied health professionals, consumers, medical specialists, youth workers and health educators. Interviews were undertaken with informants from each partner in a project.

Interviews were recorded on audiotape, with confidentiality being guaranteed. Interviews were structured. They explored questions about the organisations and individuals involved in the project and how they came to be involved, the roles various groups and individuals took on as part of projects and the nature of agreements between them, how the project was managed, perceived consequences of working together and reflections on working together. The aim of the data analysis was to identify experiences of collaboration across projects within the framework of the literature and in a way which had meaning for the informants.

Tape-recorded interviews were transcribed. These were entered into NUD.IST, a qualitative data analysis piece of software, for text management. A broad set of coding categories were developed. They were collaborative activity, work done pre-submission for funding, links pre-project, key players and their roles, resources contributed, structures, communication, integration outcomes. These categories were used to code interviews in NUD.IST in order to create a structure

for the data. Data reports were then produced for each project in each of the coding categories. Discussion was developed from these reports.

The projects studied

Projects covered a wide range of health care topics: mental health (3), indigenous health (2), pre/post-acute care (2), youth health (2), aged care (2), palliative care (1), post-natal care (1), childhood asthma (1), sun safety (1), domestic violence (1), farm injuries (1), consumer issues (1), diabetes (1) and health of the homeless (1).

The primary collaborative content of projects has been classified and is summarised in Table 3. In a number of instances only a part of the total project involved collaboration with other players. This classification concerns the nature of the collaboration rather than the total project content.

Table 3: Collaborative content, by projects

Classification	a. Shared care (n = 7)	b. Service alliance (n = 7)	c. Planning and liaison (n = 3)	d. Advice re service provision (n = 3)
Topic	Mental health (3)	Indigenous health (1)	Youth health (1)	Diabetes (1)
	Pre/post-acute care (2)	Aged care (1)	Aged care (1)	Consumer issues (1)
	Palliative care (1)	Youth health (1)	Health of the homeless (1)	Indigenous health (1)
	Post-natal care (1)	Domestic violence (1)		
		Farm injuries (1)		
		Childhood asthma (1)		
		Sun safety (1)		

'Shared care' refers to collaboration where there is some form of link between health care providers in providing services to a particular patient/client. 'Service alliance' refers to collaboration built around the provision of complementary services or resources. This includes, for example, joint work on health education activities; an alliance of screening, follow-up treatment services and data

collection; or provision of a youth health service associated with promotion of the service and assisting general practitioners to gain access to young people. 'Planning and liaison' refers to collaboration where the primary focus is on liaison and/or joint involvement in service planning. 'Advice re service provision' refers to collaboration which was limited to the ongoing provision of advice by an organisation to a division project(s) or to the work of general practitioners.

Key findings

A model of collaboration

In the majority of the projects studied, pre-existing relationships between the players were weak or non-existent. This included hospital/general practitioner collaborations. Strong links were reported to have existed in the past between general practitioners and hospitals in the three projects where divisions/general practitioners and hospitals collaborated and where general practitioners previously had visiting rights. However, they had weakened in two cases through loss of visiting rights. In the instances where pre-existing relationships are weak or non-existent, Gray's model provides a useful framework for understanding collaboration.

In many cases partners were chosen because of their capacity to contribute to problem solutions. This is consistent with Gray's model of collaboration. Coordinating structures, such as committees, were established to bring the partners together. While the projects did not reflect all aspects of Gray's model, collaborations which were considered by the players to have been successful contained elements from each phase of her model.

Interdependence

Implicit in all notions of collaborative partnership is the recognition of interdependence. Kanter (1994) describes interdependence as complementarity of resources, or the capacity to achieve together what cannot be achieved alone. Gray (1985) considers the identification of areas of interdependence as one of the first tasks needing attention in the problem setting phase of collaboration formation.

This study revealed little evidence that the partners in the collaboration conceived of their relationships in terms of *inter*dependence. Commonly, relationships were considered in terms of one player's dependence on another rather than mutual gain. However, in some projects a picture of interdependence emerged from participants' description of the benefits they gained from the project.

In one general practitioner/hospital liaison project there were two areas where the hospital had significant gains to make from involvement with general practitioners. The first was the potential to reduce the cost of pre-admission assessment while maintaining service quality through training general practitioners to undertake pre-admission assessment. The second was to achieve a greater sharing of care between the hospital and general practitioners in the light of reduced length of stay. The potential gains for general practitioners included opportunities to provide increased service to patients (in the form of pre-admission assessment) and improved information about and ability to provide continuity of care for their patients.

Where players were aware of interdependence it tended to relate to a single objective, usually impact on patient/client outcomes. In practice, the success of collaborative relationships is contingent on mutual gain and varied benefits. Awareness of the potential gains, and the various forms these can take, often shapes the behaviour of the partners. Amongst people experienced in the art of collaboration, exploration of potential benefits is an important first step. If mutual benefits can be identified, they form a foundation for further action; if they cannot, the relationship does not progress further. As discussed earlier, the areas in which gains can be made include information sharing, competitive advantage, impacts on patient/client outcomes and the acquisition of new ways of operating in a changing environment.

Understanding interdependence is fundamental to successful collaboration. However, it is a concept unfamiliar to some health care providers. Discussion of what interdependence is, and is not, would be useful for any health organisation establishing a relationship.

Bringing the parties together and managing collaborative relationships

In many of the projects the knowledge of, skills in, and experience of, collaborative activity resided in organisations other than the Divisions of General Practice. Hospitals and community health services were able to take a leading role in initiating and developing the collaborative activity.

