Intersectoral Collaboration: what are the factors that contribute to success?

John Wakerman
Julia Mitchell

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DESERT KNOWLEDGE
CRC

Contributing Author Information

John Wakerman
Centre for Remote Health. A joint centre of Flinders University and Charles Darwin University

Julia Mitchell
Centre for Remote Health. A joint centre of Flinders University and Charles Darwin University

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The Desert Knowledge Cooperative Research Centre (DK-CRC) is an unincorporated joint venture with 28 partners whose mission is to develop and disseminate an understanding of sustainable living in remote desert environments, deliver enduring regional economies and livelihoods based on Desert Knowledge, and create the networks to market this knowledge in other desert lands.

For additional information please contact

Desert Knowledge CRC
Networking and Communications Officer
PO Box 2111
Alice Springs NT 0871
Australia
Telephone +61 8 8950 7120 Fax +61 8 8950 7187
www.desertknowledge.com.au/crc

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ATSIC	Aboriginal and Torres Strait Islander Commission
CGC	Commonwealth Grants Commission
COAG	Council of Australian Governments
DK-CRC	Desert Knowledge Cooperative Research Centre
HSRC	Health Service Research Centre
IPAA	Institute of Public Administration Australia
KWHB	Katherine West Health Board
NGO	Non Government Organisation
NT	Northern Territory
SSC	State Services Commission (New Zealand)
WHO	World Health Organisation

Introduction

Many authors have identified intersectoral collaboration as an important requirement for improvement of service delivery to various communities (CGC 2001, IPAA 2002). Much of the literature comes out of the health sector, wherein the philosophy and practice of primary health care emphasises a comprehensive service approach which includes curative services, prevention of disease, promotion of health, community participation and intersectoral collaboration (WHO 1978). The Ottawa Charter for Health Promotion (WHO 1986) promotes community mobilisation to achieve health gains though healthy public policy and intersectoral action. This interest within the health sector is because of an appreciation that improved health outcomes are largely defined by factors outside of the health sector.

A whole of government approach to service delivery is generally seen as desirable. In Europe, all of the Healthy Cities projects have established intersectoral committees (Baum 2002 p513). In desert and remote Australia, there are several current collaborative initiatives under way: the seven Indigenous Community Coordination Trials sponsored by the Council of Australian Governments (COAG), the Wangka Wilurarra Regional Project and the Goodna Service Integration Project. The recent NT Government local government reform initiative is another natural experiment in this field. Moves toward regional structures in Cape York and the Torres Strait have contained strong elements which intend to move beyond rigid program guidelines and vertical service delivery, to improve the outcomes for their communities (Warchivker & Mitchell 2003).

There are various rationales, both pragmatic and political, for collaboration. Solutions to complex problems, such as the poor health of Aboriginal people in remote desert communities or complex social problems, cannot be developed within one sector alone (Gray 2002). Sometimes the 'costs of failure' are too high for government to ignore (SSC 1999). There has been a growing momentum from the community sector to change how policy is developed, so that services are based on community (or regional) priorities, not on the delineations between different levels or agencies of government (Gray 2002). Baum (2002) also argues that the complexity is characterised by failure of the market model to protect the most vulnerable, widening inequities and enormous environmental problems facing the world. In remote desert communities, diseconomies of scale result in relatively high service delivery costs. Successful collaboration should improve efficiency and slow the increase in costs of service provision.

Intersectoral collaboration can be initiated by communities, by service providers or by government. Each of these approaches has implications for levels and types of governance.

The aim of the paper is to:

- identify the characteristics of successful intersectoral initiatives relevant to desert environments
- identify barriers to implementation of recommended intersectoral collaborations
- identify key requisites for successful processes of intersectoral collaboration

The scope of this paper was to document and analyse factors that are likely to contribute to successful intersectoral approaches in order to inform current intersectoral initiatives, to identify gaps in knowledge and to provide a basis from which a conceptual framework may be developed to inform researchers in this field. The study did not collect primary data in the review of case studies of intersectoral collaboration or analyse the outcomes. We have taken at face value the reporting of outcomes, successes and failures, and of the factors which may have contributed to or determined the success (or lack) of intersectoral collaboration in the papers reviewed.

The scope did not include, at this stage, a search of 'grey' literature in this area, of which we believe there may be a substantial amount, particularly relating to case studies.

