Primary care teamwork in the Christchurch area

Part 2 - barriers to greater collaboration

LJ Toop MRCGP, FRNZCGP, JJ Nuthall, ID Hodges PhD

Les Toop is Senior Lecturer in the Department of Public Health and General Practice, Christchurch School of Medicine

Jill Nuthall is Health Services researcher, Christchurch

Ian Hodges is Senior Advisor (Research), Sector Analysis, Ministry of Health, Auckland

Correspondence to Dr Les Toop
Department of Public Health and General Practice, Christchurch School of Medicine

ABSTRACT

Aims To explore the perceived barriers to achieving increased collaboration between primary health care workers in the Christchurch urban area.

Methods The views of 909 health care professionals were canvassed by questionnaire. The views of selected opinion leaders, representatives and employers were also sought with face to face interviews.

Results There were 585 replies received (overall response 64 per cent, varying from 30 to 100 per cent between groups).

Time, methods of remuneration, confidentiality, and unhelpful professional attitudes were seen as the most important barriers to achieving the desired levels of collaboration. Interviews with 20 representatives, teachers and employers of the various professional groups reinforced the range and scale of these problems.

Conclusions A variety of possible solutions to some of these problems were suggested. If implemented, these suggestions would have significant implications not only for the training of health professionals but also for the ways in which remuneration is organised and in the coordination of their day to day work. Much of the responsibility for facilitating these developments rests with the policy makers and the purchasers through future contracts.

INTRODUCTION

There is an expanding literature worldwide on the value of interdisciplinary collaborative teamwork in primary health care. Most of the evidence and opinion suggests that greater communication between providers, together with a commitment to work towards common aims and objectives, is both desirable and necessary to deliver efficient and personal health care to individuals and communities (1-11).

In the UK it is seen as important enough to feature in the nursing code of conduct *Each registered nurse, midwife and health visitor is accountable for his or her own practice and, in the exercise of professional accountability, shall work in a collaborative and cooperative manner with other health care professionals and recognise and respect their particular contribution within the health care team*(12).

As part of this primary care teamwork survey in Christchurch we have shown that there is a strong desire for greater collaboration between most health care professionals (13).

This paper reports the second part of the study and examines the perceived barriers to achieving these desired levels of increased collaboration and teamwork.

Full collaboration between members of different disciplines is recognised as a challenge (1,2,4,8,9,14,15). There are both practical and theoretical difficulties that have to be overcome. There has been in New Zealand, as elsewhere,

little if any tangible encouragement for primary care workers to work collaboratively. Indeed, in many instances the reverse has occurred in recent years, whereby many primary care workers have developed new more specialised roles independently of each other with separate funding, premises, direction and supervision.

Whilst geographical isolation is an important barrier to collaboration, it is recognised that simply throwing a group of health professionals together and calling them a team is unlikely to make them work as one (16).

There are clearly much deeper difficulties and differences in the attitudes of the various disciplines which will have to be worked through if the goal of an integrated multidisciplinary team is to be achieved (5).

In addition to exploring these barriers to teamwork with primary care workers themselves, it was seen as important to explore the views of their opinion leaders, employers and representatives.

The aim of this part of the project was to:

Explore the perceptions of primary health care professionals and their opinion leaders about barriers to greater collaborative teamwork, also to canvas suggestions on practical strategies to overcome the barriers identified.

Whilst geographical isolation is an important barrier to collaboration it is recognised that simply throwing a group of health professionals together and calling them a team is unlikely to make them work as one

METHODS

A questionnaire was sent to 909 health care professionals working in primary care in the Christchurch area. The sampling procedure and response rates have been previously described (13). The first part of the questionnaire dealt with the reported actual versus ideal or desired levels of collaboration between the various health care professionals.

The final part of the questionnaire asked respondents to identify the main barriers they perceived to be preventing the attainment of their preferred levels of collaboration.

They were also asked to describe in their own words how they felt some or all of these barriers might be overcome, together with their impressions of the main advantages and disadvantages of greater collaborative teamwork.

