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Name of Author(s): Loxley, A.

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CHAPTER TWO

Why Collaboration in Health and Welfare

Its Place in Ideology, Models of Care and Social Theory

To achieve effective collaboration the word itself must be removed from political rhetoric and the realm of common sense where it is too often found. If this can be done, then the case for collaboration need be made only when it is likely to be effective, claims for resources can be justified, practitioners can be held accountable, and skills and knowledge can be explicit, taught and transferable.

Activities are always based on assumptions about purpose and values and necessary conditions, whether such assumptions are made explicit or not. In collaboration between health and welfare, assumptions are made about the nature of health, about the role of collaboration in providing care, and about how people work together. If these assumptions can be explored, then the function and methods of collaboration may become clearer.

This chapter, therefore, argues that considering ideologies of health and models of care, and exploring some social theories which explain how and why people work together, may illuminate some of the largely hidden assumptions. Some basic ideas will be identified to point toward a fuller understanding of the necessary conditions for collaboration.

Practice and theory

The search for a framework of concepts relevant to a theory and practice of collaboration explores some theories and practices current in the delivery of health and social care since the middle years of the 20th century. Knowledge is both *deductive*, that is, drawn from theory, and *inductive*, that is, drawn from experience.

Professional practice draws both on theory, usually learnt mostly on pre-qualifying courses and sometimes continued with post-qualifying study, and on

practice, not necessarily only that of the individual but of the professional group, insofar as it is written up or codified and seen to be of a sufficiently general nature. In social work teaching, this intermediate knowledge was known as 'practice wisdom'. Knowledge based on theory and knowledge based on practice feed each other and interact to produce knowledge which is applicable and found to be useful. Such an interaction is part of all human service professions and practitioners base their work on assumptions drawn from it. Practice very often allows little time for reflection, so such assumptions usually become implicit rather than explicit, and at risk of being unexamined. If such assumptions can be examined and evaluated and their sources made clear, whether in theory or in practice, then a claim for resources may be argued and accounted for more knowledgeably by the practitioners, managers and policy-makers.

The appeal to collaboration has largely rested on assumptions that it is 'a good thing' and these assumptions have been little explored. Collaborative activities have been much described. The associated difficulties have been much discussed. Teaching for collaborative skills has on the whole been driven by a recognition of the difficulties and the consequent desire to equip practitioners to get round them, for example, difficulties in communication, therefore teach people communication skills; mutual incomprehension, therefore teach professionals about each other. As a consequence collaboration is being understood mostly inductively; that is, from practice. So far, a theory of collaboration, for collaboration in practice, is very undeveloped. Without such a theory, practice struggles to make sense of itself and is hampered by the lack of any dialogue with a coherent framework of ideas leading to transferable knowledge and skills.

The social theories explored in the search for relevant concepts are among those which attempt to understand the interaction between individuals and groups as they live and work together, experiencing and meeting needs in a world of finite resources. Collaboration implies an interaction between at least two parties. The search for a conceptual framework therefore includes a consideration of some general social theory relating to interaction, General Systems Theory, Social Exchange Theory and Co-operation Theory.

To elicit a useful understanding of practice it is necessary to consider some of the philosophies and ideologies which colour people's assumptions about health and welfare. These philosophies and ideologies underlie particular models of health and welfare services, which determine models of intervention, the range of skills and methods and the form of organisation. As collaboration takes place within a social context, it becomes necessary to refer to ideologies which colour social organisation, such as capitalism and the market allocation of resources, socialism and state intervention, and humanist and ecological perspectives. These ideologies inform models of health and welfare which

determine the mode and focus of interventions. Concepts affecting collaboration are therefore to be sought in models of health and welfare, the range of interventions, and the organisation and management of resources such as knowledge, skills, time and material goods.

The pursuit of health

People throughout history and in all societies have tried to find an explanation for the experience of disease and an understanding of health, physical, mental and social, as both a state and a goal. Such explanations and understandings are not very often spelt out by practitioners and policy-makers, but colour their implicit assumptions affecting their values and choices. Health is individually or socially defined and individually and socially determined. It is recognised at individual and social levels which are inextricably linked because people's lives are lived both individually and in communities.

At an individual level the understanding of health in developed western societies has been predominantly categorised by biological and medical science, and the medical model of intervention is primarily intended to cure, to restore or maintain, a person's normal functioning. Within this model of intervention, collaboration between different agents of intervention may be necessary either because the needs change over time and require different specialist contributions, or because the situation is too complex for any one practitioner acting alone.