Methods

Methods included a primary literature review of studies of intersectoral collaboration nationally and internationally. We conducted searches of the APAIS, Expanded Academic ASAP and Current Contents databases, the internet using the Google search engine and the main catalogue of the Flinders University Library. The following keywords were used: Intersectoral, collaboration, partnerships, interagency, community development, interprofessional and integrated service delivery.

We also reviewed a draft annotated bibliography of service intervention, currently being prepared by the Flinders University Institute of Public Policy and Management, although this had been prepared for a different purpose and concentrated more on integrated management in service delivery rather than intersectoral collaboration.

Findings

There were a limited number of papers available that related to collaboration across a number of sectors (health, education, employment). Most related to collaboration between different levels and agencies of government or non-government organisations within one sector. There were some specific areas of interagency collaboration, particularly in social services. For example papers relating to child protection services were prevalent, but these were generally specific to the service areas and not appropriate for our purposes. There were a number of factors which facilitated intersectoral collaboration or, in their absence, inhibited it. These are discussed below and summarised in Table 1.

Nomenclature

There are a number of terms and taxonomies used to describe collaborations between services, agencies and levels of governments. Use of terminology and meaning is not consistent. Below is a summary of some of the terms frequently encountered in the literature reviewed and a brief description of their most common usage.

Whole of government: In the UK this tends to be referred to as "joined up government". The focus of this approach tends to be structural or contractual arrangements for service delivery, rather than shared involvement in policy making (Edwards 2002 Edwards 2003, Gray 2002).

Intersectoral: Has been promoted in the health sector, where the focus is multiple agencies working together to achieve particular outcomes. The emphasis in literature relating to health tends to be on who should work together, and programs and services rather than policy development or planning (Gray 2002). The Canadian literature refers to intersectoral community projects in the public health area.

Collaboration: Some papers provided a list of types of working together from informal networking to formal partnerships. Collaboration seems to refer to voluntary rather then formal or contractual arrangements.

Intergrated Service Delivery: Multiple agencies combine to provide coordinated delivery of services around a particular issue. This does not necessarily include development of integrated policy to inform the service delivery (Gray 2002).

Some literature provided a wide range of levels of collaborative involvement with corresponding terms for the collaborations generally including informal information sharing, networking, cooperation or coordination, partnerships and integrated service delivery (Bruner 1992, Cigler 1999, Gray 2002, Himmelman 2002, IPAA 2002). Levels of integration may vary from high to low (SSC 1999).

Issue/Objective | Most literature identified the need for agreement about the objective of the collaboration and the issues related to the objective, between all members of the group involved in the collaboration. This agreement is very closely related to the level of ownership of the collaboration by the participants, and thus the sense of responsibility that participants have for the process of the collaboration and the achievements of the objectives (Bourdages et al 2003, Bruner et al 1992, Harris et al 1995, Hooper-Briar et al 1994, IPAA 2002, O'Looney 1997). Successful collaborations need joint appreciation of the issues and underlying causes, and this is referred to as a "coincidence of values" (Gray 1985). The State Services Commission (SSC) of New Zealand (1999) assumes that there is a strong alignment of the objectives sought by participants, and declare this a precondition that must be met before integration of service delivery can be considered.

This can be a difficult process given that collaborations are often initiated in response to complex issues that are beyond the scope of current policy and service responses. There is an inherent or potential level of conflict (internal to participants and perhaps between participants), given that the origin of the intersectoral response may be in the inappropriateness or inability of structures to deal with a current issue or environment, and the response is to form a collaboration of those current structures. Conflict is not necessarily an impediment, but the potential for conflict must be recognised and processes for dispute resolution in place (Bruner et al 1992, Gray 1985, Gray 2002).

Causes for potential conflict can also arise from different professional orientations and requirements, and from institutional cultures, histories and mandates of the participants. These can result in very different interpretations of the causes and solutions among the collaboration group. However, agreement to set aside specialised orientations to work together is necessary to recognise the shared values relating to the objectives of the collaboration (Hooper-Briar & Lawson 1994, Gray 2002).

If a particular institution – government, NGO or profession - initiates the identification of the objective or issues, then the analysis tends to be framed within their assumptions, value systems and policy framework. The actions to be implemented then reflect this understanding, although the implementation of those actions may require significant community acceptance of the actions and issues. Sindall (1997) notes the tendency for systems, professional or bureaucratic, to become self- referential and dominated by the primacy of their own functions. Hooper-Briar & Lawson (1994) note that barriers to the development of shared values and understandings are to be expected, given the history and context of many professions, however that understanding that history and returning to a vision for change can assist in overcoming these barriers.