Respondents were initially given a list of 23 potential barriers from which to choose. The items for the list were chosen and refined by the research team following a brainstorming session and review of previous literature on primary care teamwork.

The suggested barriers could be loosely grouped into the practical problems of finding the extra time and opportunities for meetings, attitudinal differences and confidentiality problems. In addition, there were one or two other miscellaneous possibilities together with space for respondents to be creative. The data was pooled and analysed for common themes.

Quantitative data were analysed using Paradox software.

Written comments were analysed using a manual content analysis.

A number of face to face taped interviews were then carried out by two of the researchers (the first two authors).

The interviewees were generally seen in groups of two or three, occasionally alone. They were chosen as opinion leaders and all were involved either as representatives, educators and/or managers of their respective disciplines.

The professional groups sampled in this way were: GPs; senior nurses involved in practice, public health and Plunket nursing; midwives; physiotherapists; social workers.

The semi-structured interviews were of approximately one hour's duration and started with questions on perceived barriers to teamwork similar to those used in the questionnaire.

After opinions had been fully explored the summarised results from the quantitative part of the original postal questionnaire were presented for comment.

The reactions of the opinion leaders to this data were explored and recorded. Finally suggestions were canvassed for strategies to overcome the difficulties which had been identified.

The interviewers prepared a written report from each interview with the help of the tape recordings.

RESULTS

The survey

The relative importance of the barriers

Table 1 shows the proportion of respondents, from the different groups of health care professionals, answering positively to each of the suggested possible barriers to greater collaborative teamwork.

For the GPs as a group clearly the practical logistics of arranging and attending meetings was the largest perceived barrier. Confidentiality issues were recognised as potential problems by a third, but attitudinal difficulties were identified by less than one- fifth of the respondents. Approximately one quarter were concerned about the effect of greater collaboration on their income.

The pharmacists' views on the logistics of extra meetings and the problems occasioned

by recent changes in the privacy laws closely mirrored those of the GPs.

There was a stronger feeling of attitudinal problems from other professional bodies by more than a third of respondents and over 40 per cent felt their skills were undervalued.

Only a very small number were concerned about the effects of greater collaboration on their income.

Practice nurses identified the problems of time and confidentiality in similar numbers. Of the other suggestions, only the feeling of being undervalued approached 30 per cent response. As with all groups surveyed, the barriers perceived by the attitudes of the other professional bodies far outweighed those of their own.

District and public health nurses rated lack of time very highly and the public health nurses particularly saw confidentiality as an issue. Perceived attitudinal problems (of others) were rated similarly to the other nursing groups.

Independent midwives were the only group to rate professional rivalry, attitudinal problems and non recognition of skills above the practical problems of time and confidentiality.

The 16 social workers strongly identified time and confidentiality as the main barriers with attitudinal problems rating of lesser importance. The physiotherapists and dentists rated time as the main problem with a third of the physiotherapists also claiming attitudinal difficulties.

Of the 13 Plunket nurses who responded to the questionnaire the majority cited time for meetings as the most common barrier. Patient confidentiality was also highly rated by two-thirds. A similar proportion felt that their skill and contribution were not adequately recognised by others.

Overcoming the barriers

The written responses to the question on ways of overcoming the barriers were rich and varied. A significant number of respondents, particularly GPs, felt that things at present were actually quite satisfactory.

Slightly more respondents were pessimistic about the scale of the problems *The New Zealand scene in no way encourages the notion of teamwork, either financially or in other ways*, "*seems insurmountable*" and "*..won't be - only if we live on a commune*"

At the other end of the optimism scale there were many positive suggestions put forward. There were common themes relating back to the groupings of perceived barriers. The time problem came through again and again. The advantages of geographic proximity (from the same premises often mentioned) was stressed by many although the lack of financial incentives to do so were recognised.

