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THE JOURNAL OF PUBLIC SECTOR MANAGEMENT

ILLUSTRATIONS IN PUBLIC HEALTH OF A MORE COLLABORATIVE PUBLIC SERVICE

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Vol. 44, Issue 4, Dec 2014

Introduction

As the recent outbreaks of Ebola so clearly illustrated, public health organizations around the world are scrambling to maintain public health and contain disease through more effective protocols and increased collaboration. From physicians in the field to researchers to public health leadership to policy makers, the demand for everyone involved to find better ways to work together has never been greater.

The collaboration challenge is, in fact, a phenomenon that the public service in general is adapting to. For instance, it was underscored in Blueprint 2020, the Canadian federal government's public service renewal initiative. In it, the former Clerk of the Privy Council, Wayne Wouters, laid out several guiding principles to ensure that the Canadian public service remained aligned to a world, a country and a citizenry whose needs and expectations are continually evolving. These included:[1]

- An open and networked environment that engages citizens and partners for the public good, *together with…;*
- A whole-of-government approach that enhances service delivery and value for money, *enabled by…;*
- A modern workplace that makes smart use of new technologies to improve networking, access to data and customer service, *and…*;
- A capable, confident and high-performing workforce that embraces new ways of working and mobilizing the diversity of talent to serve the country's evolving needs.

In contrast to those fixated on traditional governance as a means for exercising power and control, Wouters' insight into the public service was to see it as a continually evolving organization, one whose future adaptations would reflect a series of partnerships between governments and citizens as conditions, technologies and values changed over time. It was a vision that invited inclusion, stirred innovation, and empowered collective wisdom.

Yet while Blueprint 2020 opened the possibility of redefining the role of modern government and establishing new relationships with its citizens and other social actors, the ensuing action plan that was announced in the spring of 2014, "Destination 2020," has fallen victim to an old problem that has plagued the public service whenever it has tried to move ideas into action: ideas are presented without the means to achieve them.

"Destination 2020" action plan called on deputy ministers to be role models, "to lead by embodying the change they want to see in others;"[2] for mangers to be less authoritarian and top-down, and "establish a culture where employees bring their hearts and minds to their jobs every day by making sure that their opinion is heard and that their contribution to building the workplace culture is recognized;"[3] and for employees to become more passionately engaged in their work, and "embrace their role of agents of change by adopting a positive attitude, keeping an open mind, and remaining steadfast and committed."[4] The intent of Blueprint 2020 may have been to extend the horizon of collaboration with and across government, but "Destination 2020" remains rooted in old models of leadership and top-down management.

By now it should be obvious to most 'leaders' that top-down leadership has lost its edge. Widely respected management gurus such Hamel, Senge and Hagel have abandoned it, as have many of the corporations which are intent on leading in the innovation economy. However, governments, which face even more complex operating environments than the private sector, remain stuck in a leadership model of organization that predates universal education, let alone computers and the Internet.

Governments are typically at a loss when confronted with the need to collaborate: to solve problems with others; to learn and develop solutions together; to find new ways to work together; to share power; and to co-create shared futures. They possess neither the organizational cultures of collaboration, nor the frameworks, skills, tools and mechanisms to properly affect it.

Theodore Roosevelt once poignantly exclaimed, "The government is us; we are the government, you and I." It's an observation that is unfortunately lost on many Canadians today – in and out of the public service – who view government and the citizenry as being separated by some unbridgeable chasm. We suspect that tomorrow's citizen, on the other hand, may well look back and view today's separation between citizens and government as an artificial contrivance of infirm governments and an ill-informed and technologically unsophisticated populace. Nevertheless, we feel that the signs of change are evident – even today – and that tomorrow's governments may not be so easily recognizable by the citizens of today. Our experience suggests that the current mindset is changing, and is moving closer towards Wouters' 'partnership' model – probably faster than most people realize. Why?

Because many of the assumptions that currently drive that distinction have already become outmoded, despite the popular belief among both governments and citizens to the contrary. These now contestable assumptions include:[5]

1. Government is the ultimate authority for divining social needs and setting social rules;
2. Government knows best because it controls the largest storehouse of knowledge and expertise;
3. Government has all the resources needed to solve social problems;
4. Government has all the coercive power needed to affect solutions;
5. Government has ethical and moral purposes that transcend those of its citizens[6] giving it special insight into the 'public interest';
6. Collective trade-offs are affected by government by bringing representatives of various interests to one place whereupon they engage in elite accommodation;
7. Government is the only actor that can be trusted to deliver public goods and services: services like education, health care, public infrastructure, steering the economy and the provision of social supports;
8. Only government can keep you safe;
9. Government is obligated to reinforce traditions of leadership and followership; and
10. Government changes slowly which is to the betterment of all.

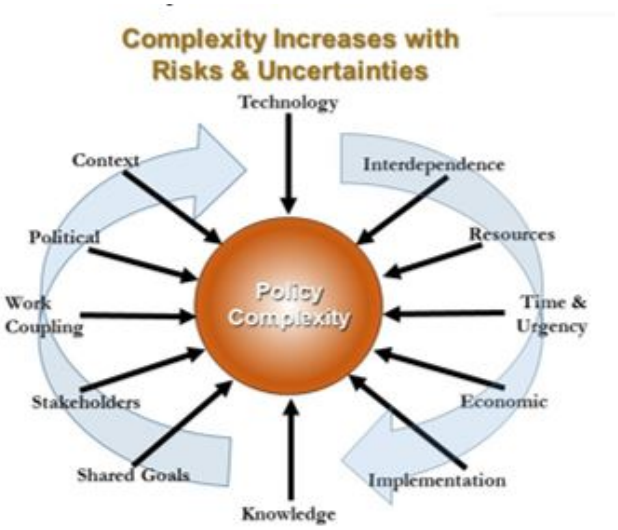
These assumptions underscore a very linear model of public policy (Figure 1)

Figure 1: Linear Policy Model

Yet, in most of the issues that are of importance to citizens, it is evident that governments commonly do not have all the knowledge, resources or power to affect their intents and resolve these issues for citizens. As Nik Nanos lamented in *Policy Options,*[7] "increasingly, fewer Canadians have confidence that our leaders can address the concerns that matter most to them." This is because those problems are wicked and complex; they exist within ecosystems of causes and effects; they are constantly evolving over time; and whatever the desired ends might be, those goals tend to change even as the potential means to achieve those ends may become known.

What has become eminently clear is that governments cannot achieve their goals by themselves, along with the corollary that they must learn to work with others as collaborators and partners, regardless of their mandated authority. Fundamentally, this turns paternalistic government on its head. What was once a largely linear model of policy development is increasingly unpredictable, uncertain and non-linear (Figure 2).