The development of trust between participants is a key success factor (Bourdages et al 1994, Gray 1985, Gray 2002, Harris et al 1995, SSC 1999). In particular the development of trust involves respect for, and willingness to accept, other participants' points of view (Bourdages et al 1994, Gray 2002). This also involves accepting the objective as the responsibility of all members of the group. Difficulties can occur where government agencies have set the direction and then invited community and other levels of government to participate. Harris et al (1995) ask the question: 'Has time been spent on building and maintaining the relationship?' This underscores the need for time to develop trusting relationships.

A key factor in 'collaborative inertia' (achievement and output is much lower than anticipated) – the feelings that there are a lot of meetings that don't seem to achieve anything - can be traced back to the difficulty in negotiating the joint purpose, perhaps leading to a continual renegotiation of objectives, the processes and implementation steps of the collaboration (Huxham & Vangen 2000).

Participants and stakeholders

This is related to agreement about the issue and objective, as the understandings of this will affect the range and composition of stakeholders and participants. The process of agreeing the objective and issue(s) should lead to the identification of the stakeholders and their respective roles. The roles of the various partners need to be defined at the commencement of the collaboration. Commitment to a collaboration is often helped by formalisation. For example, the Australian state and territory Aboriginal Health Framework Agreements set out the commitment of all parties to collaboration, and this contributed to the understanding of the roles and responsibilities of participants (Shannon et al 2003).

The legitimacy of the collaboration will depend on the inclusion of the relevant stakeholders. The management of stakeholder interactions is a key factor in the success of collaborations (Bourdages et al 2003, Gray 1985, Gray 2002, Harpham et al 2001)

Bourdages et al (2003) examine the types of participants that need to be included, for example, those with knowledge of the local communities' resources, formal and informal communication networks, the opinion leaders in the community, and note that a barrier to success was the absence of key players. This barrier is also identified in other reports (IPAA 2002). The credibility of collaborations is dependent on the credibility, visibility and influencing power of the participants.

The Commonwealth Grants Commission inquiry into Indigenous funding concluded: 'the importance of effective agreements and partnerships between levels of government and Indigenous communities, both within the health sector and in other areas, cannot be overstated' (Commonwealth Grants Commission 2001). This sentiment is very similar to the importance attached to partnerships and intersectoral collaboration in the 1989 National Aboriginal Health Strategy (National Aboriginal Health Strategy Working Party 1989).

In a report analysing success factors in Indigenous health programs in Australia, key informants within the health sector noted that it 'is important also to consider informal partnerships at the local community level which demonstrate a genuine commitment by a number of sectors to working together to address community-identified priorities' (Shannon et al 2003).

This study noted the importance of collaborative structures established under negotiated agreements within the health sector and examined several case studies of intersectoral collaboration. The case studies featured a number of successful intersectoral projects. The range of collaborators included health departments and Departments of Aboriginal and Torres Strait Islander Policy, Housing, Youth Sport and Recreation, the private sector, non-government organisations, non-government health services and academic institutions. Some of these collaborations were between agencies with a history of conflict, and the surmounting of these tensions was a major contributor to the success of the projects. To underscore the point made in the previous section, the bringing together of participants with a history of conflict to a position of achievement of common vision can provide a considerable advantage and impetus to the collaboration.

Gray (1985) advocated limiting the number of stakeholders in order to enhance the administration of, and keep the collaboration project manageable. However, he also noted the potential negative impact of this limitation on implementation. Limiting the stakeholders also means managing the exclusions (Huxham & Vangen 2000), which is part of the larger issue of managing stakeholder

interactions. There may be options for different levels of participation; perhaps a primary group of participants that have a much higher level of involvement than secondary stakeholders. Himmelman (2002) provides a range of levels of involvement of stakeholders: for example, that of a funder or of a capacity builder, and outlines the roles they may play and issues associated with those roles for the collaboration. Himmelman (2002) also notes that the method of choosing collaboration partners has an impact on the levels of empowerment and ownership of the collaboration.