Greater use of the telephone/fax and two-way correspondence were common suggestions for improvement. As might be expected from those remunerated on a fee-for-service basis, a means of removing or reducing the financial disincentives to extra meetings and non patient/client contact time was seen as crucial by many.

Capitation for GPs was mentioned occasionally with only one or two suggestions in support of a straight salary. Patient registration was mentioned by many as an efficient means of assisting the integration of care by a range of carers for a defined population group.

There were many calls to address the obviously important attitudinal differences and perceived professional rivalry and dominance. Again there was a spectrum of pessimism perhaps summed up by the following: *The deep seated medicalised views of general practitioners and obstetricians seems an impossible thing to change.*

Several comments were made about differing philosophies of care with the implication that each group has a collective philosophy some of which are seen as incompatible with other rival groups thus preventing true collaborative teamwork. Recognising one's own limitations and the skills of others was mentioned several times by a range of respondents, and it was thought by some that the very act of face to face meetings would help foster greater understanding and respect.

Greater public awareness of special skills was also suggested as important by several respondents. More communication during training and continuing education were noted as important avenues to explore by some.

There were several pleas for removing competition from the health sector although few suggestions as to how that might be accomplished in the current climate.

The confidentiality issue was rated highly in the questionnaire but few suggestions on how to overcome this were put forward.

Blanket prior approval by patients for specified professionals to share information was suggested once. Several people recommended the explicit creation of geographically responsible multi- disciplinary teams as a

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way forward, perhaps as pilot studies.

The face to face interviews

The GPs interviewed commented that greater teamwork was extremely desirable and that general practice was a natural focus for a primary care team.

They saw the current health reforms as an opportunity to break down some of the institutional barriers which have hitherto prevented this happening.

Education and training was seen as deficient in not exposing trainee primary health care workers to enough examples of true multidisciplinary teamwork.

There was some surprise and a positive response to the level of desired collaboration from the other professional groups surveyed. The barriers identified by the interviewees closely followed the written comments and feelings of the 190 GP respondents to the questionnaire.

The responsibility for facilitating the development of teamwork was seen as resting with the purchasers of services. Making it happen was a shared responsibility of the primary health care professionals themselves.

The practice nurse representatives interviewed felt that teamwork in primary care at present was at best patchy and not helped by competition between professional groups and practices.

They would like to see a greater variety of professionals working from the practice base or visiting. They developed the theme of the attitudinal barriers to fuller collaboration.

The most important potential problem was seen as centering around the practice nurse/ GP relationship. The employer - employee situation was seen as an impediment to collaboration between equals.

It was felt that, until recently, practice nurses have had a relatively poorly developed sense of group identity and direction.

The feeling was that direct payment of practice nurses rather than a part subsidy paid through GPs would partially redress this problem. The possibility of nurses sharing ownership of practices was seen as a further innovative way of re-balancing the perceived power imbalance that has historically occurred.

In the few places in New Zealand where this happened it has apparently fostered more effective teamwork.

The need to clearly define responsibility and leadership was seen as very important although difficult: *It would be nice to see [shared responsibility] but there always has to be one person who has prime responsibility to coordinate. Varies according to the time.*

On the whole the interviewees were a little more pessimistic about the possibilities of achieving the desired levels of collaboration than the (relatively few) questionnaire responses might suggest.

A further group of four senior nurses was also interviewed. They stressed the need to look at alternative structures: independent nurse practitioners, patient registration, nurses employing doctors and community ownership were all thrown into the pot as possible alternatives to consider.

The idea of the GP as gatekeeper to other primary care workers was challenged. The concept of differing mindsets, philosophies or paradigms was brought up by this group also. The suggestion was made that nurses are taught from a wellness paradigm in contrast to the illness paradigm that characterises medical education and training.

Competition was again identified as another barrier which together with commercial sensitivity and the Privacy Act *"eroded any opportunity for team function"*.

The midwife representatives interviewed thought that the teamwork with Plunket nurses, physiotherapists and Maori health workers was already good. However, their rating of the need and desirability of collaboration with GPs appeared to be at odds with the responses to the questionnaire.