Figure 2: Non Linear Policy Model



Even now, we are beginning to witness a change in the institutions of government from elements of the old big 'G' government apparatus to being participants in small 'g' governance regimes, where coordination is achieved through a variety of mechanisms that permit governments to work together with groups of stakeholders to achieve their common goals.

We are seeing a move from government as the expert with all the answers to being a valued party who facilitates solutions among a wide range of stakeholders – all of whom own a piece of the puzzle – who require someone able to orchestrate collective experimentation and prototyping to find optimal solutions. The directive form of government, often referred to in capitals as the 'State', with all its coercive power is giving way to the notion of government as a catalyst – a vehicle for bringing to bear collective knowledge, resources and influence to guide, support and validate the actions of local actors – not through compulsion – but with behaviours best encapsulated by the expression "how can we help?" In future, governments may well rely less on their legally mandated power and more on the respect and trust they generate as honest brokers of cooperative action by citizens who want to solve the problems they feel they need to address.

This migration from top-down hierarchical models of government to more open and engaging networks of collaboration is being motivated by the desire to effectively generate and capture social innovation. Yet in doing so, governments will have to ensure both the increasing density and diversity among network participants as well as a more open flow of information, for it is only by having more information in the hands of more and different people that mass collaboration and innovation can emerge.

Says Linus Torvalds, the originator of Linux and the open source software movement, "I would (and do) seriously argue that especially in the face of complexity you absolutely have to have an open and collaborative development process, exactly because it's the only thing that scales. However, it's not enough to be open and collaborative – it needs to be distributed as well. And by 'distributed', I mean the massive parallel kind where everybody can replicate the whole thing."[8] Therefore, to remain effective in solving complex social problems, governments are likely to become more like platforms upon which citizens can find shared space to work together and collaborate towards some common future.

To suggest that governments become collaborative platforms or that citizens become the primary partners in their own self-governance might seem to some to be a bit fanciful or utopian even. Nevertheless bits and pieces of this new democratic compact are bubbling up here and there across the country, regardless of established practice. Still what remains unclear – at least as far as "Destination 2020" is concerned – is how best to encourage such a transition and facilitate its emergence. Among today's bureaucrats and politicians who wear the tinted glasses that see only that the 'State knows best,' the foremost challenge is the need to wake them up and demonstrate that 'it just ain't so.'

Management guru Gary Hamel, for instance, predicts the next organizational revolution won't be technological, it'll be social. "The real problem we're up against, is not technology, it's the management DNA in companies .... When you concentrate the responsibility for innovation at the top, you're holding your capacity to change hostage. It disempowers people … Bureaucracy has to die."

We have written this paper to help try and demonstrate that collaborative approaches are happening, that the old management DNA can change and that maybe bureaucracy can rest in peace.

To explore these changes in governance, our paper uses the lens of health care. At every level of government, a central concern is the provision of affordable health care. In our work together, the authors have been accorded the opportunity to speak with a number of passionate and knowledgeable health providers and health policy champions. And despite the longstanding public reticence to confront the need to alter Canada's public system of health care, our conversations with practitioners have suggested that change is moving forward regardless – animated by the best of intentions to improve the overall quality of health care for all Canadians.

As part of an international scan of public health and other organizations involved in knowledge, development and exchange (KDE) [9] efforts, the authors recently undertook 24 interviews with health professionals from Europe, Australia, the United States and Canada. The original purpose of this scan was to look for benchmark approaches for identifying, creating, producing and disseminating knowledge products and activities by discovering emerging practices. Along the way we learned that it was not just KDE practices that were changing, but the basic approach of public sector organizations and their relationship with citizens.

Across the country, provincial health ministries have recognized that even for a wealthy nation like Canada, the rising costs of health care are unsustainable. As an indication, an actuarial analysis of the Canadian health care system conducted last year by the Canadian Institute of Actuaries concluded[10] that, at current growth rates and if the policy environment remains unchanged, a staggering 103 percent of *total revenues* available to the provinces and territories will be spent on health care by 2037, compared to 44 percent in 2012. This was also affirmed in our own interviews: governments we were told need to reorient themselves from trying to reduce health care costs to avoiding them altogether.

According to Dr. Hans Krueger,[11] the *cost reduction* paradigm must continue to deal with a growing number of sick and infirmed people even if the per unit costs decline, whereas a *cost avoidance* strategy is all about trying to keep people from falling sick in the first place.

To facilitate their ongoing improvement, health organizations – be they public, private or not for profit – are typically tasked with producing guidelines and knowledge products for use by physicians, nurses and other front-line, health-care practitioners. Government organizations are often at the forefront of these efforts trying to capture and disseminate new research and practices.

However, we were told that the process of designing, developing, distributing, and using new health care products and services is changing. Increasingly, it is less of a process that involves a few experts working away from the public eye, and more about collaboration and engagement among multiple stakeholders, some of whom are experts by virtue of their knowledge of how change might impact them personally or their communities (such as those in Aboriginal, immigrant youth and senior communities). Collaboration has become crucial for ensuring that innovation remains locally relevant, effective, efficient (including the optimal use of local resources) and sustainable over the long term. There is no longer any appetite for public investments of time and money that result in products or services that only "sit on the shelf" (if ever there was).

Most public health organizations regularly survey health-care practices and research landscapes to become informed of emerging issues, new products and services, practice guidelines or policy recommendations. But while this has been a standard approach for some time, it appears that this is no longer enough. Linear approaches that move from concept to data collection to reporting to development and distribution do not seem to be yielding the desired results. We were told that just because governments may be aware of something is no guarantee that they can either respond effectively or that communities will embrace that intervention.

The international health-care community's anemic response to the still unfolding Ebola crisis in Africa is a case in point. In a recent report by Gale and Lauerman for Bloomberg News Service,[12] the World Health Organization's slow response was attributed to poor communication; a lack of leadership; chronic underfunding; medics not deployed because visas weren't issued; bureaucratic hurdles that delayed $500,000 in spending intended to support the disease response; slow feedback from experts in the field to headquarters; and contact-tracers refusing to work over concern they wouldn't get paid. Often the shipments of much needed donations, like the protective suits provided by Canada, were delayed because there was no one to receive them. Much of the actual on the ground work was left to an overstretched charity – *Médecins Sans Frontières. "*The [WHO was] designed as the world's health warden yet it is burdened by politics and bureaucracy," say Gale and Lauerman. With so many contributing parts, even the central organization tasked with coordinating a global Ebola response has found it escalating out of control. In a statement of significant understatement, WHO Director General, Margaret Chan, described how "our response may not have matched the scale of the outbreak and the complexity of the outbreak."[13]

More generally, however, there continue to be new health issues, such as the debate over health care versus well-being, and the ongoing evolution of social norms, such as the growth of collaborative consumption, that tell us greater public engagement is becoming a precursor for both innovation in products and services, as well as end-user adoption. As one health professional told us "the engagement process is now as important, or even more important, than having an end-product" because it is often the engagement process that ensures uptake among targeted audiences.

