Health promoting hospitals: Gaining an understanding about collaboration

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Collaboration with others is integral to the way hospitals need to work if they are committed to integrating health promotion into policies and practices to improve the health of their “setting” and the broader community. This article reports on research that aimed (a) to identify the range of stakeholders a large metropolitan teaching hospital had collaborated with in undertaking health promotion work and how effective that relationship was, and (b) explore with these stakeholders how they had collaborated with the teaching hospital, and what had or had not worked well. Key findings were that the hospital had collaborated with at least 16 organisations. The effectiveness of these relationships was variable, with 55% (n=9) rating their relationship with the hospital as being “good to excellent” and 45% (n=7) as being “okay to unworkable”. Where collaboration worked well there was good interpersonal relationships and common goals were shared. In two instances more formal mechanisms were in place to support the collaboration. These mechanisms supported involvement of staff from different levels of the hospital and did not totally rely on cooperation between individuals to sustain the collaboration.Where there was decreased effectiveness in the collaborative relationships, differing attitudes and organisational and structural barriers posed the most significant barriers.

Key words: Collaboration, Health promoting hospitals

Since the Ottawa Charter for Health Promotion was published there has been an increased understanding about developing approaches to health promotion that tackle the broader social, economic and environmental determinants of health rather than continuing to focus on changing individual health-related behaviour (Gillies, 1998). There has been a focus by the World Health Organisation on advocating for “settings” to be more health promoting, where the principles of the Ottawa Charter (World Health Organisation [WHO], 1986) are applied to policies and practices of various settings, such as cities, schools, prisons, villages and marketplaces (Baum, 2002). Hospitals have been identified as important settings for health promotion, with many hospitals throughout Europe and Australia taking up the challenge of making an organisational commitment to become more health promoting (Johnson & Baum, 2001). There are emerging theories about health promoting hospitals, but more research is needed to fully understand all aspects of hospitals working towards becoming more health promoting to improve the health of the setting and the broader community.

As identified in the Ottawa Charter (WHO, 1986) and reaffirmed in the Jakarta Declaration (WHO, 1997), collaboration is considered to be an integral strategy for health promotion work and health care reform in many countries, including Australia (Richards & Gill 2002; Walker 2002). The purpose of collaboration in the area of health promotion is to strengthen infrastructure and establish coordinated action between organisations in the pursuit of improved health gain in the community (Walker). The Ottawa Charter (WHO, 1986) and the Jakarta Declaration (WHO, 1997) support the notion that collaboration strengthens the potential for interventions to succeed and that collaboration is fundamental to improve health. Collaboration within the health sector, as well as across sectors—including professional and lay boundaries and between public, private and non-government organisations—is integral to addressing the broader determinants of health in populations in a sustainable manner. Hence, collaboration is central to this broader understanding of health promotion work, where creating and maintaining health requires action from those people, organisations and sectors whose work and interests align with the various determinants of health. For hospitals that make a commitment to become more health promoting and improve the health of the communities they serve, collaboration becomes an integral way they go about doing their health promotion work.
Whereas the definitions of collaboration appear reasonably straightforward, it is well documented that collaboration is a complex phenomenon where the interpretation of its meaning is vague, or highly variable, and little is known about how it can work in practice (Henneman, Lee, & Cohen, 1995; Delaney, 1994). This is particularly so with regard to the collaborative health promotion work of hospitals, as no specific studies could be found that reported specifically on this issue. Most of the research about collaboration appears to have been focused on interagency collaboration, the purpose of which is for coordination of planning, care and service delivery, and resource maximisation.

Influence of individuals and organisations

Many commentators stress that both individuals and organisations influence the development and maintenance of collaborative relationships between organisations. For example, Walker (2000) states that the focus on both organisational and individual factors is important because collaborative activity is undertaken by individuals within an organisational environment. Harris, Wise, Hawe, Finlay, and Nutbeam (1995) state that individuals make a collaboration work, and stress that unless the individuals who are engaged in collaboration have the active support of their organisation it is unlikely that sustainable change will be possible. Conversely, an organisation that is highly motivated to work with others will succeed only if it ensures that the people taking the lead in managing the process have the appropriate knowledge, skills and resources to do so. Harris et al. indicate that collaboration must involve not only action between organisations, organisations and individuals, but also action within the organisations. Walker suggests that it is important that the people negotiating as part of the collaboration need to be individuals who have some capacity to make decisions and make changes within their own organisation. Harris et al. suggest that there are other options to this, where a senior decision-maker or opinion leader within an organisation acts as a “program champion” to establish the case for action so that resources can be secured, and to bring together the commitment of an individual and the power of the organisation in a potent way.

