

# MULTI-LEVEL COLLABORATIVE GOVERNANCE: THE CASE OF THE CANADIAN HEART HEALTH INITIATIVE

Claude Rocan, Ph.D.  
Graduate School of Public and International Affairs  
University of Ottawa

## **Introduction and context**

The evolution in democratic regimes from *government* to *governance* has been extensively documented. The view expressed is that society has become so complex that the formal, structured processes of government are no longer adequate to tackle major public policy issues in isolation. There are an increasing number of “wicked problems” to address, in which a multiplicity of factors, interests, and players are interwoven.<sup>1</sup> These issues are beyond the capacity of any one government to resolve on its own. What is needed, according to this view, is the active involvement of civil society, including the voluntary and non-governmental sector, universities, journalists, professional associations and the private sector, as well as governments. Students of the policy process have developed the concept of “collaborative governance” to describe this phenomenon in which groupings are formed of many players to address a common public policy issue. Collaborative governance has been defined in several ways. According to Chris Ansell and Alison Gash, collaborative governance is: “A governing arrangement where one or more public agencies directly engage non-state stakeholders in a collective decision-making process that is formal, consensus-oriented, and deliberative and that aims to make or implement public policy or manage public programs or assets.”<sup>2</sup> A somewhat broader definition is offered by Mark T. Imperial who suggests that: “Governance refers to the means of achieving direction, control, and coordination of individuals and organizations with varying degrees of autonomy to advance joint objectives.”<sup>3</sup> In general, what characterizes this phenomenon is a co-ordinated yet non-hierarchical, non-authoritarian form of decision-making involving governmental and non-governmental participants working toward a common objective.

Collaborative governance, therefore, seems to mirror the 21<sup>st</sup> century realities and likely will continue to do so. It is, therefore, important to attempt to understand the workings of these “new” governance models, and there is a substantial amount of literature which attempts to do so. Looking at this literature, one cannot fail to be impressed by the high level of diversity and complexity of these processes. What also emerges is a perspective on how challenging it is to implement collaborative governance and the many factors that need to be in place for these arrangements to succeed. This no doubt accounts for the fact that collaborative governance arrangements, in many instances, have not been as effective as intended.<sup>4</sup>

Moreover, the level of complexity – and therefore the risk of failure - is greatly increased when *multi-level* collaborative governance initiatives are attempted. In the case of Canada, a national collaborative governance that is meant to have an impact “on

the ground” often needs to involve, not only the federal and provincial/territorial governments, and local governments, but also needs to include non-governmental structures – voluntary sector organizations, professional associations and the like - that are themselves sub-divided in national, provincial and local chapters. In other words, the multiple levels of government are paralleled by multiple levels in the non-governmental sector.

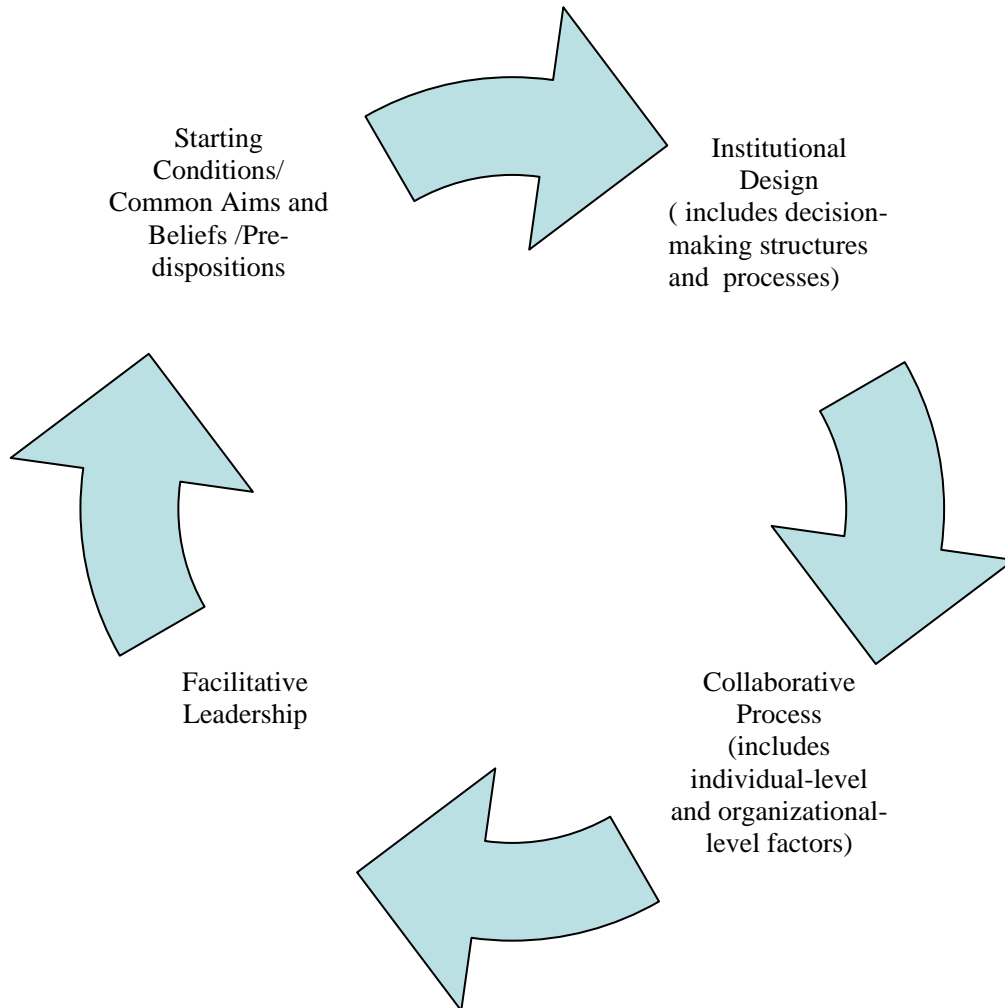
It is in this context that we will be examining the Canadian Heart Health Initiative (CHHI) as an example of multi-level collaborative governance. Collaborative initiatives are quite common in public health, especially in the health promotion and disease prevention functions of public health.<sup>5</sup> Since this is an area in which both the federal government and provincial/territorial governments have a legitimate role<sup>6</sup>, and where the involvement of civil society is needed to ensure “traction” at ground level, collaborative initiatives have become a way of “doing business.” The key question we wish to examine is how a number of diverse organizations, each independent within its own sphere, can manage to co-ordinate their actions in pursuit of a common goal. What is the initial impetus that brings them together, and the common bond that keeps them together? What structures, collaborative practices and leadership competencies do they use to achieve co-ordination and achieve meaningful results?