At a community level the understanding of health is informed by both biological, environmental and social knowledge, and intervention is intended to prevent disease or disability, to control the spread or rise of disease states within a population, and to promote health by creating the conditions which support it. Collaboration within this model is necessary because the situations being addressed are likely to be recognised as multi-factorial, involving a wide range of players.

There are other perspectives. Political and philosophical critics have attacked the use powerful professional and economic interests have made of the prevailing models of health and intervention which serve, it is argued, to maintain their power, and have proposed alternative understandings which would lead to different responses. Illich (1975) defines the concept of health as a life task, of adaptation to problems of living. He warns against the medicalisation of health, that is, allowing health to be defined only in medical terms and so handing power over it to the medical profession, and argues that the health of the individual and the health of the society in which she/he lives are one and the same. Dubos (1979) suggests that health is an ecological concept related to the social environment, in which people continually seek change and challenge, 'Earth has never been a Garden of Eden, but a Valley of Decision where

resilience is essential to survival'. The Judaeo-Christian religious understanding of health as Wholeness or Salvation, both individual and corporate, warns against seeing the pursuit of health as a problem to be solved, rather as a means to learning and growth: 'Health is... a value and a vision' (Jenkins 1990) to be pursued as an unfinished task, and to be a measure of the quality of life. The emergence of the emphasis in some parts of health and welfare provision on the centrality of the user/patient/client in the planning and delivery of service chimes in with the perceptions of these critics.

Such philosophical and religious understandings have informed the thinking of the World Health Organisation which has transformed them into goals and principles and then into programmes. The Declaration of Alma Ata, an international conference on primary health care held in 1978, restated the familiar definition of health as 'a state of complete physical, mental and social well-being' (WHO 1978) and added that it 'is a fundamental human right,... the attainment of the highest possible level of health is a most important worldwide social goal whose realisation requires the action of many other social and economic sectors in addition to the health sector'. The strategies which followed are the pursuit of care in and by the community, the promotion of the concept of primary health care understood not only in UK terms but also in particular ways related to the needs of underdeveloped countries, and the strategy of the 'healthy city' dependent on the concept of 'intersectoral collaboration'. In the Copenhagen Declaration the European WHO Regional Office translated the Alma Ata Declaration into 38 specific targets to be attained by the year 2000. The translation of principles and targets into policies and practice becomes the task of societies and governments. It is at this level of intervention that there ceases to be agreement on what is self-evidently desirable. The delivery of health and social care enters the domain of *realpolitik* and is subject to all the diverse views of a sophisticated and complex society. Some of these diverse means may be seen in the conflict between integration and differentiation, centralisation and localisation, professional and managerial dominance, competition and co-ordination, allocation by need and allocation by resources, and specialism and generalism. In the pursuit of health through social and economic policies, and the political contexts which affect them, such conflicting concepts become attached to different ideologies. The measures of costs and outputs, the allocation and sources of resources and the organisation and accountability of services are coloured by political values and lead to prevailing modes of financing, managing and delivering services.

Under a government dominated by capitalist assumptions, health is seen as a commodity, bestowed by some members of society upon others, and competed for as are other commodities. It is managed and determined by experts, and people become consumers or customers, who challenge the experts for sufficient information to make choices. Because it is perceived as a commodity, it becomes

unevenly spread throughout society and the responsibility for possessing it is laid upon the individual. The capitalist emphasis on the market supply of goods and labour, and the perception of the state as non-interventionist, leaves the attainment and maintenance of health at the mercy of economic values, supported by the appeal to the virtues of freedom and choice for the individual who takes personal responsibility for his/her lifestyle and its consequences.

The Marxist critique claims that the internal logic of capitalism with its priorities and values explains the underdevelopment of health in a society dedicated to the reproduction of capital and the political and social control of surplus population. The state cannot be disinterested but works to sustain the power of its dominant groups.

Under a government influenced by socialist assumptions, health is perceived as a right of citizenship, to be pursued by social action such as redistributive justice. This involves the state in the collective provision of goods and labour, and measures of social engineering which acquire their own momentum and give rise to bewilderment among the managers and professionals when the people resist their well-meaning programmes, for example, the failure to attain 100 per cent immunisation. The dilemma is that health and welfare services under such a system are entirely demand-led and have to respond to diseases and social problems over whose causes they have no control. The diseases or problems may be caused by the behaviour of individuals or by the social, economic or physical conditions in society, but however they are caused those who determine the cause incur no economic cost and can benefit, directly if not indirectly, from free treatment. The cost of pursuing even such desirable social goals as health through collectivist means may involve an unacceptable or unmanageable degree of control over individual choices, whilst the pursuit of health as a commodity belonging to individuals results in an abdication of social responsibility for the environment within which people live. Conflict is therefore endemic in the provision of health and welfare and any current consensus is always unstable.