Also as health is becoming recognized as more than just care and treatment, creating health is increasingly about a variety of social determinants for which governments require a more holistic focus on both individuals and groups. Thus the challenge and responsibility to promote and maintain health has broadened to become a collective concern, and not just something that can be passed off to a few experts when the signs of illness appear. Consequently, the public health system, we were told, is evolving into a complex learning system in order to cope with the multi-dimensional nature of both wellbeing and illness.

What we think we observed in our interviews is the beginnings of a public sector shift that might best be described as holacratic:[14] more people and organizations are becoming involved; temporary groups or communities of practices are forming; these communities of practice involve not only the usual suspects like researchers and physicians but nurses, community activists, teachers, employers, patients, seniors, clients and other end users. These groups can be seen to be taking responsibility for their own local learning, developing customized local solutions and then sharing their learnings with others. No one is 'in charge', but they are guided by their shared passion to find helpful and reasonable responses to address their health concerns. It is the emergence of this distributed ownership and coordination that is suggestive of holacracy.

"Holacracy is a distributed authority system – a set of 'rules of the game' that bake empowerment into the core of the organization. Unlike conventional top-down or progressive bottom-up approaches, it integrates the benefits of both without relying on parental, heroic leaders. Everyone becomes a leader of their roles and a follower of others, processing tensions with real authority and real responsibility, through dynamic governance and transparent operations."[15] Since new health knowledge and practice can emerge anywhere and at any time in the health-care continuum – from researcher to patient – what we heard is that everyone in that continuum needs to be able to contribute, and participate in co-creation and the validation of change, for any response to become effective.

In that process, the public health system is becoming more open and inclusive while shedding its mantel of leader-driven hierarchy that so limits its innovativeness, its effectiveness and its capacity to adapt in a rapidly changing health environment.

In our interviews we discovered in Canada's health-care system, two fascinating examples of this emerging holacracy: the Canadian Partnership Against Cancer (CPAC), and BC's Public Health Services Authority (PHSA). We know that this is not an exhaustive list. Nevertheless, the two are clearly suggestive of an evolving role for government entities – one that is more facilitative, more catalytic, and more reflective of a strategic partnership among governments, citizens and a host of social actors. They depict government in transition, driven by the need to serve citizens well, but also by the recognition that, in order to do so, they must help them solve their own challenges in ways best suited to them.

In the following pages, we will briefly share the stories of these organizations, which we believe are suggestive of this emerging model of public governance.

Canadian Partnership Against Cancer[16]

Background

Work on a cancer strategy for Canada, the Canadian Strategy for Cancer Control (CSCC), began in the late 90s as an agreement to collaborate among four leading organizations: the Canadian Cancer Society; the National Cancer Institute of Canada; The Canadian Association of Provincial Cancer Agencies; and Health Canada. Together and with over 30 smaller cancer-related organizations across Canada, including – cancer agencies

and programs; health delivery organizations; non-governmental organizations; cancer control and health experts; clinicians and researchers; and patient groups including, patients, survivors and their family members. In 2006, the federal government announced the creation of the Canadian Partnership Against Cancer, an organization charged with implementing the CSCC strategy, and mandated it to continue to work with a diverse group of people and organizations to do so. Since then it has received approximately $50 million annually in five-year allotments to implement the CSCC.

CPAC was incorporated as a non-profit organization, and is led by a board of directors comprising 18 members and two *ex-officio* members (Health Canada and Province of Quebec). The board is a combination of CEOs from several voluntary organizations (such as the Canadian Cancer Society, the Canadian Association of Provincial Cancer Agencies, and Canadian Blood Services), several provincial and regional government representatives, members from the First Nations, Inuit and Metis communities, and a few people who have a direct connection to cancer, either as survivors or as having held governance roles with Canadian cancer organizations. This means members often have a personal stake in CPAC's outcomes. This enriches the board with a diversity of perspectives and makes its decision-making process results oriented. CPAC, through the board, is accountable to Health Canada and, given its makeup, the board ensures that the organization's direction aligns with agendas of provincial and other major stakeholders.

CPAC has a funding agreement with Health Canada that provides it with a broad mandate to implement a Canadian cancer strategy, but it acts with a great deal of autonomy both from the federal government and the provincial governments, which have jurisdictional responsibility for health care in Canada. Through its board, it is accountable not just to one government but to all the federal and provincial governments, and to Canada's major cancer-related non-profit organizations.

In addition, the manner in which federal funding has been provided to CPAC (in five-year commitments) strengthens this sense of independence. The objective of that funding is to put their limited resources (limited relative to the huge amounts of money being spent collectively each year by all levels of government, research institutes and non-profit agencies) towards the highest and best use in fighting cancer. Its approximately $50 million in annual funding leverages the $6 billion spent each year on cancer care in Canada. Yet Lee Fairclough, former Vice President, Strategy, Knowledge Management and Delivery at CPAC, says "we make it clear to potential partners that we were not a research granting organization. We were there to bring together what we each already know separately and then find more effective ways to put it all into action."

CPAC was also given the authority to provide funding to third parties, thus it conducts its own calls for proposals for investments in the implementation and uptake of evidence, and has the flexibility to direct funding across the priorities it deems appropriate. It is the board as a whole that decides on those priorities. Consequently, instead of the traditional power imbalance that usually favours governments over voluntary and research organizations, "CPAC represents," according to Claude Rocan, "an attempt to establish a different type of relationship."[17]

In fact, CPAC seems to be unique in Canada. As a result of the federal Cabinet decision, CPAC may be the first non-profit organization that has been given both de facto policy authority and the financial resources to implement a national strategy. "This may well be unprecedented in modern times in the health sector," suggests Rocan. Fairclough, on the other hand, is more circumspect, "while we don't set policy, we are a trusted broker to influence policy. Not through traditional advocacy means but by bringing to bear the perspectives of patients and the evidence." Regardless, what seems to have emerged with CPAC and at least with respect to cancer strategies, is that national and provincial policies are being strongly influenced by a non-governmental organization.