The CHHI was chosen as the basis for this study because it had a significant (20 year) time-line; is part of our recent history; had numerous outputs; and involved federal, provincial, and local governments, and numerous players from civil society. The premise of this paper is that while the CHHI made a significant contribution to the field of heart health promotion in Canada, it was only a partial success, for reasons which will be explained below, and that weaknesses in its governance were a significant determinant in limiting its success. The paper will first describe the analytical framework and methodology that will be used; provide an overview of the CHHI; and examine various facets of the Initiative using the categories of the analytical framework as guides. Based on this analysis, the paper will offer a number of preliminary conclusions and raise some questions to be used for further research.

### **Analytical Framework and Methodology**

A number of frameworks have been proposed in the literature to deal with collaborative governance, policy networks, policy coalitions and related concepts, many of which were developed to apply to a specific case or cases. The challenge is to apply a conceptual lens that is general enough to encompass the various manifestations of collaborative governance, without being cast at such a high level of abstraction as to become difficult to apply to real-world cases. For this, the framework provided by Ansell and Gash is useful.<sup>7</sup> After studying numerous cases, across several policy sectors, in the U.S. and in many other countries, the authors propose a framework containing four broad categories of variables: starting conditions, institutional design, collaborative process, and facilitative leadership. Each of the above categories is very broad and needs to be disaggregated further, but at the same time each presents a “lens”

through which to examine cases of collaborative governance and extract key issues. We will take each of these categories in turn, briefly discuss their significance drawing from pertinent scholarly literature, and seek to apply them to CHHI. The categories will be used as general guidelines, to be applied flexibly. In some cases, we will adjust the categories to take into consideration factors that are either missing or under-emphasized in Ansell and Gash. In particular, we will adjust the framework to underline the non-linear relationship of the factors and to take better account of the federal reality of Canada. The framework, amended from Ansell and Gash, is represented below as Figure 1.



The methodology followed for the examination of the CHHI was a review of the published literature followed by seven semi-structured interviews with key informants. The process evaluation of the Demonstration Phase, prepared by the Conference of Investigators of Heart Health, was particularly useful for our purposes.<sup>8</sup> The interviews were of key players from the federal government, provincial governments, voluntary sector organizations and universities who had been involved in the Initiative from the early stages and were therefore in a position to share important information and insights. With regard to terminology, in this paper we will use coalitions,

collaborations and networks inter-changeably, recognizing that distinctions can be made between and within these broad generic terms.<sup>9</sup>

### **The Canadian Heart Health Initiative**

The CHHI was initiated in 1986 in the wake of a paper produced for Federal-Provincial-Territorial Deputy Ministers of Health entitled *Promoting Heart Health in Canada*.<sup>10</sup> It was designed “as a strategic linkage model employing coalitions to achieve partnerships and collaboration within and across sectors, and across national, provincial and local levels.”<sup>11</sup> Its long-term health goals were to:

- Improve the heart health of Canadians
- Reduce premature cardiovascular morbidity and mortality
- Reduce the prevalence of preventable or controllable risk factors for CVD
- Improve lifestyle behaviours associated with heart health, and
- Improve working conditions, social and physical environments supportive of citizens in making heart-healthy behavioural choices.<sup>12</sup>

Its short-term health goals were to:

- Increase public knowledge and awareness of the causes and consequences of CVD
- Increase the knowledge and awareness of individuals at risk on how to control their CVD risk.<sup>13</sup>

In addition, the CHHI established health system goals, which were to:

- Maintain the provincial heart health programs and coalitions;
- Entrench the issue of heart health into the agenda of governments and civil society organizations at all levels;
- Disseminate the knowledge gained through the Demonstration Phase;
- Employ a public health approach to deliver integrated heart health programs.<sup>14</sup>

