

Ballarat Health Consortium: A case study of influential factors in the development and maintenance of a health partnership.

Abstract

Inter-sectoral partnerships in health have a central role in current policy and programs. Partnerships are seen to be an effective strategy for maximising health outcomes. However, theoretical models of health partnerships are underdeveloped. Moreover, the research literature contains inconsistent findings about their effectiveness, and there has been very little evaluative research on health partnerships in this country. This paper reports on a case study of an inter-sectoral consortium using a health promotion approach to cardiovascular disease. A model of partnership formation and development is presented. From this, a research strategy was devised and carried out. Results indicate that the health consortium formed in response to a critical health issue. As a separate legal entity without recurrent funding, the consortium has been sustained through the commitment of individual members. Project funding has, in large part, dictated its operations. This case study reveals the strengths, vulnerabilities and achievements of a consortium over five years. To produce sustainable health outcomes, partnerships require strategic management to capitalise on individual endeavours, organisational alignments, and government/funder priorities. The ideological zeal for inter-sectoral health partnerships must be balanced by rigorous evaluation, together with more sophisticated indicators for measuring success in partnerships in health promotion. Theoretical development of models of health partnerships will also contribute to enhanced effectiveness.

Introduction

Intersectoral partnerships refer to cooperative arrangements between groups and agencies from different sectors that unite to address health issues (O'Neill, Lemieux, Groleau, Fortin and Lamarche, 1997). These arrangements are believed to be more effective, efficient or sustainable than might be achieved by members of the health sector acting alone (Nutbeam, 1998). Such partnerships are deeply embedded in health promotion policy and programs both locally and internationally. The Jakarta Declaration proclaimed health partnerships to be a key priority for health promotion in the 21st Century (World Health Organisation, 1997). In Australia, current national and state policies and programs heavily emphasize intersectoral health partnerships (Commonwealth Department of Health and Aged Care, 2000; Department of Human Services Victoria, 2000).

The rationale for the adoption of intersectoral and partnership approaches to promote the health of populations is as follows. First, most of the factors that directly impact on health are outside the acute or even preventive health systems (O'Neill et al., 1997; World Health Organisation, 1997). In other words, joined up problems require joined up solutions. Second, the responsibility for addressing new and broader health issues can be shared (Butterfoss, Goodman and Wandersman, 1993). Partnerships can demonstrate and mobilise widespread public support to address issues. Further, this concerted action can maximise the power and outcomes far beyond what individuals or sole groups can achieve. Partnerships provide leverage to access resources and draw in a broad range of constituencies. Finally, partnerships can be sufficiently flexible to take advantage in new situations (Butterfoss, Goodman and Wandersman, 1993).

While the ideology and rationale for intersectoral health partnerships are evident, there are three major problems that indicate the need for a more critical examination. First, there is

a great variation in terminology and meaning. While some talk in terms of partnerships, other refer to collaborations, coalitions, consortia or community capacity building (Nutbeam, 1998; Gillies, 1998; Hawe et al., 1998; Poole, 1997). Each of these has quite separate implications for the structure, functioning and goals of cooperative action. In short, the lack of consistency means that it is unwise to generalise about the effectiveness of these arrangements.

Not surprisingly then, research on the effectiveness of health partnerships has returned inconsistent findings. There have been few rigorous and systematic studies of health partnerships. Evaluations tend to focus on the health project rather than the effectiveness of the organisational structure that supports it. One major review of published studies concluded quite unequivocally that partnerships to promote health across different sectors and disciplines do work effectively (Gillies, 1998). In other words, there was a direct relationship between the level of local community involvement and the size of the impact. By contrast, others argue that there is little evidence of effectiveness or that inter-sectoral health-related actions fail more often than they succeed (O'Neill et al., 1997). One reason for these discrepancies is the absence of a sophisticated set of indicators to capture the community and organisational-level impact of health promotion (Shiell and Hawe, 1996).

The final problem is the lack of a generally accepted theoretical framework for health partnerships (Delaney, 1994). Theories utilised including community organisation and community building (Minkler and Wallerstein, 1997), community action (Poole, 1997), coalition theory (O'Neill et al., 1997), organisational change (Goodman, Steckler and Kegler, 1997), and social capital (Gillies, 1998). A useful theory might combine individual and organisational levels of analysis, strike a balance between altruistic motives and rationally calculated interests, and remain sensitive to changes in partnership arrangements over time.