There have been several factors that have encouraged this unique status. These include:

- The fact that cancer affects 1 in 3 Canadians and costs governments approximately $6 billion annually in health-care expenditures.
- While over $550 million was spent in Canada on cancer research in 2011, only a small portion of cancer-related funding went towards cancer prevention strategies even though the evidence is clear that 1/3 of cancers are preventable with the cessation of tobacco, and another 1/3 of cancers are preventable with lifestyle changes to diet and exercise.
- There has been strong and persistent public pressure to find a cure for cancer and for federal and provincial governments to work more closely together on cancer control and other health issues.[18]
- The recognition that no single government has all the knowledge necessary to eliminate cancer and that working together could provide an important opportunity to build a more comprehensive, shared knowledge base.
- All three major political parties supported the CSCC in the 2006 election campaign, suggesting a consensus that the CPAC NGO approach allowed operational flexibility and an opportunity for relationship building that was more difficult in the existing government apparatus,[19] where any government's claim to be 'in charge' would be universally challenged.

CPAC does not actually have direct service delivery capability and it does not seek to address the entire cancer control universe. Instead it seeks to "maximize the development, translation, and transfer of knowledge and expertise across Canada"[20] through the CSCC. The CSCC had eight strategic priorities: primary prevention; screening/early detection; surveillance; development of evidence-based diagnostic and treatment standards; clinical practice guidelines; research; health human resources; and patient-centred support. These eight priorities have since evolved and are currently reflected in the strategic plan of the organization. CPAC is a small organization with only 100 employees but it has no intention of growing larger as an organization – preferring that the funds it receives are used for cancer-related interventions and activities, and not for administrative overhead. As well, in implementing Canada's cancer strategy, CPAC takes great pains to engage the public, in particular, those people who have an interest in or who are affected by cancer, especially First Nations, Inuit and Métis partners who have traditionally had little voice in steering cancer strategies.

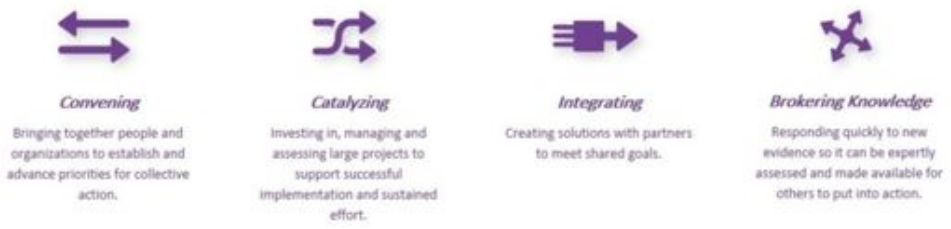
The partnership

"Our main challenge" says Fairclough, "has been how to get people together to target gaps in our knowledge and practice in dealing with cancer. Creating an organization outside of traditional provincial and federal ministries of health was key to establishing alignment among the partners. One outcome of this was to create an ability and a framework for multi-year funding of initiatives. The former allowed us to develop a pan-Canadian approach to problem solving while the latter allowed us a time frame that permitted us time to think and learn together."

What has helped tremendously in guiding the partnership is that the partners themselves are driven by their shared passion to fight cancer. Many of the participants have direct experience with cancer patients and therefore the work is personal for them. This has generated a results-based orientation that tends to prevail over organizational turf concerns and the usual propensity to put the needs of the home organization above the needs of any partnership. As initiatives come up, the partners become involved at their discretion and they can be involved in a number of initiatives at any one time. To participate, however, they must adhere to certain criteria, including: having their own relevant partner network; committing to a pan-Canadian process of knowledge exchange and joint problem solving; be willing to put knowledge into practice; and to share the risks. CPAC funds are then allocated based on the potential to discover better ways and/or accelerated ways of implementing what the partners already know, learning from one another across the country.

Operating as a separate organization from federal, or provincial, or territorial governments, has proven to be a key strength. As a result they are not viewed in the usual federal-provincial policy dynamic. CPAC is not viewed as a competitor by any government. This means it can act as a catalyst without being seen as a threat jurisdiction-wise. Furthermore, it offers opportunities for public-private collaboration that might not otherwise be undertaken due to adversarial political environments. Lastly, not only is CPAC accountable to each partner organization for results, but the partners themselves are also mutually accountable through their personal interactions and an annual reporting process that is public for all to see.

Figure 3: CPAC Partnership Model



Partnership process

The partnership process surrounding any initiative begins with networking among stakeholders to establish a purpose and goals. Then, rather than rushing to decisions and actions, time is set aside to jointly create an agenda for getting together; to build relationships; to share information and learn together; to set priorities and to assess what ultimately is done and its impact. The partnership is about collective learning and sharing the risk for developing new programs and policies. For that "we need multiple partners with different backgrounds and interests" to present a variety of perspectives, contribute different resources and provide sufficient inclusion to ensure implementation. "We encourage our partners to be involved in the development of an initiative so that there is a vested interest for them in making use of any new products or information."

Since CPAC is about implementing what is already collectively known, what does it take to do that? How do you move people from being propriety in their concerns to being open to a process of co-learning? To begin with, to ensure that they're focused on the right thing, CPAC demands that partners will use what they learn. Consequently, they develop measures of performance together to make sure the results are meaningful to everyone, and that whether they succeed or not, the experience still contributes to collective learning.

The relationships with partners vary. Partners may contribute direct funding, or in-kind services, knowledge or on-the-ground experience. Partners can be involved in multiple initiatives and they can choose for themselves which initiatives they want to participate in and which they don't. An initiative may also include a funded planning period to consider the nature of the challenge and who can do what best. Funding can shift based on a variety of factors, including: the impact of prototypes, the engagement of partners, perceived need, etc. It is a dynamic process.

CPAC deals with multiple audiences, but they are also constantly looking for new people and organizations with which to engage. Despite their principal focus being on clinicians and caregivers, the products CPAC produces are the result of a broad collection of interest groups and the results are meant to be used widely.

Putting effective governance into practice

An example of effective governance at CPAC involves its cancer screening initiative. A US study recently flagged cancer screening as an issue.[21] CPAC then decided to undertake a review of the evidence for screening. They then brought together a mix of clinicians in a learning event to assess that review. CPAC did not hand pick these clinicians. They asked for nominations from various jurisdictions and organizations across the country. With them CPAC undertook impact modeling of different kinds of interventions; they developed a framework for policy; and they fostered a policy debate around alternative prevention strategies.

