Cooperate, coordinate, communicate or collaborate?

IN HEALTH CARE we use these "C" words regularly — describing what health professionals, patients, consumers, politicians and managers need to do to improve health care systems. A snapshot of each of these is provided below.

The Institute of Medicine's *Crossing the Quality Chasm* report suggested that cooperation among clinicians was a priority.[1] Yet game theorists have long shown that cooperation results in better individual outcomes than competitive behaviour.[2] Driven to achieve the best outcomes, people will choose to cooperate more often than they choose to compete. Most recently, game theory analysis has even been applied to the evolution of cancer, with the resulting conclusion of "malignancy from cooperation"[3] — tumours grow because it is the nature of cells to cooperate. Given this tremendous innate "force" for cooperation, why is there the appearance of less cooperation among health system components than we would like?

Coordination is "the act of managing interdependencies between activities."[4] But recent communications from the Massachusetts Institute of Technology (MIT) make me wonder if there is any point in encouraging health professionals to coordinate until we have the connective technology in place. Founded in 1991, the MIT Center for Coordination Science studied how coordination occurred in different systems, including human organisations, markets, and computer networks. The Center explored how businesses and other organisations could be coordinated in new ways. But in 2006 MIT dispensed with the notion of coordination and replaced the Center for Coordination Science with the Center for Collective Intelligence. This Center focuses on: "*How can people and computers be connected so that — collectively — they act more intelligently than any individuals, groups, or computers have ever done before?*"[5] The notion of coordination has been replaced by connection, suggesting that coordination is not possible without connective technology.

Communication has been even less successful than cooperation or coordination. Peter Drucker suggests:

> In no other area have intelligent men and women worked harder or with greater dedication than psychologists, human relations experts, managers, and management students have worked on improving communications in our major institutions. Yet communications has proven as elusive as the Unicorn.[6] (p. 3)

That leaves collaboration. Collaboration is defined as:

> ... the process of shared creation: two or more individuals with complementary skills interacting to create a shared understanding that none had previously possessed or could have come to on their own. Collaboration creates a shared meaning about a process, a product, or an event. In this sense, there is nothing routine about it. Something is there that wasn't there before.[7] (p. 140)

Perhaps it is collaboration that should have been our focus in health care.

In this edition of *Australian Health Review* we are looking to greater collaboration — the process of shared creation. First, we introduce a new section, "Models of Care" that will feature in every issue of *AHR*. I am pleased to share creation with the Case Management Society of Australia and Models of Care Editor Deborah Yarmo-Roberts. I believe that this partnership will enable us to advance the understanding of health system models of care in a measured, rational way.

Second, *AHR* is pleased to introduce "nosokinetics", the science of measuring and modelling patient flow through health and social care systems. This science was new to me and may be new to many *AHR* readers. The editorial by Peter Millard and Mark Mackay (*page 22*) which outlines this relatively new science convinced me of its applicability to the health system. Please see

the diverse collection of conference papers in this section.

Third, our regular collection of peer-reviewed papers provides some insights into how we are cooperating, coordinating, communicating and collaborating in the health care sector. Papers from South Australia (*page 10*) and Victoria (*page 16*) illustrate the application of lean thinking to hospital work. Team working in nursing is presented by Walker and colleagues (*page 98*) and a team from New Zealand, Queensland and Victoria explore the impact of protocols on the capability of nurse practitioners (*page 108*).

We also have a collection of papers addressing policy and planning topics, including disclosure of treatment injury (*page 116*), the need for children's centres (*page 123*), the relation of ethnicity to acceptance of home visiting (*page 132*), a review of outsourcing decisions in Victoria (*page 140*), and length of stay benchmarking in the private sector (*page 150*).

I look forward to future collaboration.

Sandra G Leggat
Editor, *Australian Health Review*

1 Committee on Quality of Health Care in America, Institute of Medicine. Crossing the quality chasm: a new health system for the 21st century. 2001: The National Academies Press, Washington.

2 Axelrod R, Dion D. The further evolution of cooperation. *Science* 1988; 242(4884): 1385-90.

3 LeBrasseur N. Malignancy from cooperation. *J Cell Biol* 2006; 174: 908a.

4 Malone TW, Crowston K. Toward an interdisciplinary study of coordination. Cambridge, Mass: Center for Coordination Science, MIT: 1991.

5 Massachusetts Institute of Technology, Center for Collective Intelligence. 2006 Available at: http://cci.mit.edu/ (accessed Dec 2006).

6 Drucker P. Management: tasks, responsibilities, practices. London: Heinemann, 1974: 3.

7 Schrage M. Shared minds. New York: Random House, 1990: 140. □