GPs can't provide [full service]... they need our collaboration, whereas as midwives we don't need theirs to the same extent.

That's why I don't want full collaboration...because I've been there. We're a profession in our own right, and when we require assistance it's from obstetricians.

The philosophical gap and the current competitive nature to the relationship was stressed. A lack of understanding of the role and scope of practice of the midwife linked to a lack of trust in their professionalism was identified as another barrier.

Better teamwork was seen as desirable but unlikely. There was a perceived risk of loss of autonomy when working with doctors because of the *overriding belief that because a general practitioner is a generalist, other people are only add-ons.*

A system of self-referral and identification of a key primary provider was suggested. The apparent dissonance between the views of this group and the questionnaire responses was

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explored at a subsequent meeting and it was considered that the questionnaire may have been inappropriate for midwives, the sentiment that greater collaboration between independent midwives and general practitioners was not necessarily desirable or a high priority was reaffirmed. A statement from the midwife representatives follows:

Independent midwifery practice is led by the client. A midwife goes where the woman wishes; therefore relationships with particular individual professionals or groups depends on the client preference. The majority of midwifery care is carried out in the woman's home so the need for rooms/premises is not a particularly high priority. A very small number of midwives work in practices with an identified medical practitioner, this does not seem to be on the increase. The survey did not ask the question of midwives as to the type of service they provided eg,: Full [continuity)]care. Those in full care generate their own clients and occasionally work with a GP but would mainly require the service of an obstetrician in the event of complications. Those in part care are reliant [in the main] on referral from other agents.

Midwives are in a state of change from working totally subordinately in a CHE situation to taking full responsibility. Communication at any time with any other care givers is seen as very important. We feel the survey results are at odds with our members' stated needs and this may be to do with midwives not wishing to appear isolationist, nor wishing to prevent women access to appropriate carers. Midwives would like to have good communication and collaboration with carers they come in contact with on behalf of their client. This does happen in a small number of situations and its success is based on mutual respect and recognition of roles and skills. There are major difficulties where the midwifery model clashes with the medical model of providing pregnancy/ childbirth care. Midwifery exists in its own right and does not need the input of other carers throughout the pregnancy for every pregnancy. Midwives see positive relationships as enhancing care, this has to be a two way street.

In the main midwives work with healthy women and therefore usually only require specialist services [out of the primary sector].

Midwives work hard to assist clients to develop relationships for ongoing care, eg, Plunket nurses. Positive relationships have been developed with Maori Health Workers, Plunket nurses and physiotherapists but there is always room for improvement.

Collaboration/communication will always be hampered by a lack of understanding of the role of the midwife [all women birthing will have a midwife at some stage], and a lack of trust in them as professionals by other professionals. Midwives see teamwork as desirable but not at the expense of their autonomy.

The medical profession usually sees itself as the team leader whereas midwifery sees the woman as the centre and therefore care is directed by the woman's needs.

Teamwork can only be positive for all concerned but, along with our previous comments, the current competitive nature of the health reforms ,eg, encouraging groups to outbid for contracts whilst trying to make profit and still use terms like teamwork and collaboration appear to polarise groups not unite. Encouraging small groups of a variety of practitioners does not seem to us to be ensuring clients have a choice/flexibility.

The poor response from the midwives surveyed suggests to us that either the questions were not appropriate for midwives working totally autonomously and/or they have been in supposedly collaborative situations only to find themselves, their skills and knowledge ignored or undervalued.

Senior members of Nurse Maude District Nursing Association were interviewed. The current level of teamwork was thought to be quite good, considering the current barriers.

GPs, practice nurses, midwives, occupational therapists, physiotherapists, Plunket nurses and pharmacists were all seen as natural collaborators. They cited difficulties in meeting and communicating with GPs.

They also felt others did not understand the constraints under which district nurses have to work. More planned meetings were seen as essential if greater collaboration is to take place.