In this way when CPAC undertakes an intervention (eg., its recent initiative to measure improvements in cancer control for Métis in Canada), existing data informs any decisions, the partners engage in debating its implications; they co-design a response or prototype; the intervention is measured; and the measured outcomes help to inform the next stage of the intervention. However, even before serious work begins, there can also be a funded planning period to support the local stakeholders preparing a proposal. That stakeholder engagement is valued and CPAC regularly schedules knowledge exchange events with stakeholders in order to seek their input and participation.

"Each issue we undertake is about bringing people together to solve problems. There is intent, specific objectives, shared risk, and there are metrics behind it all."

CPAC's overall approach was described to us as a combination of:

a. Being clear on what CPAC is and what it is not.
b. Recognizing that a centralized approach is not workable. The issues are chosen because they demand a wide range of contributors from clinicians to health system administrators to policy makers to researchers to patients.
c. Getting interested stakeholders involved from the beginning in the development of an initiative is key (eg., Cancer screening study) where they are brought together to look at the evidence and provide fresh perspectives.
d. Events are intentionally structured to allow multiple perspectives to be shared and for everyone to become invested in the analysis and the action outputs.
e. Being clear to people in the end that "we developed things together." Any achievement is not owned by CPAC but by everyone.

Still, as Fairclough specifically pointed out, the ability to collaborate should not be assumed. While partnerships are about bringing people together to solve issues, they are not simply a 'gab fest' but they must reflect the clear intents among the partners to achieve specific purposes and goals. In order to retain that clarity throughout the process of engagement, they have program metrics behind their work to sort out what works and what doesn't. One of the big challenges CPAC faces is that this is a new way of working. Most people we were told are not accustomed to working in this fashion, and so generally speaking, these partnership skills have to be learned by the participants as they move forward. One of the core competencies CPAC has identified for itself has become the knowledge of how to affect cooperation and the practices which support it.

According to Fairclough, no matter the urgency of the issue or their goals, there has to be time for the back and forth that is needed to set an agenda. There has to be time to discuss and learn together. There has to be time to assess the impact of any interventions and who is best positioned to scale it up should it be found effective. And importantly, the discussions often take place face-to-face as an explicit tool for making the relationships personal. While online forums may be used to keep the momentum going, once it is started, they do not replace face-to-face meetings. That personal dialogue builds trust, discovers tacit information, cements moral contracts and encourages mutual accountability. CPAC has developed a toolkit to help stakeholders engage effectively in partnership and knowledge exchange that it has made available on its website, Cancerview.ca.

Even after the development process, CPAC remains engaged with its partners as part of the process of implementation. It can see the results and is able to help the group modify its approach collectively, if it becomes necessary. For the partners, it seems easier to change direction by being part of a community than by being a solitary actor with sole responsibility and a commitment to soldier on and see things through.

The impact of CPAC's collective learning approach and the process of eliciting shared commitments has a strong influence on the nature of CPAC governance. In one sense, CPAC represents a case where the role of government has been turned upside down. Instead of being the funding party that dictates terms to a non-profit, governments must learn to act as equal partners. Says Rocan, "Health Canada and the Public Health Agency of Canada often find themselves in the position of participating, not as parties with a stronger role than any other organization, but as one of many parties. If either agency has a particular interest in one of the eight strategic priorities, or in a sub-strategy within them, it may decide to participate more actively by contributing funding for a particular purpose. This was the case recently when PHAC and Heart and Stroke Canada contributed funding to CPAC for the Coalitions Linking Action and Science for Prevention (CLASP) programs to integrate cancer and other chronic disease prevention programs. Because they were providing funding, both organizations received a seat at the table to participate in steering those programs."[22]

The fact that public stakeholders can come together under an umbrella such as CPAC to work towards solving tough, complex problems, suggests governments can assume different roles in pursuit of the public interest. Government doesn't always have to be the only one to solve the problem.

In fact, sometimes it may be counter-productive for them to do so because it may eliminate the possibility of different voices from being heard or different resources from being contributed. How many of these roles – funder, policy maker, regulator, honest broker, catalyst, data provider, conflict resolver, convener – can a government assume? At this time, we don't know without greater experimentation, but we do know that the availability of more options makes any organization more adaptable.

Yet as the case of CPAC illustrates, at times government had the opportunity to act in several of these roles as an enabler/ broker/ facilitator in order to permit a variety of organizations to come together to discover and implement innovative cancer solutions. CPAC teaches us that governments can indeed help to ensure that shared learning finds its way into action and that the learnings from organizations like CPAC can productively inform policy and legislative change. The natural scope of governments may also provide a unique advantage in helping to ensure that the lessons learned from a group such as CPAC can be shared with other groups with entirely different agendas, such as diabetes or education. And the general lessons learned about collaboration can certainly be disseminated widely by government and shared to all manner of issue domains and partnerships.

In the end, CPAC represents a significant new governance model one which Michael Prince described as "a platform for communication between governments, non-government agencies, health professionals, and cancer survivors and families" as well as "an opportunity to modernize the management of chronic diseases and to further democratize the conduct of intergovernmental relations."[23]

Lessons

- Recognizing that no single government has all the knowledge necessary to solve the problem and that the existing governmental apparatus wasn't capable of achieving the cancer-related goals.
- Recognizing that a centralized approach is not workable.
- The need to be constantly looking for people and organizations with which to engage.
- The importance of having a board with a diverse set of skills, experience and perspectives.
- Taking great pains to engage the public, in particular those people who have an interest in or who may be affected by change.
- Mandating potential partners to have demonstrated prior collaboration experience and able to bring their networks to the table as a condition of membership.
- Establishing clear intents among the partners to achieve specific purposes and goals and having program metrics behind them to sort out what works and what doesn't.
- Setting aside sufficient time for discussions to take place face-to-face as an explicit tool for developing relationships and making the work personal.
- An observation of the general lack of facilitative and collaborative skills among participating partners, requiring that someone in the group have them – in this case CPAC – while ensuring time set aside for the others learn as they go.
- Operating as a separate organization from federal or provincial or territorial governments-facilitated partnership, permitting CPAC to act as a catalyst without being seen as a competitor.
- Ensuring that the organization remained focused on collaboration by capping its size and not becoming a program delivery organization.
- Recognizing the need for multiple partners with different backgrounds and interests and then organizing events and activities in such a way as to allow multiple perspectives to be aired.
- Getting stakeholders involved and taking ownership right from the beginning.
- Creating a multi-year funding framework to provide time to build partnerships, learn and experiment. Setting aside a funded planning period to consider the nature of the challenge and who can do what best.
- Ensuring that stakeholders participated in co-designing a response or prototype.
- Rather than rushing into action, setting aside time to jointly create an agenda for getting together; time to build relationships, share information and learn together; to set priorities and to have time to assess what was done and its impact.
- While CPAC was accountable to each partner organization for results, the partners themselves were mutually accountable.
- Everyone got credit – "we developed things together."