A multi-level approach was taken for the CHHI, involving; the federal government, through Health Canada; provincial governments (territorial governments did not participate); and local communities. It followed a “cascading” model in which broad directions were set at the national level; provincial-level coalitions were struck to coordinate activities in the province in question; and projects were carried out at either the provincial or local level. There was also an important international dimension, as representatives of the CHHI participated in international conferences to share information about the Initiative (at that time Canada was seen as a world leader in the area of health promotion), and to learn from what other states were doing. Furthermore, the CHHI followed a partnership approach, in which it included voluntary sector organizations and NGOs at all levels. The various levels of the CHHI and the respective roles of the partners have been represented as follows:

International level:

- Experiences from other countries drawn from
- Contributions to major international heart health conferences

Government of Canada (Health Canada) role:

- Provided initial funding – matched by provincial governments
- Developed criteria for Demonstration Phase
- Provided technical assistance and secretariat support
- Organized workshops
- Established the Conference of Principal Investigators of Heart Health
- Provided for the development, maintenance and dissemination of a national database.

Provincial role:

- Conducted heart health risk factor surveys
- Assigned a responsibility centre to oversee planning and management of the Demonstration Phase, usually located within the provincial ministry of health
- Developed individual plans outlining specific goals and objectives for all projects; terms and conditions for coalitions and demonstration projects; theoretical foundations for interventions in the form of strategic plans or logic models; plans for recruiting partners for coalitions and projects activities.

Community-level role:

- Designed projects to meet local needs (consistent with national criteria, and provincial terms and conditions)
- 259 demonstration projects in over 150 communities
- Each project supported by a multi-disciplinary, intersectoral team.<sup>15</sup>

Voluntary sector/NGO role:

- Heart and Stroke Foundation served as the major non-governmental partner at the national level
- Provincial Heart and Stroke Foundation chapters acted as key non-governmental participants at the provincial level
- Several voluntary sector and other NGO partners involved at the community level along with university researchers and private sector bodies, such as media organizations.<sup>16</sup>

Initial funding was provided by Health Canada primarily out of the National Health Research and Development Program (NHRDP), and supplemented by discretionary funding. There was a requirement for matching funding by the province which was reflected in bilateral agreements on a province by province basis. In addition, there were in-kind contributions from NGOs and the private sector.

There were five distinct but overlapping phases of the CHHI:

- Policy development, in which the broad lines of the Initiative were developed
- Provincial heart health risk factor surveys, to assess scientifically the circumstances in each jurisdiction

Demonstration Phase, in which hundreds of projects at the local and provincial levels were launched  
 Evaluation of the demonstration projects  
 Dissemination of results to the broader community<sup>17</sup>

Unfortunately, there has been no evaluation of the Initiative as a whole. However, there is a process evaluation on the Demonstration Phase, which is seen as the “backbone” of the initiative<sup>18</sup>. From this we know that the Initiative spawned 311 projects in all, amounting to a total expenditure of \$36M. Of the six strategies that were eligible to be funded under this initiative (public education; community mobilization; healthy public policy; strengthening preventive health services; research and evaluation; public health system leadership), 60% of the projects and 62% of the expenditures were on public education projects mostly related to modifiable risk behaviours.<sup>19</sup> The next most frequently used strategy, community mobilization, accounted for 17% of the projects.

The CHHI ended in 2006, when funding at the federal level was not renewed. (By this time, NHRDP no longer existed, having been absorbed within the Canadian Institutes for Health Research). The Initiative can point to a long list of accomplishments including provincial heart health risk factor surveys; several scientific papers on subjects related to heart health; and many community coalitions that continue to exist to this day. However, the Initiative must be judged as a *partial* success for two main reasons. First, it did not reach the deployment stage, as planned.<sup>20</sup> Since the first five phases could be seen as building blocks towards an implementation strategy, not reaching this phase is significant. Second, and closely related to the first point, the overall health system goal of fully integrating heart health into the public health infrastructure was not realized.<sup>21</sup> What follows will argue that governance factors were an important determinant of the CHHI not completing its mission.

### **Starting Conditions**

Ansell and Gash indicate starting conditions “set the basic level of trust, conflict, and social capital that become resources or liabilities during collaboration.”<sup>22</sup> Some authors have referred to a similar notion as “predisposition.”<sup>23</sup> Out of this come relevant issues such as a previous history of conflict or collaboration among the players. The existence of incentives, such as the possibility of accessing funding, is also often a strong motivator. Perhaps even more fundamental in setting the stage for a collaboration is the existence of a common goal and a common set of beliefs. There must be what one observer has called “common..., agreed or clear sets of aims as a starting point in collaboration.”<sup>24</sup> This is key as an initial motivator, as well as the “bond” that holds a coalition together once it is established.<sup>25</sup> Organizations seeking to act in concert with others will almost inevitably encounter differences in corporate culture, internal priorities, ways of operating and the like. Having a common set of aims or beliefs can be a very potent force in overcoming the problems that surface in a coalition or network.<sup>26</sup> Furthermore, the recognition of the mutual inter-dependence

of the players to achieve these aims is a critical part of starting conditions.<sup>27</sup> Finally, the common aims and beliefs of the players in a collaboration should not be seen as static. Although, as Sabatier and Jenkins-Smith have argued, core beliefs will be resistant to change, it is to be expected that what they call “secondary” beliefs, as well as the aims of a collaboration, will adjust as the collaboration advances and generates policy learnings.<sup>28</sup>