Undeveloped theory limits our capacity to build effective partnerships and identify those specific factors that enhance effectiveness.

The aim of this paper is to report on a case study of an inter-sectoral health consortium operating in a large regional city. Specifically, the study aimed to examine the formation and development of the consortium through focusing on factors that strengthen and weaken its effectiveness.

Conceptual Framework for Analysing Health Partnerships

Figure 1 draws together relevant theoretical and empirical literature into a model of partnership formation, development and effectiveness (O'Neill et al., 1997; Butterfoss et al., 1993; Crisp, Swerrisen and Duckett, n.d.).

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Partnership types can be top down, bottom up, sideways, or community organising (Crisp et al., n.d.). The particular type will have a profound effect on subsequent functioning.

Partnership development can be understood in three stages: formation, implementation and maintenance, and goal attainment (Butterfoss et al., 1993). Factors that contribute to partnership functioning in each stage can be identified through the application of coalition theory (O'Neill et al., 1997). Understanding which factors operate at each stage can inform strategic decisions that increase the effectiveness of the partnership. This model afforded both a guide to our line of inquiry and an analytic framework to interpret the results.

A Brief Profile of the Consortium

Mortality and morbidity data released in the mid 1990's showed that the Grampians Region of Victoria had the state's highest rates of cardiovascular disease for males and the

second highest for females (Health and Community Services, 1995). This prompted a meeting of a small group of practitioners and researchers who were interested in health promotion and heart health. Subsequent meetings led, in 1995, to the formation of the Ballarat Health Consortium and its establishment as an independent legal entity. As an inter-sectoral partnership, the consortium drew together the interests of staff from nine health, education, and recreation agencies in Ballarat. The consortium did not attract substantial seeding funding and does not have recurrent funding. It is dependent upon project funding as its sole source of income.

The Ballarat Health Consortium's original aim was "to improve heart health outcomes for the Ballarat community by using a cooperative and coordinated approach to encourage the development of long term structural and cultural change which is supportive of improved heart health outcomes". The consortium uses a community-based, health promotion approach. Since 1995, the consortium has been an active player in various cardiovascular health promotion programs in the region. The consortium's major project over the last five years has been 'Environmental Change for Healthy Heart Options' (ECHHO), an environmental approach to cardiovascular disease prevention (King, Jeffrey and Fridinger, 1995; Nutbeam, 1997; Catford, 1993). The project has attracted funding from both the Department of Human Services (Victoria) and VicHealth.

Methods

This case study employed three main research methods: interviews, documentary analysis and participant observation. Individual interviews were conducted with ten people previously or currently involved with the consortium. Interviewees included committee of management members as well as project officers. Interviews, lasting between 30 to 90

minutes were conducted separately by two researchers using a structured interview schedule. Notes were taken during the interviews. The second method involved content analysis of the consortia files containing minutes of meetings, service agreements, submissions, promotional materials, and evaluation reports. The final method involved participant observation at committee and project meetings, and during strategic planning sessions.

Data analysis involved identifying and coding the factors affecting the development of the consortium, and the factors assessed as having strengthened or weakened its effectiveness. Checks for reliability included independent coding by the researchers, followed by comparison of the coding, and cross-checking between the sources of data. These strategies led to a high degree of intercoder agreement.

Results

A Sideways Partnership

The Ballarat Health Consortium (BHC) conforms to a sideways approach to health partnership. Such partnerships exist between organisations or groupings of people who might otherwise have little or no working relationship. The consortium brought together people from a range of agencies, most of who knew of each other, but did not have an established working relationship. This is illustrated in an early file note that states “The Consortium is seen as a way of bringing together a group of diverse organisations which would not normally be involved/talk to one another.” Original participants included project workers, community nurses, and program managers. Sideways partnerships promote the exchange of information that can lead to resource mobilisation, particularly when key community leaders and health professionals are involved. As one committee member described “There’s no community

involvement as such in BHC. It's got a strong agency focus." The limited capacity of stand-alone agencies to achieve broad-based cultural and structural change was repeatedly highlighted by interviewees. This sideways partnership prompted the decision to establish BHC as a separate organisation: "Incorporation only occurred to enable funding applications to be put in. Funding drove this because otherwise funding would have had to have been channelled through other agencies."