Population and Public Health Program of the BC Provincial Health Services Authority[24]

Background

In British Columbia, the Ministry of Health establishes policy and sets priorities for health care and services. As a separate, quasi-governmental organization, the provincial Health Services Authority (PHSA), is one of seven health authorities that operate in BC. British Columbia's six other health authorities – five regional and one for First Nations – are each distinct in the way that they translate policy into practice, using various standards of evidence-based care. But even though it reports to the Minister of Health, PHSA remains arm's length in order to act as the link between policy makers and health practitioners in BC. PHSA's primary role is to ensure that BC residents have access to a network of high quality specialized health care services. PHSA operates provincial agencies and is responsible or oversees a variety of specialized provincial health services. In its provincial role, PHSA works closely with other health authorities across BC to provide equitable and cost-effective health care for people who need provincial services.

The Provincial Health Services Authority operates eight provincial agencies within it, including: BC Mental Health & Substance Use Services, BC Children's Hospital, BC Women's Hospital and Health Centre, BC Centre for Disease Control, BC Cancer Agency, BC Renal Agency, BC Transplant and Cardiac Services BC. In addition to overseeing the operations of these nine agencies, the PHSA is responsible for a number of provincial health programs and services. These include:

- BC Emergency Health Services
- BC Autism Assessment Network
- BC Early Hearing Program
- Health Shared Services BC HIV/AIDS Program
- Lower Mainland Pathology & Laboratory Medicine
- PHSA Aboriginal Health Program
- Provincial Blood Coordinating Office
- Provincial Infection Control Network of British Columbia
- Provincial Surgical Services Program
- Provincial Emergency Services Program
- Services Francophones
- Specialized diagnostics
- Specialized cancer surgery
- Stroke Services BC
- Telehealth
- The Provincial Language Service
- Trauma Services BC

All of these agencies and services contribute to the province's health care / health prevention agenda, but they also provide PHSA with unique reach across the province either through agency specific activities or through agency participation in activities that cut across both health disciplines and various regions of the province. Due to the PHSA's provincial mandate, it has a dual role around the provision and coordination of health services: i.e., the generation of innovations aimed at streamlining activities; and the coordination and province-wide health monitoring in areas such as new research and practice; public messaging; integrating expert advice; and support for the development of healthy public policy.

One of the programs nested within the cadre of PHSA services is the Population and Public Health Program (PPH) which has a mandate for chronic disease prevention. PPH has a team with expertise in epidemiology and biostatistics, knowledge translation, project management, and leadership as well as in various content areas related to chronic disease and population health and it works in collaboration with many partners. PPH seeks to inform and advise policy makers and practitioners on emerging and priority population health issues. It conducts chronic disease surveillance; encourages knowledge development and exchange on various emerging issues; fosters inter-sectoral collaboration, and convenes and

connects potential partners. Its ultimate goals are to create partnerships for collective action and to build capacity for others to sustain and advance solutions.

"We try to keep our fingers on the pulse" by reaching out to researchers, regional health authorities and other stakeholders to determine emerging issues, contextual information and local insight that could influence policy or program impacts. In this process, PPH engages a wide range of stakeholders to collaborate, refine, and sometimes re-define the issues in order to support the development of province wide policy and locally appropriate strategies.

To fulfill that role, the PPH works to:

- convene and coordinate provincial dialogue;
- facilitate the identification of common needs and joint problem solving;
- collaborate with and support regional and provincial partners to meet common needs; and
- jointly identify available resources for common initiatives.

In describing PPH's role, Lydia Drasic Executive Director, BCCDC Operations and Chronic Disease Prevention at the PHSA/BC Centre for Disease Control, suggests "the PPH Program acts primarily as a catalyst for knowledge sharing, learning and collaborative action across the full spectrum of BC's health stakeholders and inter-sectoral partners."

The ministry looks to PHSA to inform policy development and to coordinate the implementation of the policy through the various health authorities. The PHSA does not have authority to set policy nor is it technically part of the Ministry of Health but it aligns its work to support the Ministry of Health's priorities and directions. Although its partnership with the Ministry of Health is critical to PHSA, "We maintain an arm's length relationship with both the Ministry and the regional health authorities, one that allows us to work with all sectors of health care and provide a facilitative, supportive role."

In order to pull evidence into practice, PPH has undertaken several provincial consultations on current and relevant issues to identify practice gaps directly with stakeholders. They have also used standing advisory groups comprised of agencies and stakeholders to identify the issues and questions that emerge and may need to be explored. Their process specifically attempts to identify and involve people that have the ability to enact changes.

"The Health Ministry, for example, may come to us to help them understand and inform a direction or potential policy. Around obesity, say, and we would then look at it from every angle – from prevention through to treatment. In fact, on this particular topic we did a three-year process of engagement and analysis." On obesity, there was a series of broad consultations across all sectors in BC, including all levels of government, non-profit organizations, professional groups, academics and representatives of the food and beverage industry.

Partnership

The ability to establish partnerships for action that impact the social determinants of health is a key contribution of PPH. "We are constantly learning how to collaborate better and formalize equal partnerships with others, such as non-governmental organizations, local government and industry."

- A particularly important role for PPH is to foster collaborations and partnership at the provincial level. The regional health authorities tend to focus on their geographic areas and populations within them. The ministry tends to focus on stewardship and policy across the entire province of BC. "PPH brings people together to create understanding of their different roles and mandates and, more importantly, how each player has a necessary role in addressing the population health issues of chronic disease prevention."
- Another aspect of their role is being conscious of and continually assessing the current political context which inevitably provides them with opportunities and degrees of freedom for joint action with a range of partners to influence healthy public policy. "Therefore at PPH, we try and play a role in helping them all construct a bigger picture together."

A core activity of PPH is its ongoing engagement of relevant stakeholders across a wide range of people in various geographic, disciplinary, sector areas and across the provincial government ministries. "As issues emerge, we have developed networks and a really effective inter-sectoral engagement process that helps us determine what the priorities and needs are among movers and shakers; this allows us to build a champion base right from the beginning."

Many of the issues PPH deals with are complex, have political implications and cross many sector boundaries. For instance, the research evidence is more often than not defined clinically rather than as a population or public health issue that may be driven by the social determinants. As a consequence, research evidence is more often prepared to be communicated to clinical audiences rather than the general population. Therefore, a key concern for PPH is to figure out how to interpret and present available evidence so that there can be common understanding among many players and different audiences so that joint action can be realized. "This is the population health approach in action."