Understanding what affects the delivery of health and social care involves recognising and acknowledging the existence of powerful groupings which have their own interests to pursue and maintain. Policies such as community care, or primary health care or collaboration, will be judged in terms of the associated losses or gains for such groups, whether they are professionals, or managers, or organised workers, or consumers. In this interplay of powerful interests governments use or are used by them, and the pursuit of policies will not be disinterested. For example, the promotion of WHO programmes stressing community action and community care was vigorously harnessed by faculties of community medicine, who lost a great deal of influence when the functions and role of the medical officers of health were transferred from the local authority to the hospital-dominated health authorities in 1974. The

Faculty of Community Medicine (1985) published a Charter for Action which stressed promotion and prevention and argued for a reorientation of health care systems 'so that they not only respond to medical problems but are sensitive to social and psychological needs'.

The competition to become the lead agency in community care was between health authorities whose dominant profession was doctors, and local authorities through the social services. Primary health care led by general practitioners is in competition with the secondary health care sectors for finance and the allocation of work. Such competition is part of the political scene and is used by governments in pursuit of their goals.

The price paid for a limited understanding, organisation and account of health care, not only in the actual costs of delivery but also in terms of distortion of priorities, is seen in the growing divide between the health of the prosperous and the disease of the poor, both within and between countries. This divide is coming to be recognised not only as morally undesirable, but politically dangerous. It is apparent that either the individual pursuit of health or the collectivist pursuit of health each taken on its own to its ultimate conclusion becomes a meaningless dead end. Health is not a product, but a process of interaction within and between individuals and the societies in which they live. The recognition of health and welfare within society as an interactive, adaptive process without an end becomes the only creative basis for strategies, policies and practices. In this interactive process, by definition, the ability to collaborate is essential.

Models of health and disease

In European society both the early Christian church's dualism between the sinful body and the good soul, and the 18th-century development of scientific rationalism, led to Descarte's understanding of the body as a self-contained mechanical system which could be observed, described and treated. The mind was separate. It had no spatial properties, was accessible only through introspection and therefore was thought not to be amenable to scientific study and knowledge. The body became understood as the locus for disease, to be treated mechanistically within a model of medicine which included a disease label, a passive patient and a medical expert. By the early 20th century it was thought disease had a specific cause, either an invasion, a lesion or a stress, which could be identified and treated and cured through the application of knowledge drawn from the natural sciences and applied by scientifically educated practitioners. This model of illness is essentially bio-medical, individualistic, clinical, reductionist and episodic. Its influence is still strong in high-technology acute medicine, and in the social prestige and power conferred on its practitioners.

Alongside the growth of this model, under the influence of the development of psychology and its psychoanalytic application, there developed in the mid 20th century the bio-psycho-social model of medicine, and with it an extending repertoire of interpersonal skills for doctors especially general practitioners, and nurses. The philosophical base of this approach is humanist rather than scientific. For example, 'The physician's role is very much that of educator and psychotherapist. To know how to induce peace of mind in the patient and enhance his faith in the healing powers of his physician requires psychological knowledge and skills, not merely charisma' (Engel 1977). Such developments have been closely associated with the idea of holistic, that is whole person, medicine, but this medical understanding of 'social' is generally confined to an individual or family, at most small-group, perspective and is equated with 'cultural'.

A similar model of welfare as relating to an individual, a family, or at its widest a neighbourhood community was the basis for the development of social work, particularly as long as it emphasised case work with individuals. With the mid 20th century concern with poverty and the rise of civil rights movements, such an emphasis was criticised as inadequate for effective intervention in the social problems experienced by clients. A wider understanding of 'social' emerged, to include economic and political dimensions. Although therefore work with the psycho-social interaction of individual experience was generally understood by caseworkers as the model of welfare from which they drew their mandate, the economic and political extension of the meaning of social based on a 'predominantly social structural theory of causation yields a different locus and mode of intervention, which is usually at odds with the clinical orientation of medicine' (Huntington 1986). Although this may be recognised by practitioners and managers in practice, they largely feel themselves powerless as professionals, though not perhaps as private citizens, to engage in other than the traditional professional spheres of intervention.