As applied to the CHHI, although requiring more systematic validation, there is good reason to believe that the holding of common beliefs and aims was one of the key factors in bringing the players together. 1986, the year of the initiation of CHHI, was a major turning point in the evolution of public health in general, and health promotion in particular, in Canada and internationally. This was the year of the Ottawa Charter on Health Promotion, a Charter developed at the first International Conference on Health Promotion, held in Ottawa, which signalled a new approach to health promotion. This approach was committed to dealing more directly with the determinants of health, and which saw health very broadly as “physical, mental and social well-being,” and as a consequence of public policies both outside and inside the health sector.<sup>29</sup> Furthermore, at about the same time, Achieving Health for All was released, often called the Epp Report after the Health Minister of that time, reflecting the a similar approach as the WHO document and applying these principles to the Canadian context.<sup>30</sup> The focus on a population approach to prevention of disease, community-level interventions, and partnerships is seen as signalling a new approach to public health.<sup>31</sup> These developments signalled a major shift in thinking in the area of public health in Canada.<sup>32</sup>

It was in this environment that the CHHI was conceived. It was initiated by a small number of public health professionals in Health Canada and provincial governments who believed in the principles of the Ottawa Charter and the Epp Report and sought ways to translate these principles into practical reality. A report developed for Federal-Provincial-Territorial Deputy Ministers of Health, titled Promoting Heart Health in Canada, articulated this approach and became the framework for the Initiative.<sup>33</sup> There were undoubtedly other incentives for participants to join this collaboration, probably the chief one being the possibility of accessing federal funding. But this does not appear to have been the major factor. The national consultation exercise which took place in the early stage confirmed a “broad national consensus... on the goals and strategies” of the CHHI.<sup>34</sup> Moreover, the key informants interviewed stressed that the leading actors from the federal and provincial governments were, as one put it, “of one mind” about what was to be accomplished and how.

More needs to be learned about the extent to which this set of beliefs penetrated all levels of the CHHI and whether it was maintained throughout its existence. However, from all indications, this was more than simply a “coalition of convenience.” It was a collaboration in which the leading players, and the broader public health community, were united by a shared belief in both the goal and the methods in achieving that goal.

## **Institutional Design**

Ansell and Gash describe “institutional design” as “the basic ground rules under which collaboration takes place.”<sup>35</sup> There are many issues that can be considered in this context, such as frequency of meetings, optimum numbers of players, the existence or absence of dedicated support staff, the role of the chair, and so on. All are important issues which need to be taken seriously. In this paper, however, we will attempt to focus on the more “macro” issues: What are the structures of decision-making? Who are the players involved and what mandates have they been given? And what are the power relations within the group? Questions related to funding will also be included in this discussion, since these formed a critical part of the decision-making of the CHHI. How the inter-governmental relations were managed for this Initiative will also be included in this section, since it was a critical factor in the institutional structure of the Initiative.

From the literature on the governance of networks and coalitions, there appears to be no ideal model that will work best in all cases. Which model or style will be most effective will depend a great deal on a number of contextual factors.<sup>36</sup> Certain key points emerge, however. The importance of inclusiveness is highlighted, not just for tactical reasons, but also because of the need for “collective, interactive discourse.”<sup>37</sup> Transparency and fairness are also seen as important. A related question is the perceptions of power imbalances within a collaboration. Participants need to feel that they are being treated fairly; that there is a level playing field; and that they have a role in determining the broad directions of the network.<sup>38</sup> The need for good communication is also critically important,<sup>39</sup> as is flexibility, to ensure the ability to make adjustments to changing players and circumstances.<sup>40</sup>

Particular attention is given to the question of funding. There are several aspects to this question. The first is the question of the availability of funding, the importance of which is quite obvious. Also significant is the question of the funding source – does it come from only one of the parties, or from more than one source? Multiple relationships will tend to “equalize” power, and set up more constructive relationships, whereas reliance on only one source for funding could create some dependencies that have a negative impact.<sup>41</sup> There is also the question of short-term versus longer-term funding, which can also have an impact of internal dynamics. Mitchell and Shortell, among others, make the point that short-term funding can have a detrimental impact on partnership stability and sustainability.<sup>42</sup>

Also important is the question of how to accommodate the involvement of different orders of government in a collaboration. As mentioned earlier, the participation of two orders of government in a collaboration creates an additional level of complexity to what is already a complex undertaking. Mark Imperial makes the useful point that different types of collaboration can co-exist within a single policy network.<sup>43</sup> It seems fair to assume that the greater the complexity of a policy network, the greater the likelihood that this will occur. In this context, multi-level collaborations would seem more likely to encompass different types of collaboration, perhaps to the point of



having networks within networks. It seems reasonable to posit, for example, that in a federal system of government, intergovernmental partners relate with each other in a way which is different from their interactions with other members of the coalition.

In Canada, because of overlapping jurisdictions in public health, as mentioned earlier, mechanisms are necessary to manage federal-provincial relations within the collaboration in this domain. As some recent studies have demonstrated, federal-provincial-territorial relations can operate at different levels within the same policy context. Johns, O'Reilly and Inwood have made an important distinction between *intergovernmental relations*, which operates at the more strategic level and is usually handled by central agencies, and *intergovernmental management*, which is carried out by the program areas in government. As Johns et al have demonstrated, IGR and IGM may not share the same agendas, and in many cases IGR officials may feel that those involved at the program level are too inclined to collaborate with their counterparts.<sup>44</sup> This dynamic is apparently not unique to Canada; Martin Painter has made the same observation with respect to Australia.<sup>45</sup> We will return to this issue in our discussion of the CHHI.