Formation

Data analysis revealed four defining factors during the formative stage of the consortium. These were: responding to an identified health issue; the density of rural networks; individual rather than organisational engagement; and a non-competitive ethos.

Driving motivation - An identified health issue

The driving motivation for the formation of the consortium was the need to respond to a critical regional health issue (high rates of cardiovascular disease). One of the original members said "BHC attracted the activists and champions in organisations who were interested in heart health and collaboration." This is reflected in the comments of one member: "We had a real ideological commitment to primary prevention and environmental change ... we knew we didn't want to go down the road of balloons in malls." Another described the consortium as a mechanism to address the health issue, rather than an opportunity for funding:

"So many of the partnerships that have formed recently have been opportunistic in just applying for funding. We didn't start that way. It was a commitment to an ideal of working together to get things done."

The density of rural networks

The rural context positively influenced the development of the consortium in the formative stage. Interviewees acknowledged that, in a rural environment, dense networks facilitated information sharing: "People have used the BHC networks to get things done. That's been one of the big things, but it's very hard to capture or measure." The impact of strengthened networks on the functioning and capacity of the consortium in this formation stage is shown in the level of reciprocity between participants: "There was lots of information sharing and networking that was really positive." A commitment to community processes and outcomes was critical to the consortium approach: "We looked at who was motivated by community and who was motivated by business – we saw this as an important aspect of retaining the integrity of the consortium." Interviewees affirmed the pivotal role that collaboration had during the critical formation stage. Despite, or perhaps because of, the impact of a competitive funding environment, networking flourished. As stated by one participant "The consortium was almost a rejection of competitive tendering. There was quite a bit of discussion between parties about needing to cooperate and being stronger because we were united."

Individual rather than organisational engagement

Individual commitment to the formation and maintenance of the consortium was unequivocal. The majority of formation members (with the exception of the education sector) had a background in community development and health promotion. As identified by one interview participant: "Similar backgrounds and philosophies gave us a strong network base from which to draw expertise and build trusting and positive relationships." Because the consortium was initiated by like-minded activists in response to a pressing health issue, it did not engage agencies at an organisational level. This is illustrated in an early file note: "The

members of the Consortium don't necessarily feel that they have the commitment of their organisations backing them in their deliberations and decisions." The extent to which the formation stage was driven by individual workers has been a defining characteristic. The commitment of these individuals was not matched by the agencies which employed the workers. In the long term, this weakened the consortium's capacity to achieve systemic change despite the presumption that there would be a convergence in individual and agency agendas as the consortium consolidated its work. In hindsight, participants acknowledged that they:

"Didn't get organisational support early enough ... it didn't really get written into the strategic plans or priorities of each agency ... One of the problems is that the consortium hasn't really engaged people at the higher levels of member agencies. This means that the consortium doesn't really have a high priority on the agendas of agencies."

The engagement of individuals rather than organisations resulted in a trade off of power for commitment. A number of participants commented on this:

"Member organisation representatives don't necessarily have control on final decisions made by their organisations on project involvement". "The BHC is a collection of individuals from agencies who came together as a committee. But it wasn't an engagement of the organisations themselves."

More recently, the consortium has improved its communication systems with its member organisations and has undertaken a strategic planning process aimed at organisational engagement.

Independent and non-competitive ethos

Just as the organisational context has had implications for long-term development and effectiveness, so too have the consortium's business rules. The business rules were established during the formation stage and, until recently, have continued unchanged. The degree of formalisation of business rules was, in the formative stage, limited. Despite a lack of formalisation, participants uniformly agreed that there are a series of operational guidelines which remained constant. The guidelines embraced both non-competitiveness and consensus. Processes for decision-making and conflict resolution are managed through an open and consensual approach. In establishing this approach, consortium members reported that they "...kept at the forefront that we wanted to preserve the integrity of the group and ensure that no one would feel alienated so we established a process for this to happen." This allowed for the development of a culture of equal status between all partners based on strong formative relationships: "You can't impose good will and trust .. it's about building relationships". The consortium also resolved that it would not tender or submit for any funding that is core business for any other agency as "It is critical that we are viewed as enhancing rather than threatening the work of regional agencies. We offer support to agencies that are seeking funding." This partnership approach was described as atypical for its time:

"We were doing things that were well ahead of the game. For example, we formed partnerships in the Kennett (government) era when agencies were being pushed apart." "The BHC was almost a rejection of competitive tendering. There was quite a bit of discussion between us and the General Practice Division about needing to cooperate and being stronger because we were united."