The one field of medicine which has been influential in political and economic fields of activity, especially in the past, has been public health, now incorporated in community medicine and environmental health, the one a health service organisation, the other in local authority and not staffed by doctors.

Historically in the UK, especially in the years from the mid 19th century to the early 20th century, the passing of public health measures reduced the incidence of water and airborne diseases which could be controlled by legislation, public works, immunisation or isolation. The environmental, population-based field of activity for medically trained epidemiologists rests on an ecological and biological model of health, which is strongest when major environmental causes of disease are recognised as the responsibility of the whole society. In the 19th century clean water was the result of a succession of Acts

of Parliament and major engineering works and in the mid 20th century clean air was achieved by legislation, that is by public action not individual choice. The control today of the adverse effects, for example, of the proliferation of private transport is much more complex and difficult to achieve. At the same time, the WHO's philosophy of the 'healthy city' (WHO 1978) and the associated intersectoral collaboration has emphasised again the importance of the ecological-biological model of health and its relation to the structures of a society, so that the concept of health and welfare is inextricably linked with the understanding of social not as cultural, but as structural, the concept familiar to social work.

The overlap between the different models of health and welfare ranging from the individual to the group and on to the population demonstrates that each perspective can only be incomplete; each alone cannot explain nor organise an adequate response to physical, mental or social problems or the maintenance and promotion of health and welfare. The ability to combine and to collaborate is essential.

The range of models of practice

The range of models of practice in the delivery of health and welfare services is organised around cure, prevention, promotion, maintenance and care.

Demographic pressures, social and economic changes and medico-technical developments in the second half of the 20th century have affected the evolution of health and social care as politicians, managers, professionals and users struggle with the costs and implications of needs and services. A continuum across the whole range of response to need extends from intensive high-technology care, and moves on through a range of intermittent care in institutional or domiciliary settings with professional and personal services to, at the other end, permanent care for people requiring full maintenance or containment in a residential establishment.

This continuum has implications for different models of intervention. At one end is the traditional bio-medical model of diagnosis and treatment, leading to rehabilitation and sometimes cure. At the other end the response is based on a long-term care model of bio-psycho-social assessment and the co-ordination of a monitored programme or regime for people with permanent physical or mental impairments or degenerative conditions, leading to amelioration, maintenance or containment.

In reality these different models of intervention are rarely discrete. The experience of patients or clients as they progress through episodes where they require resources from professional, formal networks may begin with a crisis requiring intensive high technology medicine, followed by a period of hospital care followed by supervision from a combination of hospital-based and primary

health care based staff, and ending with minimum support in the community. Needs might, on the other hand, slowly manifest themselves with a slow decline of faculties requiring more and more support from informal and then formal networks of professional staff, until perhaps it becomes necessary to move into residential care staffed by a mixture of qualified and support staff.

The policy of community care is based on the model of needs assessment leading to the management of packages of care drawing on a kaleidoscope of formal and informal services within domestic settings. Although the local authority is named as the lead responsible agency, the contribution of a wide range of other health, welfare, statutory and voluntary agencies is expected. The philosophy behind community care is based on that of normalisation, which originated in the attempt to remove stigma from mentally ill and learning impaired people contained in large institutions. The idea of normalisation has developed into the philosophy that the goal of care is to enable and empower patients or clients so that they become participants in the assessment of their needs and the management of the services. For this they need access to information and access to resources, and the power to choose. The ideal model of community care is therefore a complete contrast to the traditional medical model of the powerful expert and the passive patient.

The implications of the late 20th century changes in needs, in the organisation of services and in the possibilities and philosophies of health and social care are enormous, both in terms of cost and the effective use of resources, and in requiring professions and agencies which hitherto set out clear boundaries between acute and chronic, and health and welfare, to smudge and blur these boundaries and to work across them. The need to work together is challenging to professionals whose claim to expertise rests on knowledge and skills which are perceived to be specialist and exclusive.

Specialisation and the division of labour

The basis of specialisation is the division of labour, the organisation of increasing specialisation within a complex whole. The wider the number of divisions and the deeper the degree of specialism, the greater the need for co-ordination in the service of whole people in the complexity of their needs. The recognition of interdependence may be clear, but it is also associated with differences of power and consequent struggles for demarcation and territorial dominance. The more technically based the specialism, the more secure its claim for pre-eminence within its clearly marked out sphere, but trouble arises when such a specialism, say orthopaedics, makes a claim for its authority to go beyond technical competence into spheres where others claim to exercise knowledge and skills, say physical therapists and social workers working to help a person accept a necessary prosthesis which has negative meanings. Alternatively, where

knowledge, skills and roles may overlap, the conflict over occupational territory may actually be more acute and demarcation disputes need even more negotiation (Bywaters 1989).