For long-term collaborations, the membership may change as the functions of the collaboration develop. It is necessary to be able to manage changes to the group without renegotiating the objectives (and underlying issues) of the collaboration (Huxham & Vangen 2000). Managing stakeholder interactions also requires a mechanism for facilitating dispute resolution and open airing of issues that is sensitive to different cultural approaches.

The National Rural Health Alliance is an Australian coalition of disparate organisations – service agencies, academics, professionals and consumer groups – that over the past decade have overcome disciplinary and historical differences to work to a common vision of improving the health of rural and remote populations in Australia (Humphreys et al 2002). This collaboration's success has been due to a number of factors: a common vision, a common target of advocacy - a federal government perceived to be recalcitrant to non-metropolitan needs – and an electoral threat from the bush against the mainstream parties. Related to this last point, timing is often a feature of successful collaborative efforts (Gray 2002 p 45).

There are other issues relating to the nature of participating agencies. The State Services Commission (1999) analysis of integrated service delivery highlights the fact that if the participating organisations do not belong to the same sector – public, private or level of government - there are likely to be substantial problems with structural integration. In its report on integrated governance, the IPAA (2002) notes that integration at various government levels is complex and requires attention at all the levels of government in order to be successful. The report also notes that integrated governance is about changing bureaucracy, as that is the most prominent of the barriers.

Lack of consistency can be a substantial barrier. Hapham et al (2001) noted that changes in key members if committees and of the agency staff at an operational level has a detrimental effect on the collaboration, principally due to the message it sends to staff and partners about the importance and priority that the collaboration is accorded. Turnover of staff leading to loss of corporate memory and continuity was identified as a barrier to success in the South Australian Government's Working Together project (IPAA 2002).

Community involvement The role of communities in the literature depended on the focus of the collaboration. Where the focus of the project or paper was on the role of differing government agencies and service integration, the role of community was not discussed (SSC 1999). However in many other cases, particularly in the area of social services, there is an assumption that the objectives of the service integration will be beneficial to the community.

Where the collaboration actually involved the community as participants, ownership of the initiatives of the collaboration by the community, is a success factor (and the lack thereof a barrier) (Bruner 1992, Gray 2002, Shannon et al 2003). The demands on a community or community leaders to work across a range of different initiatives, particularly in the remote desert setting, may be problematic. Cigler (1999) notes that it is important to support community participation by providing government support to avoid "volunteer burnout". Harris et al (1995) also discuss the capacity of collaborators – knowledge, skills, attitude, resources - to engage successfully.

Community representatives are accountable to their community, and there can be a barrier if the collaboration does not allow the community representatives the ability to represent their communities' views appropriately (Gray 2002). This can also be a cause for a lack of willingness for community members to become representatives, as this role implies they must be able to effect change for their community, but they are assigned advisory roles without sufficient authority (Himmelman 2002). Thus the ability of community representatives to effect change for their community is severely restricted, and this may be a barrier to the collaboration and its initiatives achieving legitimacy in the community.

Himmelman (2002) notes that implementation of collaborative initiatives often requires significant community acceptance, but that the control of decision making or the ability to allocate resources to the initiatives are not often transferred to the community.

Power, 'turf' and interdependence Many papers commented on the need to balance power relations within the collaborating group (Gray 2002, Gray 1985, Harpham et al 2001). For example, the community sector may feel disadvantaged, particularly when its funding is dependent on government. At the same time, politicians may not tolerate the influence of unelected community leaders on policy (Gray 2002). Mutual respect and appreciation of all participants' skills and contributions to the collaboration is necessary, and a lack of this is a barrier (Bruner et al 1992, Gray 2002, Gray 1985). While

countervailing power can sometimes lead to a stalemate (Gray 1985), these and problems with un-equal power can be resolved by going back to objectives, re-enforcing pre-defined roles and recognising the interdependence of partners in a collaboration.

Power issues are closely related to 'turf' and the crossover between the perceived responsibility that participants have for the collaboration, and their existing service responsibilities. These can be geographic, social or political jurisdictions. Where there is a crossover, there need to be clear definitions of roles and responsibilities within the collaboration. For example, the evaluation of the Healthy Cities project in five developing countries (Cox's Bazaar – Bangladesh; Dar es Salaam – Tanzania; Fayoum – Egypt; Managua – Nicaragua; and Quetta -Pakistan), provides an example of where geographical service responsibility boundaries differed between participants, and had not been clearly defined at the outset. This resulted in disputes within the collaboration, and non-participation by some participants in collaborative activities outside of their own defined service areas (Harpham et al 2001).