Using these operational practice rules as a framework for development, the consortium has increasingly formalised its business rules as it has moved out of the formation stage and into the implementation/ maintenance stage of development.

Implementation and Maintenance

Data analysis revealed four influential factors during the implementation and maintenance stage of the partnership. These were: a project-driven consortium; a multidisciplinary approach; a discrete rural district; and business rules.

A project-driven consortium

The search for and attainment of project funding has had major impacts on the consortium. Initial seeding funding was given by a member agency to provide support in incorporation, submission writing and administration. For almost two years, the BHC applied unsuccessfully to numerous sources for project funding. This excerpt from an early filenote reveals the impact: “The Consortium seems to have started off with enormous expectations of a major project which did not occur and it is now struggling for its identity.” In hindsight, this was seen to have certain advantages. As stated by one member:

“It was fortunate that the consortium didn’t get funding straight away because it would have put the focus on the project rather than building trust and goodwill... if there had been a funded project there would have been pressure to produce without setting the foundation.”

In 1995, notification of three-year funding for the ECHHO project propelled the consortium into its next phase of development.

The provision of project rather than recurrent funding leaves the consortium vulnerable at a variety of levels. Long-term development is limited when attempting to

balance a broad based ideology against the framework of a specific project. As identified by a number of participants:

"We desperately need more projects and funding to strengthen the consortium so that we don't just become the ECHHO project management group...the consortium has to be bigger than the funded project and yet, without the funded project there are no funds to move forward... we have gotten used to the self sufficiency provided by the worker."

A multidisciplinary approach

The consortium approach provides participants with rewards at both the individual and service level. Participants identified that the consortium's inter-sectoral and multidisciplinary dimensions allowed for input on an issue to be gained from a number of individuals from diverse backgrounds and organisations: "We each provided a reality check of what would work with constituent groups." Among individual members, the consortium provides for skill development and participation in broader health projects:

"My skills have increased over time as I have learnt and seen things from different perspectives – it has particularly enhanced my insight and views of best practice in program delivery ... I have a real sense of achievement in being involved in projects that my own agency could not have been involved in as a sole player."

Discrete rural district

Throughout the implementation and maintenance stage of consortium development, the rural context has continued to have a positive impact. Geographical and cultural factors have strengthened networks and consolidated regional partnerships. Participants commented

on improved solidarity between organisations: “The trust that was already there has increased and contacts within agencies have been consolidated.” Another commented that: “The inclusiveness of Ballarat, its strong links and communication between agencies has strengthened the BHC.”

The consortium was advantaged because it operated in a defined geographical area with relatively few competing players:

“One of the factors contributing to BHC’s success has been the distinct area of Ballarat. It’s only worked across one council. Links with the university and other agencies have been much easier.”

This degree of cooperativeness was particularly evident to consortium members who had previously worked in capital cities:

“People are more friendly, open and less territorial. The level of openness is surprising having come from a metropolitan area. There’s never been a threat of being taken over. This is due to the strong relationships between the individuals on lots of levels.”

Business Rules

At the current stage of consortium development, activities have become increasingly formalised and strategic. A recently completed strategic review identified several priority objectives including:

- Development of memoranda of understanding with regional agencies
- Formal needs assessment and professional development training for consortium members
- Clarification of the functions of member agencies
- Review of the consortium's organisational mission, and
- Strategies to engage consortium members at an organisational level.

Goal Attainment

The ultimate goal originally set by the consortium was the reduction in cardiovascular disease in the district. Secondary aims included using a structural approach to health promotion, and enhancing coordination between agencies and the community.