The division of labour in health and welfare is related to different facets of wholes and exists both within and between professions and agencies. It may be classified in relation to the client or patient's status, say a child or aged person; it can relate to the social problem, for example unemployment or illness, even to a part of the body, as in medical specialities; it may be defined by the skills of the worker, for example, therapist or community worker, or it may relate to the population served. It may be a structural divide, such as that between purchaser and provider.

Division of labour is a response to complexity and diversity, but because of differences in power and social status, it is not static. In search of security, status and power, professions and agencies seek to draw into their exclusive domain new responsibilities and skills, competing with others for dominance. Sometimes the value of the division of labour runs counter to a dominant ideology, such as that of genericism in the development of social work in the 1970s, which led to a disavowal of the need for specialisms within an occupation which was seeking a common base to strengthen its attempt to acquire power and influence social policy. The purity of this ideal was soon compromised by the pressure of the expectations of others, such as the media and doctors, who were not interested in the common base of social work but only in outcomes which were felt to be hampered by the lack of specialist knowledge and skills in, say, child care or mental illness. Speciality was seen to give not only expertise, but also credibility.

This chapter has argued that an understanding, an expectation and an experience of health and welfare are not static but are socially defined and socially determined. Philosophies of health implicitly underlie the public policies which determine the organisation and funding of health and welfare services. Models of care and practice are not absolute but are convenient devices in the organisation of service. In reality there is blurring and overlap, which require co-ordination. A division of labour arises because the growth of knowledge and technical advance leads to the development of specialties which are seen to be rational and purposive, but in meeting the needs of whole persons the more the divisions, the greater the interdependence on each other for the effective delivery of service. Health is therefore a process of interaction for both individuals and populations. Interaction implies interrelationships and interdependence. Complexity and diversity have to be taken into account in responding comprehensively and effectively. A range of responses both rhetorical and practical attempt to make complexity and diversity manageable. The management of diversity requires the professions and agencies involved in health and social care to work together. The totality of people's needs challenges the

absurdity of infinite self-contained and self-sufficient divisions of labour: the complexity of society and the historical growth and development of valuable skills and detailed knowledge within professions and organisations challenge the adequacies of genericism. If professions and agencies are required to work together, they need to know what makes it possible; working together implies allocating resources, building structures, managing processes and employing skills. Working together requires knowledge and education not only for responding to patients or clients, but also for relating to collateral members of the service network.

Some social theories relevant to an understanding of collaboration

Some of the social theories which are particularly relevant to the issues identified in the previous section are General Systems Theory, which addresses the concept of 'wholes', Social Exchange Theory, which considers social transactions and questions of costs and benefits, and Co-operation Theory, which attempts to illuminate the limits and opportunities of working together.

General Systems Theory

The biologist Ludwig von Bertalanffy, in his study of living organisms and their ecology, began to be aware of the limits of specialist disciplines in addressing complex social problems. He criticised reductionist explanations, and set out to explain wholes, not in metaphysical terms but as scientifically observable entities with a view to identifying regularities and properties which were valid whatever the size of the object of study (Bertalanffy 1971). Von Bertalanffy and his successors developed the concept of 'system', which could be used across all disciplines from physics and biology to the social and behavioural sciences and whose properties were present in all living phenomena. Wholes are more than the sum of their parts, interactions between entities are purposeful, boundaries between them are permeable and cause and effect are not linear but interdependent. The philosophy underlying Systems Theory is of the unity of nature, governed by the same fundamental laws and principles in all its realms. The consequence of the systems approach for health and welfare practice is to challenge the 'nothing but' view of human beings, a challenge applicable equally to the socio-economic explanation of radical social work, the bio-medical explanation of high-tech medicine, the utilitarian explanation of human relations management and the commercial explanation of social interactions as markets.

One of the crucial characteristics of systems relevant to applied service organisations is the exchange across permeable boundaries between one system and its environment, which is of course another system. This exchange in a social system is of energy in the form of goods, knowledge, work, an exchange

which is experienced as an interdependent process of events, 'the news of difference which makes a difference' (Ross and Bilson 1989). The exchange is regulated by feedback and through structures, so that stability and meaning are maintained and adaptability is promoted. Without both maintenance and adaptability there would be in all human and social systems an inevitable decline into disorder and dissolution.