A high level of trust is required for participants to share power, turf and resources. The participants need to be willing to share risks, responsibilities and rewards (Himmlemen 2001). One key to developing trust is the level of mutual respect for each participant's contribution, as outlined earlier. A number of authors comment on the time required to develop new ways of working and building relationships (Gray 2002, Angus 1999 cited in Gray 2002, Harris et al 1995).

Power also relates to the decision to terminate the collaboration and this is generally in the hands of the institutions (Himmelman 2002). This can be a barrier to participation, especially by communities, if the decision to change or stop resources to the collaboration is outside of the control of the whole collaboration group. At the same time, Bradshaw (2000) notes that where a participant sees its involvement as a funder only, then the sense of responsibility to the collaboration may be perceived differently. The level of commitment and control of resources beyond termination of the collaboration need to be agreed.

Interdependence is a fundamental part of collaboration: the need for an approach beyond a single service or agency. However that interdependence needs to be recognised and supported in the processes of the collaboration, and the lack of a sense of interdependence is a barrier.

Leadership | The status of participants in the collaboration is important. Much of the New Zealand literature notes that the capacity to carry out intersectoral collaboration and integrated service delivery is very much dependent on leadership (Gray 2002, SSC 1999).

The representatives also need to be champions of the collaboration within their organisations. The representative needs to effect the change necessary within their own organisation that is required to support the collaboration (Bruner et al 1992, Gray 2002, O'Looney 1997). Involvement of front line staff of agencies participating in collaborations is dependent upon the leadership and the commitment the staff perceive that the organisation as a whole is contributing. Leadership is key to instilling that commitment. For example, the Director General of Health was an internal champion in the Queensland Health Indigenous Workforce Management Strategy and a key factor to successful implementation of that project (Shannon et al 2003).

Political Commitment | The political will of and commitment by government has been identified as a success factor by several authors (Gray 2002, IPAA 2002, Shannon et al 2003). Perceived commitment by the state or other institutions is also important to gain community confidence and support for the collaboration. The Healthy Cities project provides examples of the effect of the communities' perception of commitment (and lack of it) to the projects (Harpham et al 2001). One of the barriers identified in the Working Together project was associated implementation capacity at the middle management level, and the willingness to change the existing systems, that could have perhaps been overcome with a greater political commitment and direction (IPAA 2002).

Outcomes | This factor is linked to the need for clear and agreed objectives of the collaboration. Not only will the collaboration improve the outcomes in question, but there needs to be evidence of this during the life of the collaboration. Feedback on progress in achieving outcomes maintains and strengthens the collaboration (IPAA 2002). There is an imperative for projects to show some quick results. These outputs need to be relevant to the day to day activities of participants and the community involved in order to ensure ongoing support (Bourdages et al 1994, IPAA 2002). Participants will have to make decisions to redirect current resources (and the benefits from their

current use) to the collaboration, so there is need to have perceived benefits form the alternate use of those resources (Gray 1985). The New Zealand literature identified that the cost benefit analysis of proposed and current service integrations was not well developed (Gray 2002, SSC 1999).

Evaluation

Lack of evaluation is identified as a barrier to the collaboration, as participants and the community are not aware of progress (Bourdages et al 2003, Gray 2002). Evaluation needs to be collective, and across participants such that the total impact of the collaboration is captured and not just the effect on a single participant or program. It also needs to be regular and be used as a feedback to the collaborating partners (Bruner 1992).

There is little evidence that intersectoral collaboration improves outcomes – health or otherwise- for individuals, families or communities. Most evaluations generally consider process indicators. A difficulty in demonstrating outcomes is that many of the desired outcomes of these collaborations are complex and change occurs over a long period. It is important to keep a historical perspective, remembering how long the problem or issue has existed when developing evaluations, such that small successes and changes in process indicators are important (Hooper-Briar & Lawson1994).

There were several examples where process evaluation was utilised and appropriately so. Papers related to Healthy Cities indicated that the focus should be on process rather than outcomes for the first few years (Bourdages et al 2003, Bruner et al 1992, Harpham et al 2001). Bourdages et al (2003) provide examples of process evaluation indicators such as the convergence of interests among group stakeholders; the legitimisation of the collaboration's existence; and the evolution of stable working relationships.