The first point that is striking about the CHHI from an institutional design perspective is its lack of mandate at the federal level, and its lack of sanction from a federal-provincial-territorial (FPT) perspective. The Health Canada officials who were involved with the Initiative did not see the need – and may have deliberately avoided – seeking policy authority through a Memorandum to Cabinet (MC). They may have felt that their mandate could be drawn from the National Health Research and Development Program, but in actual fact, the CHHI was far more than a research program. Whatever the reason, the practical consequence of this was that Health Canada officials were participating in CHHI without a specific mandate to do so, and outside of formal scrutiny from within the federal government. This was compounded by the fact that the CHHI did not report to an established FPT committee. The health sector in Canada is characterized by an elaborate FPT structure, in which inter-governmental committees and processes normally (but not always) report to an FPT committee at the Deputy Minister and/or the Ministers' level. In this case, the CHHI functioned outside the "orbit" of this committee structure, and therefore without the sanction or scrutiny of a senior FPT forum. Using Johns et al's useful distinction, therefore, this is clearly a case where inter-governmental relationships were handled at the program level, not the strategic level. Although the initiative began with an FPT Deputy Ministers' working group, the CHHI was not established as part of an FPT agreement or formal process. It would have been largely invisible to those dealing with inter-governmental relations at the more strategic level. This is an important point, to which we will return later.

Consistent with its nature as a collaboration, the CHHI's decision-making was consensus based, de-centralized, and flexible. The primary governance was established, not by an over-arching framework agreement, but rather by a series of bilateral agreements between the Health Canada and individual provinces. The agreements were negotiated on a staggered basis, starting with Nova Scotia followed by each of the other provinces at a time of their choosing. The agreement, developed

collaboratively by Health Canada and the province in question, was then submitted to the National Health Research and Development Program, housed within Health Canada. They were drafted as research projects for the purpose of developing knowledge about interventions at the community level related to heart health. Once received by NHRDP, they were sent for peer review to ensure the scientific validity of the methodology. When approved, funding was made available, with the condition that this funding be matched by the provincial government. Consistency was achieved by the fact that once the first proposal was reviewed and approved, it was used as a model for agreements with the other provinces.

At the national level, the CHHI was led by the Conference of Principal Investigators of Heart Health, which met at least annually. This committee did not seek to oversee what was taking place at the provincial level – rather, its function was primarily to establish the science behind the CHHI, discuss what additional knowledge products were needed, and strategize about next steps. Working groups were created and studies were commissioned on a range of topics related to heart health. Beyond this, a forum called the Canadian Heart Health Network would be called approximately once or twice a year to provide an opportunity for information sharing and skills development.

From an inter-governmental perspective, the relationships seem both collegial and science-based. Generally, the program leads for Health Canada and for provincial governments were health professionals, usually chief medical officers of health. This provided a common language for the participants to use. It might fairly be said that the usual federal-provincial diplomacy was supplanted by scientific and technical issues that formed a common base for the discussion and for the relationships between the lead players. The fact that the CHHI was characterized as a research initiative would have reinforced this tendency.

Notwithstanding the collegial nature of the relationships, there were power differentials within the CHHI. In the first instance, Health Canada took a leadership role through its access to funding. This enabled Health Canada officials to set the parameters around the funding, and therefore the Initiative as a whole. It also appears that Health Canada officials provided a great deal of the intellectual leadership for the Initiative. Neither of these factors seemed to have caused any apparent inter-governmental friction. On the contrary, Health Canada's leadership was welcomed.

More fundamentally, there was an important power imbalance between governments and the non-governmental sector. The Heart and Stroke Foundation of Canada was identified as a national partner, but did not have the same status as a government. The power differentials were likely even greater at the provincial and local levels. The fact that federal and provincial governments provided most of the funding for the demonstration projects would have put them in a stronger position than NGOs, whose role was more related to delivery than to direction-setting. This is somewhat at variance with the literature that calls for players in a collaboration to be on a "level playing field." However, power imbalances are often very difficult to avoid, particularly when governments are involved.<sup>46</sup> Lawrence O'Toole has observed that

networks “must combine the vertical elements of hierarchy and the horizontal components of functionally induced interdependence.”<sup>47</sup> In view of these power imbalances, the CHHI might be seen as a sort of collaborative governance “hybrid.” If so, it is probably in good company. As Innes and Booker have observed, collaborative governance in its “pure” form, happens only rarely, if at all.<sup>48</sup>

The decision-making structures at the provincial level were both flexible and highly variable. By the terms of the funding agreements mentioned above, each province was required to form at least one coalition to carry out the demonstration projects. Eight of these operated at the provincial level, 33 at the local level. The composition and functioning of these coalitions differed from one case to another, and in some instances, their roles evolved as the process matured.<sup>49</sup>

From this review of the CHHI’s institutional design, therefore, we would draw the following conclusions:

the CHHI was established on weak mandate, particularly at the federal level;  
inter-governmental relations were handled in a collegial, program-orientated and technically-focussed manner, outside of the orbit of more strategic inter-governmental discussions and relationships;  
it used a flexible, de-centralized, and consensual governance style;  
and that while power imbalances were present, this did not seem undermine the CHHI’s effectiveness as a collaboration.