Kanter (1994) emphasises that collaboration is achieved when organisations develop mechanisms (structures, processes, and skills) for bridging organisational and interpersonal differences. However, individuals and organisations work against a backdrop of resources and practices that shape and constrain what may be achieved (Phillips, Lawrence, & Hardy, 2000). Delaney (1994) argues that collaboration is not just a technical matter to be resolved by the right administrative arrangement. It is a political matter of bargaining and negotiation.

Barriers to effective collaboration

Richards and Gill (2000) state that, for a variety of reasons, collaboration is inherently more difficult than “go-it-alone” strategies. The reasons include differences between stakeholders and the professions in terms of: the theoretical basis of their approach to the work; organisational structure, function and culture; professional perceptions of the purposes of the services, need and risk; approaches to outcomes, effectiveness and accountability; and definitions of the groups that constitute vulnerable clients. Richards and Gill conclude that potential partners might have different aims and agendas, both overt and hidden. Communication difficulties may arise from differing professional “languages”, problem perspectives, and organisational routines. Other key issues, such as inequalities of power, may exist between the intended partners; influences of the historical organisational context may also have an impact. For example, at the local level, new attempts at collaboration are often grafted onto existing scenarios (in which relationships may have been good or poor, there may have been previous successes or failures, and in which there may be conflicts and power struggles) without attempting to resolve or learn positive lessons from past issues. This phenomenon can be explained from a communications theory perspective, where communication is viewed as a never-ending/never-beginning flow in which all communications have some antecedents (Walzlawick, Beavin, & Jackson, 1967) and thus bear the burdens as well as the fruits of earlier encounters (Tannen, 1986).

Pampling, Gordon, and Pratt (2000) state that interagency tensions will not go away just because there is money to oil the wheels. Collaboration between organisations is hard to achieve and differences are not easily overcome. Creating a truly shared purpose is paramount. Success will depend on local autonomy and initiative, but tensions will
arise between the collaborators unless there is a genuinely mutual process of setting priorities and targets. It is relatively easy to mount a collaborative bid and become a trailblazer—sustaining enthusiasm and commitment over time is altogether different.

The South Australian Community Health Research Unit (1994) identified many barriers to effective collaboration in the literature—lack of time and resources, funding issues, lack of knowledge, poor information, lack of personal links and trust, philosophical differences, professional issues, and staff and organisational changes. Other barriers included lack of clear boundaries and agreed goals for the process, as well as territorialism and lack of a systems view. These can undermine collaborative efforts, as can lack of support from leaders within organisations. Costongs and Springett (1997) identified a barrier to effective collaboration exists where there is an emphasis placed on formal interorganisational structures, without a focus on the process of people working together as well. O’Neill, Lemieux, Grouleau, Fortin, and LaMarche (1997) identified the attitude of health-related professionals as a barrier to collaboration. They state that health-related professionals are used to operating in a very prestigious sector of society and they often approach other sectors expecting them to “buy in” to health-related issues without regard for how the health sector can support the legitimate agendas of other sectors. As such, language used, and how problems are framed, can be a barrier to effective working relationships.

Internal organisational arrangements can impact on the success of collaborative efforts. Spar (1994) identified that inappropriate or ineffective internal organisational arrangements make it difficult for an organisation, and the individuals within that organisation, to collaborate with others effectively.

Local context

There had been significant changes made in the area of health promotion at the metropolitan teaching hospital that is the focus of this study. The hospital made a strategic decision to disband its health promotion unit and adopt a “settings approach” to health promotion. This approach aimed to integrate health promotion into the roles and responsibilities of all staff, rather than it being the sole responsibility of staff of a dedicated health promotion unit. A Health Promotion Adviser was appointed in 2001 to facilitate the integration process.