Impact on cardiovascular health

There is little evidence that the BHC has had an impact on cardiovascular health. The most recent data indicate that the Grampians Region continues to have among the state's highest rates of cardiovascular disease for both men and women (Human Services Victoria, 1999). It is unrealistic to expect impact on these health indicators in the short term.

Structural approach to health promotion

On the other hand, consortium members assert that they have influenced how health issues are being addressed in the region:

"We've raised agency awareness of the issue and have been instrumental in working toward better frameworks for health promotion in cardiovascular disease." "There's probably been little demonstrable impact of the BHC on heart disease. But our impact is on how the issue is being addressed. We're getting people to think about a settings approach as opposed to individual approaches."

The consortium profile has risen and it is identified as a key regional player in primary prevention of cardiovascular disease. This is evidenced by the involvement of the consortium in regional health promotion projects (such as the Healthy Communities Program) and statewide rural health initiatives (such as the Victorian Rural Health Promotion Program).

Coordination of efforts and organisational engagement

Goal attainment can also be measured in terms of impact on constituent agencies. As described above, there has been little activity by the consortium in this area. Recent strategic planning by the consortium identified this as an area requiring urgent attention. Recurrent funding is also needed to consolidate the work of the consortium. Funding for the current ECHHO project recently ended, and this raises another cycle of issues for the consortium:

“I’m concerned about the long term future of BHC. Without a project worker, BHC could not survive. The original members are used to having a project worker. They would be hard pressed to go back to their original level of involvement.” “There’s a danger of BHC being too project driven. It needs to meet the needs of the wider consortium members – not just those whose agencies benefit from or are interested in the funded project.” “In the long term, BHC requires more funding for projects that relate to the member agencies’ core business. Unless more funding is forthcoming, it will drop back to being a networking group.”

Discussion and Conclusion

This case study examined the formation and development of an intersectoral partnership in health promotion over a five year period. The study offers a candid insight into the direction and operations of a partnership in a large provincial city. By focusing on the consortium’s organisational structure, this research reveals the complex interplay of factors affecting partnership effectiveness, including the long-term implications of strategic decisions made during the formative stages.

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The results highlight that the consortium was formed by a network of professionals in response to an identified local health issue. These professionals were committed to improving cardiovascular disease through health promotion. As a sideways partnership operating in an era of competitive tendering, the cooperation between members appears atypical, and a source of both strength and weakness. The strength lay in the individual commitment, intensive networking, and shared responsibility for outcomes. The weakness of this approach was that the individual members did not have the capacity to make decisions on behalf of the agencies they represented. Therefore, the consortium had little impact back on its member agencies. The decision to establish the consortium as a separate legal entity made it autonomous but meant it lacked a resource base, particularly recurrent funding. The imperative to secure project funding continues to dictate the activities of the members. In terms of goal attainment, the consortium has yet to have a significant impact on cardiovascular health. On the other hand, the consortium's specific funded project (ECHHO) is currently being evaluated; early results are promising. Consortium members have recently concluded a rigorous strategic planning process, aimed at reviewing the conditions that shaped the implementation and maintenance stages of consortium development, in order to enhance overall goal attainment. Constant reappraisal is important for successful partnerships.

Producing effective health outcomes through sustainable intersectoral health partnerships demands strategic management. The partnership must be positioned to exploit individual endeavours, organisational alignments and funding priorities. This study illustrates both the need for different strategies and organisational designs at each stage of development to enhance functioning (Butterfoss et al., 1993).

Goal attainment can be assessed against a consortium's stated objectives. In addition, a more general set of measures can be linked to the particular type of partnership. For example,

the effectiveness of sideways partnerships can be measured by: the level of community activation; collaboration and information-sharing between organisations; network density; and reorienting services and programs provided by constituent organisations (Goodman et al., 1997). Data from this study allow us to draw some tentative conclusions regarding each of these measures.