Government evaluations of collaboration focus more on the benefits achieved from improved service delivery, and tend not to consider benefits achieved from collaboration on participation in policy development (Gray 2002). The lack of inclusion of policy development in collaborations, whether through reluctance or oversight, is common, and well-developed evaluations of projects can assist in bringing policy development into the collaboration. An example of this is the Katherine West Health Board, where a well constructed evaluation was able to effectively feed back into government policy (Shannon et al 2003).

The increase in administration load, particularly related to data collection, reporting and management of the collaboration can be a detrimental by-product of the collaboration (Bradshaw 2000). The benefit of evaluation to the objectives of collaboration necessitates adequate resources be committed to evaluation.

<div style="text-align:right">Accountability</div>

Accountability and evaluation are often linked. However in the success of intersectoral collaboration, accountability seems more tied to the responsibility that partners individually identify that they have to the collaboration, and the evaluation tied to the collective measurement of the outcomes or process of the collaboration.

Vertical accountability issues have been identified as a major barrier to collaboration (Gray 2002). Accountability for government services is often focussed vertically on financial inputs to programs and services, and up through the departments to ministers and parliament, rather than on outcomes of programs, or the requirement that they address needs of their client communities (CGC 2001). Gray (2002) notes that one of the rationales for service integration is to reduce the tendency to focus on vertical accountability of individual departments, and shift the focus to whole of government interests and client focussed services.

A key reason for collaboration is often the recognition that dividing complex problems into discrete and rigid agency responsibilities with different policies, resourcing and operational guidelines is ineffective (Bruner et al 1992). Those individual agencies and programs have a developed set of accountability guidelines, and collaborations need to be able to have joint objectives with an accountability that is different from that of each participant. A key question for agencies involved in collaboration needs to be: Is the collaboration an effective use of resources, given the agencies accountability for use of resources (Bruner et al 1992, SSC 1999)? This may involve cost: benefit analysis, which can be difficult where the objectives target long term social or health issues. However the benefits of identifying the cost effectiveness of the collaboration will assist in resourcing and accountability issues (Bruner 1992, SSC 1999).

Where the collaboration involves community participation, there will be political accountability (the collaboration's responsibility to the community and participants) and a management accountability (the responsibility to individual participants for the day-to-day management of the services, programs, resources and administration of public funds) that the collaboration will need to consider. The

role of the community participants or representatives in the evaluation and accountability processes will be important for legitimacy of the collaboration, as will a balance between the institutional and community or client accountabilities (Himmelman 2002, Hooper-Briar & Lawson 1994).

Depending on the level of formality of the collaboration, contracting can be a way of clearly setting out accountabilities (and evaluation processes) (HSRC 2001). An example of this is the NT Aboriginal Health Forum, where specific roles and responsibilities of the participants were agreed and signed off in an agreement as part of the forum process (Shannon et al 2003).

As discussed above, there may also be 'turf' issues. Accountabilities include service responsibilities for particular jurisdictions (geographic and social) and the effects of the collaboration on those responsibilities needs to be identified, and a process for resolving conflicts or difficulties arising from this included (Harpham et al 2001).

Table 1
Factors facilitating and inhibiting intersectoral collaboration

Factor	Facilitating collaboration	Barrier to collaboration
Issue or Objectives	Agreement on purpose and object – shared vision Joint understanding of issues and underlying causes "coincidence of values"	Dominance of different value systems (professional, institutional, cultural)
Participants & stakeholders	Presence of key players (legitimacy and credibility) Good management of stakeholder interactions, including exclusion and changes Bring together parties previously in conflict to a shared position Definition of roles Time to develop relationships and trust	Absence of key players Poor management of stakeholder interactions Poor management of exclusions Poor management of interaction between different levels of government or public/private Ill defined roles Lack of consistent representation Inappropriately short project periods
Community involvement	Participant & collective ownership of collaboration Community representatives accountable to their community and able to represent community Sufficient capacity to engage – knowledge, skills & resources	Lack of ownership Community representatives expected to represent collaboration to community without sufficient information and appropriate resources Limited capacity to engage
Power, 'turf' & interdependence	Recognise and support interdependence Share power and resources	Power imbalance poorly managed Participants rigidly adhere to different jurisdictional boundaries
Leadership	Representatives have power to effect change in own organisations Representatives champion the collaboration	
Political Commitment	Political commitment (and perception of such) to effect change	
Outcomes	'Runs on the board' early in the collaboration Clear agreement on outcomes	'Collaborative inertia'
Evaluation	Demonstration 'quick runs on the board' Monitoring, evaluation and feedback to collaboration Evaluation adequately resourced	No feedback to participants, community or funders
Accountability	Evidence of effectiveness of collaboration (cost: benefit)	Vertical program requirements predominate