General Systems Theory therefore offers a shift of perception from that bounded by separate parts to an understanding of the processes of interaction which take place within and between whole entities. 'Holistic' is therefore not opposed to 'reductionist'. Such an opposition would make it an impossible and overwhelming goal for separate agencies and professions. Instead, using the concept of system it becomes possible to acknowledge parts as themselves separate systems, but also as relating to others within a greater whole which is more than the sum of the parts because the interdependence and interrelating of the parts themselves are recognised as properties of a whole. This may be either one already existing, like a family with individual members, or a new one, like a purchasing consortium spanning several existing agencies.

The key elements from General Systems Theory relevant to an understanding of collaboration are those of interaction and interdependence, the emphasis on the management of processes, the recognition of equifinality(that is the achievement of the same goals from different possible starting points), the acknowledgement of the role of conflict in the evolution of change, the use of network analysis, and the bringing about of shifts in perception. The main insight is that it is possible to manage complexity and difference through the recognition and use of common properties which apply both to the parts and to a whole, experiences which are shared.

Concepts from General Systems Theory have informed or been specifically used in health and welfare models and practice and have influenced management and policy. In management, the idea of holism underlies the promotion of 'corporate management' as Whittington (1979) points out, but the emphasis on control from the top and administrative efficiency fails to acknowledge other systemic properties such as interaction and adaptation. A very influential use of systems thinking has resulted in the development of the bio-psycho-social model in physical and psychiatric care (Engel 1977) and the growth in the idea of holistic medicine. Associated with this is the idea of equifinality, that is, change in any one part of a system will bring about change in others; this has implications for problem definition and the focus of intervention and research. Clare and Corney (1982) show that the interaction between health and social needs means that change can be achieved by working with either.

In the early 1970s there were attempts to apply concepts from General Systems Theory to social work practice. One of the most influential produced a model for network analysis, or mapping of the relevant field for intervention

(Pincus and Minahan 1973). This model set out a descriptive analysis of four key systems which they called the *change agent system*, composed of those employed to bring about change; the *client system*, those who would benefit from the intervention; the *target system*, those who needed to change, and the *action system*, those who worked together to bring about change. Pincus and Minahan's model also developed a problem-solving process, but did not address skills. The significance of it is the clarity it achieves in identifying the client system, and more importantly for an understanding of collaboration, the highlighting of the relationship between the target system and the action system, and of the need for members of the latter to work together and to accrue sufficient power to lever the target system toward the necessary change.

The elements of General Systems Theory which have been specifically applied in interdisciplinary work in family therapy interventions or behaviour modification programmes include the use of responsive feedback to achieve either balance or a shift in perception which brings about the necessary change for growth and development. The desirable change is not necessarily linear or incremental, but may be in the direction of adaptation and an understanding of the meaning and significance of behaviour within the family. The use in family therapy of the concept of boundary or interface within the family, and between the family and the environment, and the management of the process across boundaries is one which could be transferred to an understanding of collaboration, as could the idea of shifts in perception about the problem focus.

Systems Theory then can contribute key ideas about structures and processes to a framework for understanding collaboration. Such a framework could lead to an analysis of the necessary conditions and an indication of the necessary skills. Systems Theory draws attention to relationships, structures, processes and interdependence. It has been widely and credibly applied in the human service professions, and permeates many now taken-for-granted assumptions.

Social Exchange Theory

Anthropological studies which showed that social exchanges were more than barter but carried meanings beyond the market value for the participants were the sources for the development of Social Exchange Theory in the social sciences, such as social psychology, sociology, anthropology and economics. In social exchanges, it is argued, there is a strong element of reciprocity, a calculation of return. The success of an exchange is dependent on some benefit. The benefit may not be direct or in kind as in barter, but may be some other satisfaction, either immediate or delayed or indeed to some other person or group in the social network. There is some element of self-interest in all instances of social exchange, and the incurring of obligation or indebtedness. Bargaining, negotiation and exchange are a function of interdependence

(Challis *et al.* 1988). The processes of social exchanges involve calculations of costs and benefits, recognition of power differences between the participants, the negotiation of expectations and an understanding of roles and relationships. Clarity about these boundaries of roles and relationships is essential to avoid the muddle and confusion which hamper the success of social exchanges.