First, there is little evidence of broad community activation by the consortium. The BHC has however, contributed actively to other community-based health projects such as the Healthy Community Program. The consortium's main project, ECHHO, has had an impact in particular workplace settings. In summary, community activation appears to be segmented and diffused. The second measure – collaboration and information sharing between organisations – shows the consortium to be a sound performer. As an intersectoral partnership, the consortium formalised cooperative relationships between workers from nine agencies. Reciprocity between consortium members has been very positive and sustained, though primarily at an individual rather than organisational level. Network density, as the third measure, was observed to be exceptionally strong. Members capitalised on the opportunities afforded by the regional setting. Fourthly, the consortium has had little success in reorienting services and programs provided by constituent organisations. Explanatory factors for this failure can be identified in the consortium's formative stage. In attracting activists who were committed to heart health and health promotion, BHC did not engage staff who were empowered to make decisions on behalf of their organisations. Moreover, the strategy of establishing the consortium as a separate legal entity founded on a non-competitive and consensual decision-making model, meant that it wielded little power to change the priorities of other agencies. However, as discussed earlier, the consortium is concluding a strategic review which is addressing these issues.

Regarding health partnerships generally, further work is required in three main areas. The zeal for embracing intersectoral health partnerships should be informed by progress on theoretical, empirical and methodological fronts. Theories are required to provide a framework through which deliberate decisions can be made about the most appropriate partnership approaches to achieve specific goals (Bensberg, 2000). In addition, further evaluative studies of partnerships (as well as assessing the specific health projects they conduct) will provide evidence about the impact of particular factors on levels of effectiveness. Finally, we reiterate the call for a more sophisticated set of indicators by which to gauge the achievements of different partnership approaches.

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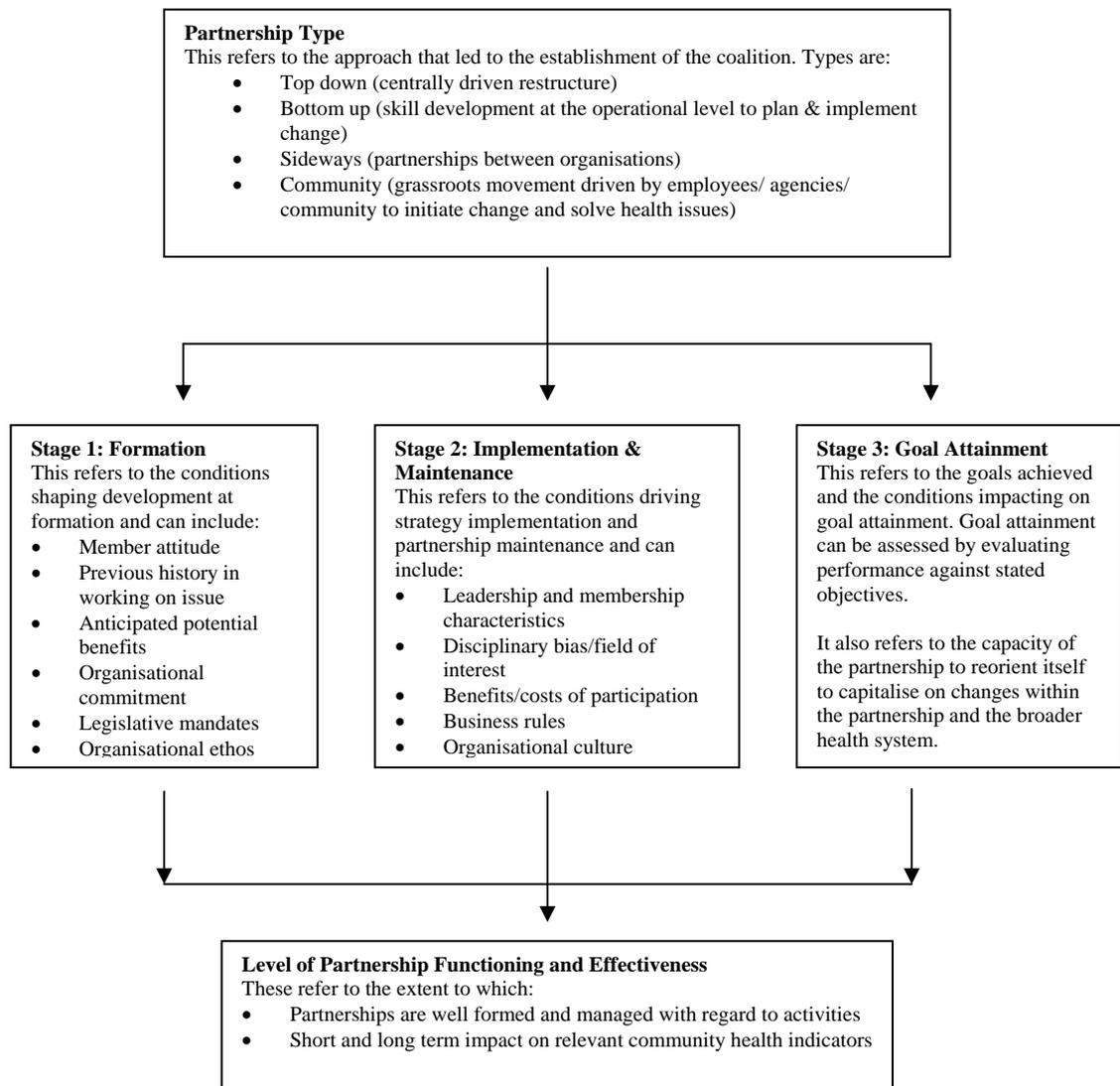