Discussion

There is a significant literature around intersectoral collaboration, particularly in the health sector, and integrated services. There is a limited literature that documents a rigorous evaluation of case studies and analysis of the barriers to, or factors that contributed to the success of intersectoral projects. There was more that related to collaboration within one sector, for example, social services or health. The literature included a spectrum of collaborations that ranged in the degree and formality of integration, from informal networks to formal partnerships. The number of case studies at the more integrated end was also limited. Much of the literature contained descriptions of the integration process, with a smaller proportion containing an analysis and discussion of the success factors and barriers to the collaboration. There was very little published literature pertaining specifically to factors as they apply to the desert or remote environment.

Table 1 summarises the factors facilitating successful intersectoral collaboration and barriers thereto. Harris et al (1995) also provide a useful checklist. This is a simple representation which does not reflect the complex interplay between these factors. Clear and agreed objectives which reflect the necessity for the collaboration are essential. These will also determine the nature and range of stakeholders. Careful management of both active participants and other stakeholder interactions, which can be complex and changing, is key factor in success. This may involve formal processes (contracts) to assign roles and responsibilities, define relationships as well as document common values.

Where different levels of government were involved, there were substantial problems with integration (SSC 1999). This is supported in comments made in the IPAA (2002) report noting that :

> *While there are different government levels at which integration can operate, each*
> *level is hindered by the lack of integration above it. Therefore integration is complex*
> *and requires attention at all levels of government in order to be successful (IPAA xii)*

This is supported in many reports that identify barriers in the bureaucracy associated with different levels of government, particularly in relation to integrated funding. The Commonwealth Grants Commission (2002) notes this issue in relation to services to remote Indigenous communities.

Community involvement is almost universally acknowledged as key to successful intersectoral collaboration. Successful engagement is predicated on appropriate representation, adequate capacity, a sense of ownership and power within the collaboration, a sense of political commitment to the endeavour and ongoing feedback about achievements of the collaboration.

An adequately resourced, participatory evaluation with appropriate indicators – usually shorter term process indicators – is a factor that can strongly contribute to the success of the collaboration. There is a lack of research and subsequent evidence that collaboration leads to improved long term outcomes. Another underdeveloped area of evaluation is the effect of implementation of collaboration back on policy (Gray 2002, Himmelman 2002, SSC 1999).

Edwards (2002), discussing future issues for public sector governance, notes that the current government policy of "steering rather than rowing" has resulted in the government being unlikely to have sufficient knowledge of problems at a grass roots level, such that the negotiation and development of solutions will rely increasingly on the non-government organisations that undertake much of the contracted out service delivery. The experience of the Katherine West Health board (KWHB) is instructive, particularly that the ability to demonstrate positive outcomes was a key factor in the influence that KWHB were able to have on policy (Shannon et al 2003). The NRHA also provides a good example of a coalition of disparate health service, professional, academic and consumer groups who, because of good timing and other factors, have been able to effectively work with government to develop rural health policy (National Rural Health Policy Sub-committee & National Rural Health Alliance 2002).

Our survey of published literature suggests that further detailed analysis of efforts at intersectoral collaboration, particularly using a case study approach, would inform current and future efforts to address complex multisectoral problems. This is particularly so in the desert and remote environment, where diseconomies of scale and a cross-cultural setting provide specific challenges and opportunities.

The difficulty of integration of activity at different levels of government, and the importance of collective ownership of efforts at collaborative action – 'top down' or bottom up' origin – have been highlighted. There are a number of current natural experiments in intersectoral collaboration, such as the COAG Indigenous trials and state local government reform programs - that could provide informative case studies of barriers of working with different levels of government, and the steps to overcome these. The grey literature, which we have not examined, may also provide a rich range of case studies. Finally, there is a dearth in the literature as it relates to longitudinal analysis of the impact of collaboration on health, social and environmental outcomes, which is another area of research potential.

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