What these observations may have meant to the eventual success or lack of it of the CHHI will be discussed in the conclusion of this paper.

### **Collaborative Process**

The collaborative process variables go beyond the structural features of a collaboration to ask: “what makes the collaboration work?” These factors can operate at both the level of individuals and at the organizational level. In the former case, there is a considerable emphasis in the literature on the importance of trust, and particularly trust-building, among the players of a coalition.<sup>50</sup> Other factors which have been identified are the importance of direct communications, intermediate outcomes to provide some short-term movement to a process, and shared understandings of the initiative through mission statements and strategic plans.<sup>51</sup>

At the organizational level, participants in a coalition need to find a balance between their needs as an organization, and the role they play as a partner in a coalition.<sup>52</sup> Network members, particularly voluntary sector organizations and NGOs, in the first instance, must still strive to ensure their survival as an organization.<sup>53</sup> How this balance is struck is a central issue. An important concept in this context is congruence between the objectives of the individual organization and the objectives of the coalition. In an ideal world, the organization, by pursuing the needs of the coalition will be pursuing simultaneously their own organizational objectives. An NGO which

champions for example, cancer prevention, may be very supportive of an initiative which addresses modifiable risk factors relating to heart health, because cancer and CVD share many of the same risk factors (tobacco use, physical inactivity and unhealthy eating.) At the same time, however, that agency depends on fund raising, and will likely want to avoid losing its visibility in an initiative which is based on another disease group, or even an initiative that is more generic in seeking to address common risk factors. Unfortunately, there appears to be very little research on this issue.<sup>54</sup> Questions remain about what might be the “tipping point” in an NGO’s willingness to support an initiative which might be aligned with its objectives, but may run contrary to its need to survive. A related question might be whether NGOs in the same coalition consistently see themselves as collaborators or whether there are their times when they see each other as competitors? Clearly, this is an area which warrants more attention.

There are a range of other issues which operate at both the individual and the organizational levels. For instance, it is not necessarily clear how the players maintain their level of commitment as a collaboration evolves. As discussed earlier, a set of shared aims and beliefs is fundamental to a collaboration. However, shared beliefs alone may not be sufficient to sustain a coalition when it almost inevitably runs into challenging issues.<sup>55</sup> As participation in a coalition is usually voluntary for the participating individuals and organizations, the benefits of participating must outweigh the costs for players to stay on board.<sup>56</sup> What these factors are will undoubtedly vary greatly depending on individual circumstances.

Applied to the CHHI, certain key issues emerge. At the inter-personal level, trust certainly appears to be one of those factors. As previously stated, the CHHI was initially brought about by a relatively small group of like-minded individuals who knew each other from previous capacities. As medical officers of health, they shared a common training and understandings, and approaches. A number of interviewees also pointed out that while the leaders were strategically placed within federal and provincial governments, their involvement was driven by their personal and professional interest and commitment to public health, rather than by the formal positions they occupied within their respective organizations. Indeed, because they were for the most part below the level of deputy minister, a part of their role was to advocate within their respective organizations for support, including financial support.

Another factor which was important was the achievement of “intermediate outcomes”. The phased-approach of the CHHI might well have built in a sense of momentum and provided encouragement for the players to carry on. The fact that the first two phases, to set the overall policy direction and to conduct the heart health risk factor surveys, were conducted fairly quickly may have contributed a sense of positive movement. Several scientific reports from working groups assigned to various issues were also produced at different stages. Finally, the Demonstration Phase was focussed on projects, primarily at the local level, which would have given a tangible sense that the Initiative was producing outputs and therefore helped to fuel the process.

At the inter-organizational level, the picture appears more complex. As we have seen, the inter-governmental relationships do not seem to have been problematic. What is not clear is how the voluntary sector organizations and the NGOs balanced their own organizational interests with those of the CHHI. At the national level, since the Heart and Stroke Foundation of Canada was the “lead” non-governmental organization, and the initiative was about heart health, one can infer a considerable amount of congruence.

What took place at the community level is much less clear. Both the process evaluation of the Demonstration Phase and the Situational Analysis<sup>57</sup> refer to “turf wars” having been a significant liability throughout the CHHI. This was also confirmed through interviews, although one key informant suggested that the conflicts may have been more of a problem in the earlier stages of the Initiative. Unfortunately, what is lacking is a clear picture of what was behind these conflicts. From the information we have, it seems that these conflicts were primarily at the community level during the Demonstration Phase. Indeed, an initiative like this one, involving as it did hundreds of organizations, is bound to experience instances of internal conflict. There is some indication that the tension was between NGOs, as well as between the national, provincial, and local chapters within certain NGOs. However, a much more intensive scrutiny would be necessary before any firm conclusions could be arrived at. What can be said is that there appeared to be an absence of mechanisms to deal with these conflicts when they arose. Training was available in different forms in different communities, including in conflict resolution, group management, and team-building. In some cases, facilitators were provided to the projects.<sup>58</sup> More broadly, however, there is no evidence of a deliberate, consistent approach to the management of conflict when it arose.