While PHSA's agencies spend approximately $180 million annually in health research, PHSA itself is not a research organization. It facilitates research as a means of informing the evidence and monitoring emerging health issues. Through a research committee comprised of its agencies and research partners, PHSA uses a collaborative approach to evaluate evidence and then make both grant and policy recommendations. Its eight member agencies are augmented by affiliated research partners which include:

- BC Cancer Research Centre,
- Child & Family Research Institute,
- BC Mental Health and Addiction Research Institute,
- Women's Health Research Institute, and
- UBC Centre for Disease Control.

In this way, PPH ensures that the combination of research and 'on the ground' evidence are both key components of its work. They partner closely with academic experts to help inform them of issues that may need attention, and with practitioners to help introduce research-based actions among their network of partners.

In terms of population health and health prevention, the focus of PPH's collaborative work begins with trying to determine the areas where there is a lack of clarity or where concepts or roles are unclear. "We are looking to create clarity on the right thing to do. We are looked at as the organization that can help sort through the reams of research and help apply it to experience." PPH considers itself a catalyst for joint action. It provides people with the tools they need to work together in areas where things are unclear or where evidence is conflicted.

For instance, there are two major preventive health concerns that at times compete with one another for public attention and resources: obesity and chronic disease on the one hand, and health equity on the other. "While in the past, many chronic disease prevention strategies have focused on interventions aimed at modifying individual lifestyle and behavioural risk factors that are associated with the increased risk of chronic disease (such as smoking, diet, and physical activity), there is growing evidence that such approaches have limited success. Research shows that community- and systems-level approaches that target the social, economic, and environmental root causes of poor health can be more effective at preventing chronic disease and can greatly improve the overall health of the population."[25]

In this context, a recent concern of PPH was the negative impact of weight bias not only on mental health but also in preventing successful outcomes for well-intentioned, obesity reduction interventions. It was suspected that repeated messages that encouraged weight loss may also be having negative impacts on self-image and mental health. As a consequence, PHSA put together as discussion paper[26] and shared that with its network of stakeholders and experts. "We did a discussion paper that was about how to promote mental health in the context of weight and overweight." From the feedback they received, the issue of weight and wellness was confirmed and PPH then convened a consultation with international experts to discuss mental and physical well-being in the context of obesity and weight bias, and present options. In it they facilitated discussions on the research and on the state of related practice. "We believe we've helped move the discussion of health from centring on weight to having a focus on well-being."

Subsequent to this consultation, another engagement process was undertaken across a wide range of BC stakeholders representing health authorities, governments, and community organizations soliciting them to come forward with recommendations for collective action. The goal was to reduce health inequities among various groups and improve the quality and accessibility of the health system's policies, programs and services. As a result of this process, a variety of activities continue under PHSA's umbrella in order to encourage health practitioners to consider equity in the context of their work.

"We use a sound methodology to sort through it all. Putting practitioners and researchers together is critical to sorting things out and then coming out with recommendations for going forward." Subsequently, PPH continues to support the ongoing work of partners until a partner, or group of partners, steps forward to take on the work for themselves. "We provide them with the information so that they can do their own work."

Partnership Process

"We set ourselves up as catalysts," says Drasic. "We have no authority over our partners but we do have some latitude in what we do. Our role as convener of dialogue is to create common understanding and joint action that is built from 'ground up' to inform policy and practice."

"We learned we can't go out with a fully formed idea and try and sell it to people. We often start with a conversation with key stakeholders about what we've been hearing, 'this is what the evidence is saying,' and then try to get them to help define the issue as it affects them directly. When we have been sufficiently inclusive and obtained many different perspectives, we will have a more comprehensive view of the issue."

This more comprehensive view provides PPH with the basis for an even broader public conversation, out of which they identify a core group of people who are willing to work together in a task force to develop specific intervention ideas or policy suggestions or suggest a concrete strategy to deal with the issue. These suggestions are then taken back to the larger stakeholder group to validate and to generate commitments. "Our process is as a true facilitator. We don't pretend to have the answer and because of that, we can coordinate to meet the needs and support the work of others."

Their process therefore has basically four components:

1. The ministry or a key partner highlights an issue and seeks help from the PPH;
2. Acting as a catalyst at arm's length from government PPH: completes a scan of the literature and needs; conducts outreach to potentially interested parties; convenes forums; and surveys stakeholders and others to further define the issue and gain local context;
3. A task force involving key stakeholders is formed to discuss the information and issue in depth and come up with suggestions for policy and collaborative action; and
4. A larger group consultation takes place to govern the work, collaborating on design, implementation and evaluation.

Putting effective governance into practice

This inter-sectoral approach is central to addressing the many inter-relationships that may exist among chronic diseases. In addition, PPH also contributes to inter-sectoral action by working across ministries to combine health issues with other areas of public policy. For instance, the Healthy Built Environments initiative illustrates the connection that exists between health and the way communities are designed and built.

The BC Healthy Built Environment Alliance is an initiative of the PHSA. It is a voluntary alliance of 26 different organizations, including: four provincial ministries, two universities, First Nations groups, a number of municipalities, architects, urban planners, community partnerships and foundations. Mobilizing around the shared need to bring health and planning sectors together to create healthier, more livable communities, PHSA helped to provide concerted leadership and direction. It facilitated collaboration to create resources to bring common understanding and to fund joint dialogue for action that has resulted in an increased capacity at the local level for health practitioners and local governments to work together to build healthy communities. PPH was the catalyst for bringing the sectors together and it enabled them with tools for their joint understanding and action. Today PPH is looking to groups like the National Collaborating Centre for Environmental Health, the Planning Institute of BC, regional health authorities and local governments to disseminate and build on this work.

PPH tries not to institutionalize its presence as a program delivery agent. It prefers to work towards transferring ownership of an emerging project to its collaborators who, it is felt, are best positioned to do the work in their own local contexts. PPH sees its value contribution coming from its collaboration and facilitation skills and not from running a variety of different programs. Consequently, over the course of their involvement, they intentionally try to decrease expectations of their ongoing participation as a project unfolds to make it easier for the project team to adjust when PHSA eventually takes its leave.

One of the principal considerations for PPH is working within the political environment. Addressing emerging issues is a challenge as they may have to highlight areas that neither society nor governments are particularly comfortable with and therefore require time to integrate into main stream thinking. Despite being part of the government health system, PPH has to balance the framing of issues, the needs of its many diverse partners and the potential opportunities for ensuring its work has real impact. In the end, creating the conversations around the issue and allowing each partner to identify their own role and contribution to it are the keys to ensuring action on issues can take place and that adversarial politics do not become a barrier to action on healthy public policy.