Figure 1: A Model of Health Partnership Development and Functioning

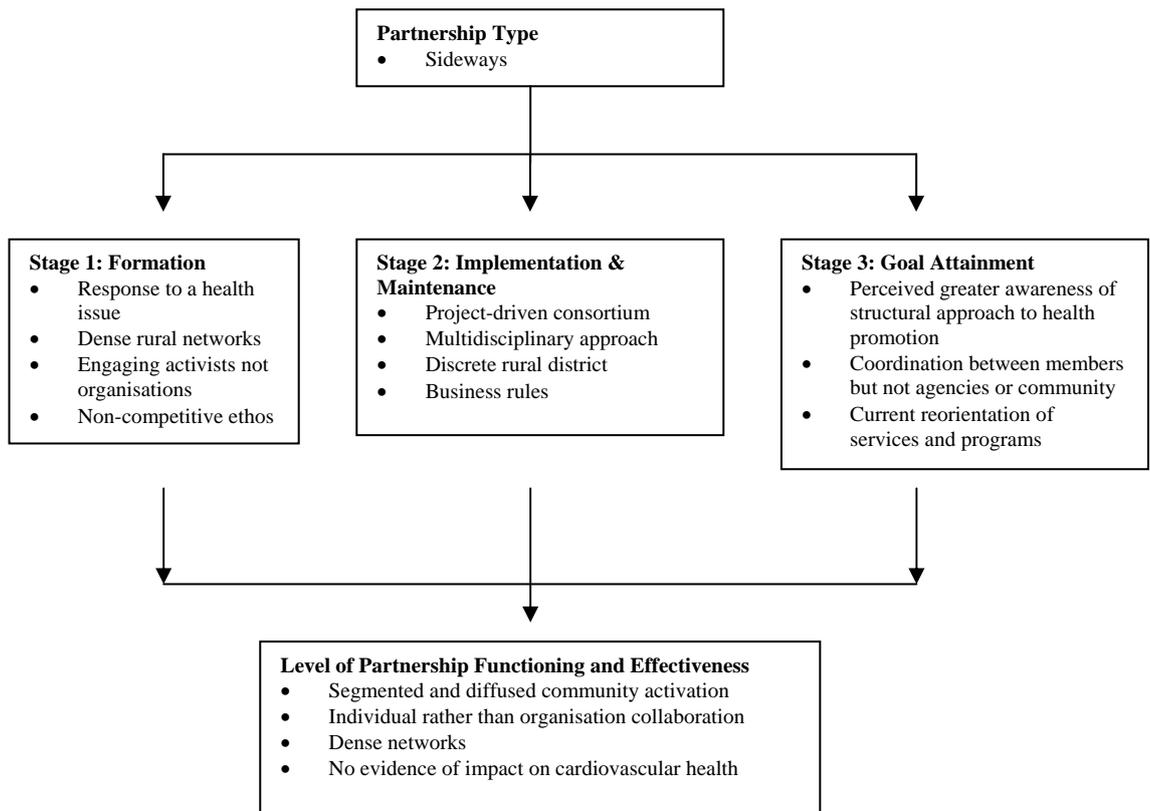


Figure 2: Summary of Findings for Ballarat Health Consortium