In trying to understand collaboration, which has within it greater implications of difference and conflict than has the idea of co-operation, which belongs more in the realm of consensus, the concept of social exchange helps to highlight that something is happening, some things are being exchanged, and conditions for the success of exchange are necessary. The medium of exchange between practitioners, managers and policy-makers in interprofessional and interagency collaboration is all the elements which give their work purpose and meaning, especially resources which include clients or patients, information, services, influence, esteem and power. The demand for or possibility of such exchanges may be very threatening, especially if they are perceived as involving the likelihood of loss of power or control. The loss of resources or threats to domain will be seen as costs of collaboration. There are costs of actually setting up or maintaining collaboration which may not be questioned in times of plenty, but which in times of scarcity will need to be clearly offset by perceived benefits. The benefits usually have to be argued for more strongly, because at the beginning they are still in the future whereas the costs can be more immediately calculated. Trade-offs may be necessary to minimise costs or to make compromises between what is ideal and what is practicable. The benefits from social exchanges can multiply, and provide fruitful conditions for further exchanges. The slow build-up of trust between participants who experience successful exchanges, starting with little incidents involving small risk, will develop into social bonds of mutual commitment. Such commitment makes it possible to take greater risks because of the confident prediction that obligations will be met.

A study of Philip Abrams' classic work *Neighbours* (Bulmer 1986) makes a further conclusion of relevance to the concept of collaboration, and that is the importance of being competent to engage in social exchange. Competence includes not only having sufficient power to engage, but also knowing how to take part. The need for people to be trained and to acquire skills is identified, as is the need for conditions conducive to social exchange to be present, such as time, and appropriate social structures and organisation.

There is clearly a conflict between the need for occupations and professions and agencies through the slow growth of trust to build up joint activities to serve their own interests as well as those of clients, and the need for government and policy-makers to introduce new policies. When community care was proposed, perhaps the recognition of the need for it may be understood as the 'shift of perception' referred to as 'second order change' in General Systems

Theory, which will bring with it the energy to implement change and act on the new understanding, but if the insights from Social Exchange Theory are relevant, government must recognise that trust cannot be commanded, only slowly built up as resources, structures, skills and rewards are deployed and costs and benefits at all stages and at all levels are acknowledged.

Co-operation Theory

Robert Axelrod, a political scientist, published his book *The Evolution of Co-operation* in 1984. Believing that only co-operation would ensure the survival of the species, he sought the conditions which made co-operation possible between self-interested egoists in a complex world. Axelrod made a specific use of Games Theory, that is, a mathematical theory setting out the optimum choice of strategy in conflicts of interest. Axelrod promoted a computer tournament around a game he called 'The Prisoner's Dilemma', which was a means of examining the various strategies which could be employed by people with inadequate information and different objectives when they were required to come to a decision which would bring most benefit and least harm to all the parties. Two prisoners, charged with the same crime and unable to communicate, are each separately faced with the gaoler's proposal. The gaoler suggests that if one prisoner confesses, he will go free and his confederate will be imprisoned; if *both* he and his partner confess, the sentence for both will be reduced; if *neither* confesses, the evidence will only be sufficient for a short sentence. The last option is the optimal individual strategy, but runs the risk of one confessing, leaving the other to be imprisoned. So the most co-operative strategy is for both to confess and to have a reduced sentence.

Hundreds of computer games were played and scored. Axelrod, studying the results, arrived at a strategy he called 'Tit for Tat'. This elicited behaviour which allowed both players to do better by co-operating than either did by working alone. The strategy was based on the certainty of reciprocity 'enlarging the shadow of the future'. If defection from agreement to co-operate brings retaliation, then making sure that participants recognise each other and know that they will meet again leads them to conclude that unless there is co-operative behaviour by both parties, there will not only be loss to the overall enterprise, but also to each party.

As well as reciprocity and durability of relationships, a third condition is *provocability*, that is the ability to make a quick response to uncalled-for defections. This depends on each participant having enough power in the situation to make the other realise defection, or non-co-operation, is more costly than co-operation, and that defection will be followed by the certainty, or strong probability, of punishment from the outside world.

Ideas which appear in Co-operation Theory are echoed in experience of interprofessional collaboration. Empirical research into collaboration between district nurses, general practitioners and health visitors (Bond *et al.* 1985) attempted to set out a *taxonomy of collaboration*, ranging from isolation, in which professionals never meet or communicate, to collaboration throughout an organisation in which the work of all members is fully integrated. The study rated the extent of collaboration, and found it was highest where professionals got to know a few others well and worked under such conditions that there was a strong likelihood of frequent contact. It was lowest where professionals either never met at all, or met so casually that they did not get to know each other. This finding echoes Axelrod's condition of durability, and trust contingent on evidence and history.