There are particular problems with providing a coordinated district nursing service in Christchurch brought about by the need to deal with referrals from two Crown Health Enterprises (CHEs) with different structures and from general practice.

The theoretical advantages of working with specific groups of GPs are acknowledged and a pilot scheme to develop this is already underway.

However, at the time of the survey, there were only 14 registered nurses (working as case managers in a largely supervisory capacity)

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servicing the whole of Christchurch.

Each one therefore has to relate to many GPs and vice versa.

The limitations imposed by the Privacy Act were also developed. Referrals such as "District Nurse to visit 'NO INFO' due to Privacy Act" are clearly inadequate and potentially dangerous if for instance the patient is suffering from an infectious disease. Further and more reasonable interpretation of the Privacy Act was seen as urgently required. They felt contracts should have liaison costed in.

The need to develop further understanding of roles was again emphasised and input into the medical undergraduate curriculum was seen as desirable.

Members of the management team of Healthlink South's (one of the CHEs) Child and Family Service recommended a contracting environment that promotes teamwork across boundaries. "Teamwork doesn't just happen."

"The leadership may vary."

This is not seen as a problem provided the group nominates the leader and everyone is clear: *otherwise what you've got is an amorphous group that has no boundary to it, has no clear roles within it, has no clear communication process to which they are committed to problem solve, develop, initiate or whatever - just an amorphous concept which they say they are working on but which they've not negotiated.*

It was suggested that RHAs could fund pilots in areas where people are already working together well and identify leaders who could model effective teamwork rather than spend too much time on those who are stuck.

The lead agency or budget holder may not necessarily be the best at negotiating good working relationships and "ownership" of patients could create barriers.

Senior representatives of the Children's and Young Persons Service (CYPS) and the New Zealand Association of Social Workers (NZASW) suggested the place to start was by improving the level of understanding between professionals working in the community.

Personal contact over clients helped create trust in the individual worker and thence in their organisation. In its present form CYPS is "almost entirely a secondary service for very difficult cases", but workers could possibly be based on the same site as other local professionals, enabling easier contact.

NZASW representatives stressed the advantages and desirability of working closer to other primary care workers; for instance it was seen as *a big step forward* when mental health services moved to districts from the larger regional base.

There was considerable support for attachments of social workers to group medical practices. They commented that health workers were having increasing difficulty reaching appropriately qualified social workers and counsellors. No-one was coordinating information on the growing number of private counsellors, and established services were constantly changing their names, briefs and procedures.

With the more competitive environment, cooperation was being blocked and agencies were narrowing their outputs. The feeling was expressed that with limited resources: *We're getting away from the good health model and back into the sickness model and therefore the role of the primary health social worker is going to disappear.*

Senior representatives of the local private Physiotherapy Association were interviewed. The level of communication with the main referral source, the GP, was seen as reasonable although the information flow back was variable.

They did not often have contact with other primary care professionals except through the GP. The simpler the referral process the more likely they were to refer. Thus they frequently worked collaboratively with podiatrists and pharmacists but found it hard to reach social workers.

In some specialised areas, particularly sports medicine, good interdisciplinary collaborative teamwork was seen as beneficial. There were particular difficulties between physiotherapists and osteopaths and chiropractors. As with other groups which offer competitive services, there is a fear of losing income; also beliefs, language and training were not well understood.

DISCUSSION

The gap between the present and desired levels of collaborative teamwork between health professionals working in urban primary care in New Zealand is real and significant (13).

In this paper we have started to explore some of the more important barriers preventing movement towards the stated ideal situation. Whilst there are differences in emphasis between the groups of professionals both the quantitative data and the extracted quotations and interviews suggest that there are common problems perceived by all of the groups.

The gap between the present and desired levels of collaborative teamwork between health professionals working in urban primary care in New Zealand is real and significant

Time comes through strongly from many groups as an almost insurmountable problem. Many workers in primary care are demand driven and try and provide instant availability. This method of working does not lend itself to prearranged meetings. The financial cost of time not spent in contact with patients is seen as a particular disincentive to those who are both self-employed and working on a fee-for-service basis. Capitation payments or even salaries are seen by a few as possible solutions.