With respect to the factors related to the collaborative process, therefore, the CHHI presents a multi-faced picture. On the one hand, among the leaders of the Initiative, one can observe strong inter-personal relationships among individuals who shared common beliefs and a common professional training. There were also a number of intermediate outcomes in the form of surveys, reports, studies, and projects that would have served to give encouragement to the participants and a sense of momentum. The duration of the Initiative for a twenty-year period is an indication in itself that the collaboration was functional. At the same time, the existence of internal “turf wars” is indicative that there were weaknesses within the collaborative process. This may have been the result, as one interviewee indicated, of lack of clarity, or differences in perception, about roles and responsibilities. It could also be due to inadequate internal communications, conflicts about funding issues; interpersonal conflicts; or a combination of some or all of these. These are questions that require more in-depth investigation. At this stage, however, it can be said that the lack of a consistent and effective mechanism to deal with these internal conflicts was potentially damaging to the Initiative’s effectiveness and sustainability.

### **Facilitative Leadership**

The centrality of leadership in a collaboration is almost impossible to over-emphasize. Roussos found that in studies on partnerships, leadership was the most often reported internal factor.<sup>59</sup> It seems clear that every coalition will need champions – sometimes called policy entrepreneurs, or policy brokers – to help define and articulate its mission and to seize opportunities that arise on the policy landscape.<sup>60</sup> Furthermore, given the nature of a collaborative venture, a certain style of leadership will be called for, hence the use of the term *facilitative* leadership. As many of the partners will see themselves as equals, a rigid hierarchical model is not appropriate. This will be particularly the case in a collaboration involving different orders of government, each sovereign within their own jurisdiction. This style of leadership is well-captured by Roussos et al in saying that it is “a process of persuasion or example by means of which an individual (or leadership team) induces a group to pursue objectives held by the leader or shared by his or her followers.”<sup>61</sup> Gilles Paquet goes further, and argues that modern governance requires “stewardship” rather than leadership.”<sup>62</sup> While the style of leadership more typical of a collaboration is somewhat “gentler” in comparison to the “command and control” model, it nevertheless demands a high level of tenacity and single-mindedness to ensure the collaboration holds together and moves forward in achieving its goals. Huxham refers to this balance by saying that leaders of collaborations have to operate from two perspectives: a spirit of collaboration and what he calls “collaborative thuggery.”<sup>63</sup>

Some scholars have made the important observation that collaborations generally evolve over time, and that the type of leadership needed will change as the coalition matures.<sup>64</sup> Butterfoss has suggested four stages in a collaboration: formation, implementation, maintenance, and accomplishment of goals or outcomes.<sup>65</sup> What might be needed at the formation stage to provide a vision and mission for a collaboration may not be the same skills as are needed at the implementation or maintenance stages. Whereas policy entrepreneurs might be needed for the first phase, given their ability to recognize and seize opportunities and to take personal risks, it is likely that the needs will shift more to policy managers in the more mature phases. The skills of the latter will be more given to sustaining the coalition and adapting as necessary to adjust to changing circumstances.<sup>66</sup> Some authors have gone so far as to say that coalitions may contain the “seeds of longer-term partnership failure” if they do not adjust to these changing leadership needs.<sup>67</sup>

Good leadership appears to have been one of the CHHI’s great strengths, and perhaps, from a long-term perspective, one of its weaknesses. From the published material, and confirmed through interviews, it is apparent that the leadership for the initiative was concentrated in a small group of individuals, and with one individual in particular, emerging as the central figure.

Throughout its evolution the leadership of the Initiative at the national level revolved primarily around Dr. Petrasovits, described by Riley and Feltracco as the “linchpin” of the CHHI.<sup>68</sup> This characterization was repeatedly emphasized both in the written material and in the key informant interviews. From all evidence, the leadership style of the Initiative, was more “charismatic,” in the Weberian sense, than bureaucratic, and

appears to have remained so for its entire duration. Moreover, there is little to suggest a shift towards a more managerial style as the Initiative evolved. Although the commitment of Dr. Petrasovits and his colleagues is evident, the CHHI does not appear to have been “institutionalized” within Health Canada, which left it vulnerable when changes of personnel or priorities occurred within the Department. It is perhaps indicative that the demise of the Initiative coincided generally with Dr. Petrasovits’ unfortunate death. Other factors, of course, were also significant, in particular the termination of the NHRDP, the primary federal funding source, as well as an increased interest in “integrated” as opposed to single disease health promotion strategies. Although it would be difficult to weigh the relative importance of these factors, the lack of a transition from a charismatic style of leadership to a more bureaucratic style would need to be considered highly significant.

Unquestionably, the leadership of the CHHI went beyond this small group of individuals at the national level. Leadership was needed at the provincial level for the risk factor surveys and to establish and maintain the provincial and sub-provincial coalitions the demonstration phase, as well as the evaluation and dissemination phases. Given the large number of projects that were initiated as part of the CHHI, this also suggests quite a diverse pattern of leadership styles applied in a wide range of circumstances. What this pattern was, and what leadership styles emerged at the provincial and local levels are questions that can not be addressed here.

