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In part 2 of this special issue on Partnerships in Primary Health Care, we take a further look at the interorganisational and interprofessional collaborative approaches adopted in the quest to achieve a more integrated and coordinated Australian primary and community health sector. The papers herein ask if there are indeed universally critical components of successful partnerships and how significant the contribution of good policy, sustained funding and overcoming system resistance?

McDonald and her colleagues conclude that popular organisational models, such as 'hub-and-spoke' and 'networks', need be astutely combined with supportive systems and interprofessional allegiances in order to make significant inroads. Naccarella explores the determinants of successful interprofessional allegiances by observing the types and qualities of general practitioner work related relationships, and the manner in which they are established. Kendall *et al.* dig further still to provide us with the medical practitioner's perspective on the purpose and function of a health partnership, and their capacity to engage in collaborative activities. Likewise, Foster *et al.* discuss the restrictions, realities and somewhat unexpected 'impacts' of funding incentives to delivering multidisciplinary team care. This clutch of papers challenges the current policy emphasis on structural reform and financial incentives as legitimate enablers of genuine collaborative care.

A number of papers in this issue provide updates on the progress and outcomes of existing collaborative approaches. Kennedy, in her letter on one primary care partnership experience, grapples with the notion that while sustainable partnership success appears to rely heavily on the determination of 'in-house champions', the greatest successes are often achieved when aligned with supported and structured change. Poulsen *et al*. provide us with an example of how progressing practitioner–community–research triumvirates might build capacity in a community to address complicated health issues, such as childhood obesity. Allison *et al.* and Kowanko *et al.* provide practical reports on why coordinated care is vital for the provision of services for marginalised groups such as Aboriginal people and children living in rural and remote areas.

Optimism comes in the form of Walker's discussion on the propensity of primary health care partnerships to provide a foundation for sector wide responses to the issue of our times, climate change. Tait's letter supports this in proposing that, 'primary health care's strength is that it provides both a philosophical framework for analysis and planning at a macro level, as well as a mechanism for action at public health and in clinical practice at the micro level'.

I trust that the articles and letters in this part 2 of the special issue leave you the reader well informed and well placed to heed the pitfalls of partnership development and garner the significant advantages that successful sophisticated primary health care partnerships can and do achieve.

It remains a privilege to contribute to this journal and work with Professor Rae Walker and her team and I appreciate the opportunity to commend these articles to you.

Sean Lowry
Guest Co-editor

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