Members of a team being geographically close to each other and responsible for the care of the same group of people is seen by many as a way of facilitating greater efficiency and collaboration.

Both capitation and defined populations will require some form of enrolment or registration of consumer to provider and many of the respondents acknowledge this.

Whilst many, from all groups, saw advantages in working together from the same premises the difficulties in funding this were identified.

Government assistance (perhaps through low interest loans as has been so successful in the UK) was suggested as a possible solution.

Fully integrated general medical and general nursing care is unlikely unless the doctors and the different nursing groups are caring for the same population. If this is to happen a complete reorganisation of the current geographical boundary model will be required.

Confidentiality and the recent privacy laws are seen by most of those surveyed as a significant barrier to the free flow of information, a *prerequisite* for collaborative teamwork.

From this study it seems that the practical implications of the new law are far from clear to primary care workers.

Further work needs to be done on achieving standardised interpretation to a set of workable guidelines that can facilitate rather than stifle collaborative teamwork.

One suggestion was made that individuals might give a blanket approval, valid over a certain time, for information to be freely exchanged between a stated set of professionals. It is difficult to imagine the practicalities of obtaining and sharing this type of consent.

As part of this project a survey of a random sample of the public has been carried out on this very subject (in preparation). The results show a wide range of opinion on the confidentiality issue and reinforce the need for a public and professional debate on the whole topic of confidentiality and access to health records held by health professionals.

Perhaps the advantages and disadvantages of enrolment or registration should be included in this public debate?

Perhaps the most contentious and certainly the most sensitive issue is the one of professional attitudes. The negative professional attitudes (of some other groups) are seen by many (? most) as barriers to greater teamwork.

It is perhaps of no surprise that these feelings are more sharply focused in the minds of the opinion leaders and representatives. Where there is potential overlap of provision of service (competition) raw nerves are understandably most apparent. There is a widespread perception that some doctors feel they "own" patients and see others as subsidiary; whereas many believe that different team members can take the leadership so long as this is negotiated and clear. Many respondents feel that their particular skills are neither recognised nor valued. This can lead to professional rivalry and jealousy, emotions in no way conducive to collaboration.

These attitudinal differences are by no means unique to New Zealand and many go back a long way. It could be argued that historically it has been the organisation and funding of the system that has kept people apart thereby perpetuating the often incorrect inter-professional stereotypes learned during training (15,17,18).

The practice nurse subsidy is an obvious and far-sighted exception and has allowed practice nurses and GPs to work closely together. Had there been strings attached to the subsidy requiring the *team* to show evidence of the evolving complementary nursing role and more balance to the decision making power then the collaborative relationship might be a little further ahead than it is now.

More overlap and integration of training and continuing education were suggested as ways of starting to overcome these attitudinal differences. Presumably as greater contact occurs the understanding of skills and limitations will follow.

Some of the groups identified the basic philosophies of the other groups as being sufficiently different from their own as to be a barrier to working as a team.

The "medical model" crops up frequently and whilst undefined appears to summarise all that is wrong with the practice of medicine today. Several comments were made about different "languages", perhaps best exempli-

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Table 1: Percentage of respondents who identified the following barriers to greater collaboration and teamwork

All figures below are percentages	General Practitioners (n=190)	Pharmacists (n=88)	Physio-therapists (n=37)	Dentists (n=92)	Practice Nurses (n=62)
My office is located too far away from theirs	30	28	19	20	24
Requires too many meetings, there's not enough time in the day as it is	75	46	54	46	66
Difficult to arrange meetings at mutually satisfactory times	61	49	62	34	55
The patient benefit payment system	36	19	19	17	15
Too much extra paperwork	35	19	24	14	7
Requires a good patient registration system	4	13	3	3	4
Patients don't like it	5	9	0	2	5
Means less time spent with patients	38	13	51	17	29
Confuses patients	16	11	11	8	8
Requirements of patient confidentiality	35	43	22	16	45