### **Conclusion**

Our opening proposition was that factors related to collaborative governance played a major role in the CHHI’s not being able to achieve some of its key objectives. This is not to argue that the CHHI was a failure. On many scales, it made a very important contribution to the field of heart health, and health promotion in general. It was an experiment that was closely monitored, and sometimes emulated by other countries. As one key informant put it, “the initiative changed the discourse in Canada from heart disease to heart health,” a major accomplishment in its day, which eventually was carried to the global community. It commissioned several studies and reports that were very useful in their time and which are still pertinent today. Some of the “demonstration” projects proved themselves to be sustainable, and are still in operation in some provinces. Finally, the CHHI established a platform on which future health promotion strategies could build. For example, it has been pointed out that the Pan-Canadian Healthy Living Strategy, launched in 2005, could be considered part of the legacy of the CHHI.<sup>69</sup>

However, as stated earlier, on the basis of at least two important criteria, the CHHI fell short. First, it did not get to the stage of full implementation (deployment), as had been planned. Second, it did not realize its objective of integrating heart health into the public health infrastructure across Canada. At least three factors related to governance contributed to this result. First is the lack of sanction and mandate. As we saw, the CHHI never achieved formal sanction from federal and provincial/territorial

governments. This was a mixed blessing. On the one hand, this meant that the CHHI could operate free of constraints, which provided an opportunity for flexibility, innovation and experimentation. Furthermore, the fact that it was outside the “strategic” inter-governmental relations discussions allowed it to avoid becoming entangled in the fairly acrimonious FPT disputes in the 1990’s relating to funding for health care. It might even be questioned whether the Initiative would have been launched if it had sought formal FPT sanction. On the other hand, the lack of sanction and mandate also meant that the Initiative could easily be ignored or forgotten. When the NHRDP funding, on which the CHHI depended for funding, ended in 2002, there was no formal agreement or mechanism on which to base a case for its continuation. There was no formal decision to end the CHHI, because there had been no formal decision to initiate it. The consequence was that it ended with a whimper, not a bang.

The second factor was the existence of “turf wars” among the participants. Further research is necessary to discover what was at the root of this problem and what measures might have been taken to prevent these issues at the outset. What seems evident, however, is the absence of effective, consistent mechanisms to manage and resolve these conflicts once they occurred. Although the existence of conflict resolution mechanisms is not consistently raised in the literature, many scholars have indicated the importance of having processes to deal with conflicts that will inevitably occur in a collaboration.<sup>70</sup>

The third point relates to the CHHI’s leadership at the national level. As was discussed, the style of leadership adopted was facilitative, and quite concentrated around a small number of individuals, and one in particular. From all accounts, it was remarkably effective for many years, but there does not appear to have been a shift from a visionary, charismatic style of leadership to a more managerial/bureaucratic style. Again, this may be a two-sided coin. The visionary style likely kept the spirit of the Initiative innovative and experimental and was obviously highly effective in bringing key individuals together around a new initiative. However, the fact that the leadership was not more institutionalized meant that when the key individuals left the scene, for a variety of reasons, there was no bureaucratic structure in place to maintain the momentum of the CHHI and to take the Initiative to the next stage.

As was stated earlier, there are still many questions to be examined to better understand the reasons for the CHHI’s success, and its demise. The conclusions presented here should be seen as preliminary, subject to closer scrutiny and validation. It is hoped that the questions raised here can help direct research on some of the issues that need additional scrutiny.

For public health practitioners, some broad themes emerge from this research. Perhaps the most obvious is the importance of **preparation**. Multi-level collaborative initiatives, as we have seen, are inherently complex and have a high risk of failure. This serves to underline the importance of giving serious consideration to the governance aspect of a new initiative from the outset, and avoid treating this as secondary to the “content” issue, be it heart health, cancer prevention, or healthy living in general. The second



point, closely related, is about giving care and attention to the **design** aspects of a collaborative initiative. This involves finding an intricate balance between building an initiative on a strong platform of mandate and accountability, while at the same time retaining a measure of flexibility, in recognition of the fact that in a collaboration, decision-making must be shared with others. It may or may not be true, as some have suggested, that in a collaboration, “no one is in charge.”<sup>71</sup> However, it seems clear that no one party can expect to be in control, at least not for the long-term. Indeed, to derive the maximum value from an enterprise of this nature, no one party should seek to be in control, because of the stifling effect on the creativity of others.

The next broad theme is the importance of **nurturing** a collaboration. The number of factors affecting a collaboration is very great indeed, and any one of those can negatively impact an initiative. This means that those involved will need to have the time and resources to monitor constantly the process and have the capacity to make the necessary adjustments. Collaborations will simply not run on “auto-pilot.” Chris Huxham has indicated that “those who want to make a collaboration work have to be prepared to ‘nurture, nurture, nurture’ them,” and must be prepared to do so on a continuous and permanent basis because “no sooner will gains be made than a thunderbolt...will come to disturb them.”<sup>72</sup>

Finally, there is the crucial issue about **leadership**, or “stewardship” as some would argue. The key players will need to inspire, motivate, and in some cases mediate, without losing track of the notion that the process belongs to all of the participants, not just to one or a few. This is a style of leadership that is both challenging and, one would argue, uncommon. Also, as the case of the CHHI suggests, the leadership skills that are required will shift somewhat as a collaboration matures, which brings back to the notion of monitoring the process and adjusting as necessary.

All the above points serve to underline the difficulty and complexity of making collaborations successful. Yet challenging as they might be, collaborations, for the reasons given at the beginning of this paper, are a part of our world. They are clearly a fundamental part of public health in the 21<sup>st</sup> century. It is hoped that through a close examination of the CHHI and other similar initiatives, we will deepen our understanding of collaborations and improve the tools at our disposal to make them successful.

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