Two earlier studies, conducted by the South Australian Community Health Research Unit (1994, 1999), explored the collaborative linkages between the hospital and community-based health services in the region, when the health promotion unit was in existence. Both studies found that there were very few collaborative linkages relating to illness prevention and health promotion between the hospital and other community-based services. The health promotion links that were most evident in these two studies were those made between community-based services and the health promotion unit.

As indicated previously, collaboration is an integral strategy for hospitals conducting health promotion work to improve health gains in the community in line with recommendations by the Ottawa Charter (WHO, 1986) and the Jakarta Declaration (WHO, 1997). When aiming to improve the capacity of a hospital to become more health promoting, and to improve the health of the broader community, it is important to have a baseline understanding of the way that hospital is currently working in this area, so that strengths and weaknesses can be identified to inform future developments. As a consequence, it was considered important by the Health Promotion Advisor—who would be required to facilitate the integration of health promotion into this hospital—to gain an understanding of the extent and effectiveness of collaboration with the hospital from staff and identified stakeholder perspectives.

Between January and March 2001, the Health Promotion Adviser (Principal Investigator in this study) undertook a consultation process with staff at the hospital to explore a range of issues related to health promotion. During this process diverse groups and organisations were identified as being stakeholders that staff of the hospital had collaborated with in the conduct of health promotion work. The research reported in this article was undertaken for the purpose of:

- Identifying the range of stakeholders the hospital had worked with to undertake health promotion work.
- Identifying how effective those relationships were determined to be by those stakeholders.
• Exploring with these stakeholders how they had worked with the hospital in the previous three years, and identifying what had worked and what had not worked well.

It was anticipated that this type of study would contribute to understanding the nature of the collaborative efforts between the hospital and identified stakeholders, as well as contributing to the emerging body of knowledge about the integral work of health promoting hospitals.

Methods

Interview technique
This was applied research and as such was based around the need of a teaching hospital to evaluate and further understand its approaches to collaborating with stakeholders in the conduct of health promotion work. The approach to this research was based on using a method that would actively engage the stakeholders and provide an opportunity for shared understanding and developing relationships. To meet this requirement, face-to-face semi-structured interviews were conducted with stakeholders between February and April 2002.

A research assistant conducted all the stakeholder interviews using a specifically designed interview guide. Reiteration and clarification were used during the interviews and notes were made to record the interviews.

Interview sample
For the purposes of this research it was decided to initially focus on interviewing “disease-specific community organisations” and “regional health services” that had been identified by hospital staff during the consultation interviews mentioned previously. The initial round of interviews was conducted with the 12 stakeholders identified by hospital staff, and, subsequently, with four other organisations identified by stakeholders. Using the snowballing technique, a third category of stakeholders emerged. This was the stakeholder category of “local government”. Snowballing technique was chosen for the purpose of hopefully being able to identify if there were stakeholders other than those identified by hospital staff.

The Principal Investigator contacted the most senior person at the organisation identified by hospital staff. All organisations that were approached agreed to participate in the study. The most suitable organisational representative to be interviewed was identified during that initial phone contact. A letter was then sent to that representative of the participant organisation outlining the project, and to confirm an appointment for an interview with the Research Assistant. A copy of the interview guide was also included.

Analysis

Data about the collaborative working relationship between the participant organisations and the hospital were collated and themes identified, with a particular interest in what the focus of the collaboration had been about, and what had worked and what had not worked well. Effectiveness was measured using a Lickert scale of 0-5 (zero being unworkable through to five being excellent).

No individual organisation was identified in the write-up of the results. The themes were compared to theories and concepts identified in the literature about health promotion and collaboration. A draft copy of the results was sent to the organisational representatives who were interviewed. They were invited to make comment on the analysis of the data they had contributed and changes were made accordingly.

Validity and reliability
The findings of this study can only be applied to the hospital at the centre of this study, and are not meant to be generalisable to other hospitals. However, other hospitals making a commitment to integrate health promotion into policies and practice may gain some insights from the findings of this study. Other hospitals may decide to replicate this study and interview stakeholders working in collaboration for the purpose of health promotion work.

Results

Number of participant organisations
A total of 16 participant organisations were included in this study. Staff of the hospital identified 12 participant organisations, and four others were identified by participant organisations using a snowballing technique. Of these:

• Six were from disease-specific community-based organisations.
• Seven were health services in the region.
• Three were local government organisations.