Percentage of respondents who identified the following barriers to greater collaboration and teamwork

	General Practitioners (n=190)	Pharmacists (n=88)	Physio-therapists (n=37)	Dentists (n=92)	Practice Nurses (n=62)
Recent privacy laws	30	32	19	10	26
Attitudes of my professional body	9	1	8	8	15
Attitudes of other professional bodies	13	36	24	13	26
Professional rivalry	24	32	38	14	23
They don't recognise my skills or the contribution I make	8	42	30	14	29
I am too restricted in the medicines and treatments I am allowed to provide	3	30	3	6	18
It might reduce my income	24	6	19	15	5
It might increase my overheads	27	17	14	17	5
Personality differences	8	10	3	5	3
Attitude differences	25	31	24	16	23
I prefer autonomy	13	3	0	11	5
They prefer autonomy	13	25	11	7	12

fied by the current "patient" versus "client" dichotomy (15,19,20).

Each group of course sees their own philosophy as "holistic" in-as-much as the whole person is considered; similarly each group thinks that it has a major illness prevention and health promotion focus. It could perhaps be argued that truly holistic care can only be offered by a team with a range of skills which can fulfill the definition of "the whole being greater than the sum of the parts".

Formal links between the various training institutions with greater opportunities to develop overlapping curricula at the postgraduate level would be a useful place to start breaking down these apparently deep seated and strongly felt attitudinal differences.

What of the responsibilities of the policy makers? The institutional requisites of interdisciplinarity have been listed by Mariano as time, room, support, relevance, legitimisation, positive motivation and reward (14). Time is needed for teams to work effectively, time protected and paid for.

Space and proximity have been discussed, resources and direction are required to make effective teamwork happen. Contracts should require evidence of effective collaboration and recognise the skills required and the costs of teamwork. Teams have to be valued and given a degree of decision making autonomy if they are to work.

All of which translates into the need for ***commitment*** from professionals, RHAs, policy advisers at the ministry and from government, to the value of, and the need for, greater teamwork in primary care in New Zealand.

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Table 1 (cont.): Percentage of respondents who identified the following barriers to greater collaboration and teamwork

All figures below are percentages	Social Workers (n=16)	Plunket Nurses (n=13)	Independent Midwives (n=32)	Public Health Nurses (n=23)	District Nurses (n=32)
My office is located too far away from theirs	44	39	9	35	34
Requires too many meetings, there's not enough time in the day as it is	81	77	41	57	84
Difficult to arrange meetings at mutually satisfactory times	56	85	38	61	63
Patient benefit payment system	0	0	19	22	3
Too much extra paperwork	19	23	9	13	34
Requires a good patient registration system	0	0	6	13	16
Patients don't like it	6	8	0	9	9
Means less time spent with patients	63	62	19	22	59
Confuses patients	13	0	13	9	9
Requirements of patient confidentiality	63	69	28	61	22

Percentage of respondents who identified the following barriers to greater collaboration and teamwork

	Social Workers (n=16)	Plunket Nurses (n=13)	Independent Midwives (n=32)	Public Health Nurses (n=23)	District Nurses (n=32)
Recent privacy laws	56	54	28	57	25
Attitudes of my professional body	13	15	13	17	3
Attitudes of other professional bodies	25	31	41	35	41
Professional rivalry	25	39	59	35	16
They don't recognise my skills or the contribution I make	31	62	47	44	13
I am too restricted in the medicines and treatments I am allowed to provide	0	15	0	17	16
It might reduce my income	6	0	13	0	3
It might increase my overheads	6	0	3	9	3
Personality differences	0	0	3	4	0
Attitude differences	23	31	47	30	28
I prefer autonomy	0	0	25	4	0
They prefer autonomy	13	23	19	4	19

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