One of the key features of Gray's model is the identification of stakeholders within a domain where personal links and relationships are weak, or non-existent, and where interests may appear to be in conflict or in competition. Identification of a starting point for finding stakeholders under these circumstances requires some knowledge of the domain, usually the service system for which the problem or issue has relevance. A number of interviewees highlighted the difficulties for general practitioners in gaining an understanding of the service system and the

players within it, given the organisational constraints they face. These include the breadth of patient/client issues with which they deal, the amount of time focused on individual patient/client contact, and the lack of organisationally created opportunities for learning about a changing service system.

The experience uncovered in this study indicates that, within domains where personal links between divisions and others were weak or non-existent, it was often players other than general practitioners who identified the stakeholders and brought others into the collaborative effort once the process had begun.

In Gray's model, a collaborative effort needs a convener who has a vision of the potential, and the skills to manage the negotiations between the stakeholders. It was evident in the study that this was sometimes, but not often, a general practitioner. One general practitioner project manager observed that:

> *Most of them (general practitioners) are brought up to be terribly individualistic. So ... moving to a team approach is not necessarily easy and it doesn't work if doctors always want to be the head of the team ... Medicine trains you to do what you think is right. Yes to justify, but not to accept other people's points of view and incorporate that into your own practice model.*

The convener role also requires time. In cases where general practitioners did play this role, they were often in part-time practice or semi-retired.

The project officers who were not general practitioners were often crucial in developing and managing the processes of collaboration. This included managing the interface between general practitioners and other organisations in a way which educated general practitioners, and other practitioners, about better ways of dealing with the interface.

In collaborations involving organisations where Division of General Practice directors or other key general practitioners within divisions had links, they tended to play a central role in pulling the collaborating parties together, either alone or with others from within the organisations. In two of the collaborations involving a hospital, one or two general practitioners who had been involved in the hospital appeared to be instrumental, as did a division staff member who had previously worked in the hospital and one of the senior hospital staff who was also committed to the purpose of the collaboration. In another division/hospital collaboration the general practitioner project manager who had patients/clients in the hospital worked with the Director of Community Services to pull together the appropriate people. In two others, general practitioners approached psychiatrists who were directors of the mental health service.

Where non-medically focused organisations, or networks, became involved in collaborations, it tended to be people other than general practitioners who

brought the parties together. In most instances the main facilitators were managers/clinicians within other organisations who had personal networks outside general practice. Examples include the following.

• Two medical specialists involved in community service networks (related to the specialty) who saw ways general practitioners could assist in meeting needs identified within the service network which would benefit general practitioners. They brought the Division of General Practice and key players in the network together.

• The coordinator of a voluntary agency who identified the stakeholders relating to a particular issue and linked them in with a general practitioner.

Once employed, project officers played a significant role in bringing non-medical people into the collaborative activity. In a number of cases, individuals and organisations outside divisions did not become involved until after the project began. While in some instances personal networks appear to have played a role in bringing non-medical people in, structural or systemic knowledge about who plays what roles within the community appears to have also contributed.

As a group, general practitioners are not the health service providers most skilled at developing and managing collaborative activity. However, if others engage with them in appropriate ways, general practitioners can be active partners in joint projects.

Structure and process

A clear message from both the literature and the projects is that the partnership from the earliest, pre-planning stages needs to be explicit. Joint negotiation of priorities and definition of problems strengthens the collaborative effort and enhances the resources collaborating organisations are prepared to commit.

Implicit in Gray's model is a high level of face-to-face negotiation. This was identified by participants in the projects as one of the key features of success. It was a particularly important device for influencing relationships. Other communication devices were more useful for information transfer or regulation of relationships (for example, protocols). Formal structures for ongoing face-to-face communication and decision-making, once decisions had been made about the shape of the collaboration, were also perceived to be important. Structures which maximised informal face-to-face interaction (along with effective use of resources), such as co-location and sale of specialist staff time, were also seen to be useful.

Consistent with Larson's (1992) findings, written agreements were only seen to be important when they provided players with a clear understanding of what they had agreed to. The importance of documentation to accommodate changing personnel, both within Divisions of General Practice and collaborating organisations, was also stressed. However, for most participants who raised the issue, documentation needed to be supplemented with other processes which inducted new personnel into the collaborative activity.

Ovretveit (1993) refers to the need for structures and processes which foster commitment at multiple levels within organisations: at the strategic level, the operational level and the practitioner level. In many projects, collaboration only took place at one or two of those levels. Where all levels were involved, a sustained commitment appeared to be less difficult to achieve and fewer problems were identified.

Conclusions

Collaboration between general practitioners and other organisations was effectively mandated in the Divisions of General Practice project grants program. The projects included in this study were chosen because there was evidence that collaborative relationships had been established. Those relationships manifest many of the recurring themes found in the literature on collaboration between organisations: pre-existing networks were important in the establishment of collaborations; communication between people (especially face-to-face communication) was critical and regarded as more important than written agreements; individuals with the right skills, irrespective of their profession, were influential in the collaboration development; and capacity to contribute to problem solution was usually a criterion for membership.

The most useful model of collaboration to use in understanding these projects was that developed by Gray (1989) to understand how joint action can be used to solve apparently intractable problems impacting on many organisations. In her model there is a recognition that interdependence is important in motivating organisations to work together. Curiously, in the projects in this study there appeared to be a low level of awareness of mutuality in the relationships. Nevertheless, it is clear that over the life of the projects the partners achieved goals that were important to them and learned a great deal about ways of working with other organisations.

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