Focus of collaboration
The majority of participant organisations had been, or were currently, involved in health promotion work with the hospital. The focus and scope of the larger activities were often determined by funding opportunities that arose. Activities with a smaller scope were often determined by the need for input from staff at the hospital that had expertise in a certain area.

Twelve areas of work were current, including: a smoking cessation program; an informal network of health promotion workers; several patient education strategies for asthma, diabetes and kidney care; a communication playgroup for toddlers; a community-based youth program; and an arts-in-health program. In most instances the work was conducted with individuals or individual hospital departments. In two instances, where specific funding was available, there was involvement with several areas of the hospital, including clinicians and managers.

Disease-specific community-based organisations tended to focus on their own “disease” and worked with clinicians (e.g., doctors, nurses, and allied health) that worked directly with patients with a specific disease. The range of health promotion work involved the development of written material for patients (e.g., newsletters and leaflets) and health education and lifestyle management sessions for patients.

Regional health services generally had a broader spectrum of involvement across a number of hospital areas, some of which related to patients with specific diseases and some being oriented towards networking, education and support programs. For example:
• Cancer screening and prevention activities.
• Food and nutrition related activities.
• Networking of health promotion staff (Health Promotion Forum).
• Staff training to deliver smoking cessation programs.
• Collaborative grant applications.

Local government organisations tended to focus more upon community-based programs. For example:
• Youth mental health issues.
• Nutrition (healthy eating for one, shopping and cooking on a budget).
• Community gardens.
• Promoting positive relationships (peer relationships and self-esteem).

Effectiveness of working relationships
Rating of working relationships
Table 1 summarises the participant organisations’ responses regarding perceived effectiveness of working relationships, using the scale of zero to five (zero unworkable to five being excellent) effectiveness of working relationships.

<table>
<thead>
<tr>
<th>Response</th>
<th>% of responses (n=16)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Excellent</td>
<td>25% (4)</td>
</tr>
<tr>
<td>Good</td>
<td>30% (5)</td>
</tr>
<tr>
<td>Okay</td>
<td>30% (5)</td>
</tr>
<tr>
<td>Not good</td>
<td>0%</td>
</tr>
<tr>
<td>Unworkable</td>
<td>15% (2)</td>
</tr>
</tbody>
</table>

This equates to 55% (n=9) rating their relationship with the hospital as being “good to excellent” and 45% (n=7) as rating their relationship with the hospital as being “okay to unworkable”.

What worked well?
In response to the question about what had worked well with the collaborative efforts between the participant organisation and the hospital, the most commonly identified themes for those four organisations that had an “excellent” relationship with the hospital were having:
• Good interpersonal relationships with specific staff.
• Good two-way communication.
• Shared goals and objectives.
• A formal structure and role agreement to oversee the program, while also having informal networking opportunities.
• Links with staff at a range of organisational levels (clinical and executive).
• Funding to implement the program.

Other practical issues that contributed to “okay to good” relationships included:
• Having negotiated roles and boundaries.
• Basing the program upon current evidence.
• Consumer participation.
• Mutual respect.
• Having one person at the hospital clearly identified for co-ordination.

What could work better?
Commonly identified barriers to a more effective working relationship between the hospital and the participant organisations were categorised into two themes. These were “the hospital’s attitude” and “organisational and structural issues”.

Hospital Attitude
For future collaborative working relationships to improve it was felt that the issue of “attitude” would need to be addressed by the hospital. This was stated especially by those participant organisations that valued “health” as opposed to a narrow “illness” focus, and oriented their work to address the social determinants of health within the community. Comments from these participant organisations were, “There is lack of recognition by the hospital that it is part of the broader community and can have an impact on the health of the community”. For example, several participant organisations stated that the hospital was often seen as a monolith with very few connections with the local community, and common comments were “the hospital isn’t IT”:

The hospital needs to recognise and validate health promotion as a legitimate activity, as well as a valid part of service delivery which includes working with other stakeholders in the community. Often clinical work is seen as the imperative, to the exclusion of developing and sustaining collaborative links about health.

Organisational and Structural Issues
The theme of organisational and structural issues was seen as being a barrier to some participant organisations. The issues included:

• The need for sufficient resources to be invested by both the hospital and participant organisations to work collaboratively (human and financial). It was acknowledged that collaboration takes time and it is not always factored into undertaking a collaborative project.