If the parties to co-operative enterprises do not have sufficiently equal power to reciprocate if one defects, then co-operation can degenerate into coercion.

The danger of exploitation and collusion in interprofessional collaboration where a weaker party enters the territory of a stronger without acquiring an adequate power base and not only undermines its own work but also fails adequately to represent an alternative view of society and health is discussed by Paul Bywaters (1986) in writing about medical social work in hospitals. This argues the need for *both* parties to be able to reciprocate and to be seen to be provocable, and that co-operation must not be offered unconditionally.

Co-operation Theory assumes that the parties will co-operate for their own benefit, which becomes a mutual overall gain. What if co-operation is required for the benefit of a third party, that is the client or patient? The implications of this theory are that the client should be an active not passive participant, able to assess the need for co-operation for his/her well-being, and able to reciprocate, or punish, if co-operation is not forthcoming. The delivery of health and welfare care at a very general level of control is determined through the agency of government interpreting what society considers desirable and hence, as in the policy of community care, government not individuals can be the third or proxy party requiring interprofessional collaboration. At an individual level the power of the client or patient to participate depends on the degree of choice available to him/her, that is the person's power to reciprocate or withdraw. In a market-place such power is exercised as a consumer. In public sector services, the pseudo-market creates purchasers who are agents for the users. Agents may be a fund-holding general practitioner, or a care manager in community care. Individual patients or clients may have the power to complain, but complaints processes are cumbersome and time-consuming, in the face of which organisations are often defensive. It would be a very well-informed and persistent user who alone would pursue a complaint about failures of collaboration. So such third party beneficiaries to collaboration are likely to accrue power either by

being valued by their agent or by combining with others or by invoking the media.

In the idealistic 1970s Axelrod maintained that the social outcomes of co-operation transcended individual situations, and resulted in what he called 'evolutionary credit creation' with ultimate widespread benefits. Some economists (Hutton 1995) argue even in the harsher climate of the 1990s that the benefits of trustworthiness in business enterprises is seen to be effective in establishing relationships which reduce the risks of the heavy costs incurred by imperfect information and lack of commitment in short-term contracts. 'Trust is dependent upon parties to a deal caring about their reputation as moral beings and monitoring their own conduct with integrity... rewards for trustworthiness include love which becomes a means of entrenching committed behaviour'.

Co-operation Theory highlights for collaboration the recognition that it can be mutually beneficial if parties bring to it the willingness to trust the other but the power to reciprocate if the other defects. That power rests partly on the 'shadow of the future', the knowledge that any defector cannot just cut and run, but will continue to be involved in the relationship.

Conclusion

The concepts drawn from these three social theories about interaction which are relevant to a clearer understanding of collaboration in health and welfare by policy-makers, managers and professionals may be organised into three categories. All these categories are contained within the idea of competence and are therefore related to learning, which is intended to equip practitioners with competencies.

The first category is that of *attitude*. Into that falls the concept of commitment, not only to the perception of the need for collaboration, but also to the other participants and the build-up of trust and predictability. The recognition of the legitimacy of calculating costs and benefits, rather than resting on an appeal to a vague altruism is essential, as is the acknowledgement of power relationships and the differences of expectations and perspectives.

The second category is that of *knowledge*. An understanding of the common characteristics of social systems, such as boundaries, structures and processes and the concept of equifinality is necessary to effective collaboration. If participants do not know what they have to deal with in working together, and share their knowledge in terms they can all recognise and understand, they will be overcome by all the difficulties so frequently documented.

The third category is that of *skills*. The main skills which emerge are the ability to describe and map the essential elements of the relevant social network, and the ability to manage the processes of interaction between them. Such management will involve setting up appropriate structures and resources, and

clarifying roles and responsibilities, as well as defining the task in terms to which all participants can subscribe, and to which people can be held accountable.

The requirement for organisations and professions to collaborate around the needs of other parties depends on a sufficiently shared perception of what is necessary, and what is to be gained. The gains may be individually different, and the perception of what is necessary may be a continuum on which professions overlap at some points. The crucial perception for interagency and interprofessional collaboration is the recognition of interdependence, and of long-term credit creation, which may benefit not only individual clients or patients, but also the professionals and their agencies, and the effective use of expensive resources in society.

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