• The need for collaboration from the beginning, not just from when funding has been obtained. It is important that there is collaborative planning for health promotion so that issues can be identified and planned together. Too often money is obtained and the participant organisations are invited to be involved, but have to work to the agenda of the hospital.

• The lack of clearly determined links between the hospital and participant organisations. This is at the individual practitioner level and at an organisational level. This makes it difficult to know how to approach the hospital to work collaboratively on an issue.

• Many hospital staff not appearing to have awareness of community services. Due to this lack of awareness staff do not always identify the range of stakeholders needed to collaborate with.

• The need for opportunities for staff at all levels of the hospital and participant organisations to meet and network formally and informally. It was thought that collaboration would be made easier once personal relationships were formed.

Future relationships with the hospital
Some participant organisations identified the need for the hospital and their organisation to develop mutual understanding and respect for the different paradigms of thinking about and addressing health issues, and recognising the role that each organisation can play in achieving improved health outcomes for individuals and the community collectively.

The participant organisations had a strong perception of the hospital being a tertiary centre operating strictly within the medical model. This was seen as a significant barrier to developing a mutual understanding of health promotion and developing common goals with other organisations that have a broader perspective of health. It was also recognised that there needed to be a mutually understood acceptance of the hospital as part of the community, rather than a stand-alone monolith.
One participant organisation specified that they were only interested in collaborating in health promotion work with the hospital if there was commitment at the most senior level (i.e., CEO), as they had previously had a bad experience during an attempt at collaboration when an individual staff member did not fulfil promises.

There was scepticism from several participant organisations about the true commitment of the hospital to collaborate to achieve improved health outcomes in the community when instances had occurred in the past of token collaboration.

Level of interest in developing a relationship

Some participant organisations felt that they were involved in health promotion work that was going well, and they were strongly enthusiastic about continuing; for example, "the ball is rolling and can't stop here". In contrast, two participant organisations had had negative experiences and were not interested in further developing a relationship unless there were significant changes in the attitude and commitment of the hospital and its staff. Overall, however, most participant organisations wished to foster sustainable relationships with the hospital. There was general goodwill expressed to achieve this, despite past difficulties for some participant organisations.

There were strongly held views by some participant organisations that, to achieve this, the following needed to occur:

- The hospital needs to recognise, understand and validate health promotion as part of its core business and a part of service delivery.
- The need for an increased understanding by hospital staff of the broader determinants of health. This would enable a more respectful planning process to occur, where there is acknowledgement of a broader approach to address issues, rather than just focusing on the strategies from the medical model to address issues at an individual level of intervention.
- The need for mechanisms to be put in place to support the hospital and participant organisations to become familiar with each others' roles and encourage collaboration; for example, improved formal and informal liaison between the hospital and participant organisations, both on patient-specific issues, and collaboratively determining and addressing broader health issues.
- The need to be committed to a sustainable approach to collaboration; for example, collaboration from the inception of an idea and in implementing projects in a sustainable manner.

Discussion

The number of collaborative working relationships for a hospital with over 430 beds and a range of community-based services appeared to be relatively low, with only 16 organisations identified. However, no other studies could be found with which a comparison could be made. The relatively low number of collaborative relationships for health promotion work raises questions such as: "Is the hospital involved in health promotion work with external organisations?" and "Is the hospital committed to collaborating with others?" One could assume that collaboration with other organisations for this purpose would have been more evident if the hospital had a strong commitment to an integrated approach to health promotion work. However, the number of instances of collaboration had increased since earlier research conducted by the South Australian Community Health Research Unit (SACHRU, 1999). Also, the range of hospital departments that collaborated for health promotion work had expanded—beyond the previous health promotion unit—to now include various clinical and management staff.

Features of collaboration

The focus of the collaborative relationships in this study tended to relate to what was seen as the shared purpose and core business for the participant organisations and the hospital. There tended to be a disease focus for those disease-specific community-based organisations and some of the health services in the region. Some of the “disease” activities were project-based. In two instances, funding to address mutual goals had brought the hospital and participant organisations together.

Where funding was the catalyst for the collaboration, multi-disciplinary involvement was evident, as was involvement from different levels of the hospital. Also, the scope of the collaborative arrangements tended to be structured more formally, in one instance with a Memorandum of Understanding in place. This agreement outlined the roles and responsibilities between the
collaborators. In another example a contract with the funding body determined the roles and responsibilities between all the collaborators. This type of collaboration is more consistent with a structured partnership (Rowitz, 2001).

Funding was not the catalyst for collaboration in the majority of instances. The collaborative relationships tended to be more informal and were developed with an individual staff member or a specific department within the hospital around issues of common interest with the participant organisation. The features of this type of relationship were loosely structured and more in line with a coalition, where people and organisations come together to cooperate for a specific purpose (Richards & Gill, 2002; Rowitz, 2001).

The purpose of collaborative relationships between some regional health services and the hospital was for staff training connected to a health promotion project, and networking among health promotion staff. These were generally oriented to cooperating to develop infrastructure to address specific issues. This is consistent with the purpose of collaboration and is an important part of developing the capacity of health services to work collaboratively (Walker, 2000).

Effectiveness of collaboration
Cooperation appeared to be the dominant form of collaboration in most relationships, which relied on the development of collaborative relationships between individuals, rather than more formal arrangements between organisations. This may account for five participant organisations stating that they had an “okay” relationship and two stating they had an “unworkable” relationship with the hospital. Harris et al. (1995) identified that individuals make a collaboration work. However, they also stressed that sustainable change is unlikely if the individuals who are engaged in the collaboration do not have the active support of their organisation. It was evident in this study that there were not consistent organisational mechanisms in place to support all collaborative relationships. For one participant organisation, where the relationship was unworkable, there was no hospital mechanism in place to enable resolution of the barriers to developing a collaborative relationship with the hospital. There was also no apparent mechanism for bridging the interpersonal and organisational difference identified as important for effective collaboration by Kanter (1994).

Despite the perceived relationship with the hospital as being unworkable for two participant organisations, and only okay for another five, most participant organisations wanted to be able to further develop their relationships with the hospital. This indicates a broader commitment and acknowledgement from these participant organisations that collaboration with the hospital is important to improve health outcomes for the community. In some cases, this is set against a background of previous unsatisfactory collaborative efforts. However, it was also acknowledged that this history would impact on the way future collaborations are formed. This is supported by Walzlawick et al. (1967) and Tannen (1986) who state that the history between organisations will impact on the way future collaborations are formed, especially in forming trusting relationships.

Conclusion
It can be concluded that collaboration between a large teaching hospital—committed to becoming more health promoting—and stakeholders is not easy to achieve. It is evident that successful collaboration is more than individual workers “getting on well”, and requires the hospital to address issues to do with attitude and organisational and structural issues. There are key lessons about collaboration to be learnt from this study for hospitals that wish to make a commitment to integrate health promotion into policies and practice.

Hospital attitudinal barriers are of concern, because they represent deep-seated beliefs and practices of staff and the strategic and tactical direction of the hospital. These cannot be achieved through staff education alone—to increase knowledge about the social determinants of health and health promotion philosophy and strategies, and improve skills to work collaboratively, they require a long-term organisational commitment and strategy. It is essential that hospital executives and clinical leader’s value:

• That the hospital is part of a broader community and needs to relate to that community and its health needs, not just the community’s illness needs.

• Health promotion is a legitimate activity and a valid component of service provision for the hospital.
The role that other organisations can play to achieve improved health outcomes for individuals and the broader community.

That genuine collaboration is important and needs to be fostered over a long period of time.

The need to respect the different models of health and ways of addressing health issues for individuals and the community.

The development of sustainable long-term relationships with stakeholders, which ensure that mutual respect, trust, shared power and authority are created and maintained. It is important that the hospital avoids the temptation to only focus on short-term tokenistic collaboration in response to funding opportunities.

It was evident in this study that the hospital did not have mechanisms in place to support collaboration with other organisations.

Organisational and structural issues that could improve future collaboration are:

Collaborative planning to identify and address health issues in the community.

Developing informal and formal links between the hospital and other organisations at a range of levels.

Formalisation of working relationships with stakeholders through developing agreements to ensure trust, integrity and honesty are fostered, especially where this has been problematic in the past.

Factoring in the human and financial resources needed to develop and sustain collaborative relationships.

Ensuring mechanisms exist to resolve conflict should problems arise in collaborative relationships.

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