Lessons

- The work of collaboration begins with determining the areas where there is a lack of clarity or where concepts or roles are unclear.
- Don't pretend to have the answer. PPH didn't go out with a fully formed idea and try and sell it to people.
- The need to find ways to deal with complex issues through some process of reframing or reinvention.
- Being clear on our role as a catalyst.
- Understanding that the lack of authority is a collaboration asset.
- Working at arm's length from government allows greater flexibility.
- Recognizing that organizations choose to engage with a convener because they can be helpful as a facilitator and coordinator.
- There is a value-adding role in helping stakeholders construct a bigger picture together.
- Recognizing that collaboration skills and partner management are core competencies and a convener should be careful not to farm these out to consultants.
- Being clear from the start with partners that the convener's role is as a catalyst to start understanding and support collaborative action, but that ongoing sustainable program delivery is not within its mandate.
- Focusing the partnership on the issue not the politics. This permits the inclusion of multiple voices, and a focus on the evidence and shifts away from advocacy.
- Putting practitioners and researchers together has great value.
- Knowing when to stop and pass things on to a partner to manage in the long run. PHSA catalyzed intermittent and ongoing alliances until a partner, or group of partners, stepped forward to take on the work themselves
- While having its own systems of accountability, PHSA recognized that collaborative development required transparency among all the partners in the process.
- Real change requires ongoing engagement of relevant stakeholders across a wide range of people in various geographic, disciplinary, sector areas and even across government.

Conclusions

Every community "is fundamentally an interdependent human system given form by the conversation it holds with itself. The history, buildings, economy, infrastructure and culture are [artifacts] of the conversations and the social fabric of any community."[27] It is an understanding that seems to be gaining ground in government, particularly in health care.

In Alberta's *Strategic Approach to Wellness,* for instance, Dave Rodney, the province's Associate Minister of Wellness and James Talbot, the province's Chief Medical Officer of Health have declared that "it's time to have a different conversation: a conversation that begins long before we are sick or diagnosed with a disease. A conversation that shifts the dialogue from the delivery of health care – to a discussion about our health and

wellness. Health as not simply the absence of illness and disease, but as something we build with our families, schools, communities and workplaces, in our parks and playgrounds, the places we live, the air we breathe, the water we drink and the choices we make."[28]

However, *Alberta's Strategic Approach to Wellness*, also makes it clear that the provincial government believes that the pursuit of wellness is not something it can do entirely on its own. "Government cannot tackle this issue alone. We will collaborate and work with stakeholders on multiple levels in order to make a difference in the lives of Albertans. Some of these actions may be best placed within government policy, while others will have greater impact when community-led."[29]

And while physicians, researchers and policy makers may well design approaches to improve wellness, there is no guarantee of their implementability because of the unique conditions within each community. "Our communities are not homogeneous but multifaceted – which means we need health prevention strategies that can be responsive to that diversity. Our success depends on how we build relationships to work together and create communities and environments that support and improve our health and wellness."[30]

To ensure policy is aligned with the reality at the community level, Alberta's Wellness Strategy embeds the importance of engagement and involvement as a core principle called its *Practice Inclusion Principle*. "Inclusion means ensuring that everyone has a seat at the table and an opportunity to contribute and be heard. Some groups have 'quieter' voices than others – we need to make efforts to ensure that all people feel that they can contribute in conversations about wellness, and that their contribution is included in any plan or strategy moving forward."[31] This isn't the usual charade that passes for consultation where governments pretend to listen and citizens pretend they've had an impact. It's about engaging people in a real conversation that make them co-creators of the solutions that matter to them.

In fact there are other core principles of Alberta's Wellness Strategy that also reinforce this notion of the citizen as a co-creator with government and they include:

- Dignity and mutual respect
- Respect for diversity
- Collaboration
- Shared responsibility
- Social justice and equity
- Accountability, innovation and transparency
- Evidence-based decision making
- Community engagement, ownership and mobilization
- Proactive approaches that acknowledge the interconnectedness of individuals, families, communities and their environments and work to address health threats before they start.

From our own interviews and in the light of the wellness approach of the province of Alberta, it seems that the role of government in health care is shifting from being 'top-down' to one that might best be described as 'holacratic'. In such situations, the quantity and the quality of information flow is increasingly important, as is the capacity to deal with information overload through self-organizing teams that form and 'unform' based on the perceived need of those most affected. Indeed, capturing more of society's inherent diversity by bringing competing voices to the table becomes a necessary strategy for ensuring social innovation.[32]

In this context developing the tools, practices and skills to foster both engagement and collaboration becomes critical. As the above cases reveal, public health issues are fraught with complexity and uncertainty and so can benefit from the contribution of multiple perspectives and relationships that necessitate an experimental 'learn as you go' approach.

They also place great value on the local knowledge of audiences, conditions, values, in addition to multiple perspectives. The cases reveal the importance of ownership among stakeholders to ensure that evidence is properly contextualized, collective learning takes place and that potential solutions are put into practice.

To summarize then, these cases identify several evolving patterns of practice that seem to be shaping a new approach to social coordination and governance, including:

1. **Self-organizing teams of stakeholders**
   The complexity surrounding public health issues ensures that no one person or organization has all the knowledge, resources or authority to resolve it. The need is therefore for groups of stakeholders with multiple perspectives to engage together with shared ownership to collaborate on responses. As the cases reveal, the success of these teams is based on their self-organizing capacity, their ability to develop patterns of emergence and holacracy, the density of their networks (essentially more people and more different people), and their access to information.
2. **Strengthening the role of public authorities to act as conveners, catalysts, and collaborators**
   To facilitate these self-organizing teams, public organizations need to spend more time on outreach and engagement. To facilitate the ownership and contributions of stakeholders, public organizations need to focus more on their competencies for convening, stewarding and enabling other organizations and citizens within the networks that make up an ecosystem of shared interest.
3. **Arm's length role of government**
   To meet the needs of the public interest, public organizations should consider diversifying themselves, with some elements evolving an arm's length relationships with formal governments and the creation of government policy. This would create quasi-public organizations with more of a capacity to act as honest brokers, catalysts for innovation, facilitators of collaboration and as tools to strengthen public accountability – both upstream and downstream in the public system.
4. **Stewardship or collaborative leadership and shared accountability are essential for collaboration**
   From this case experience, the traditional notions of leadership – having the answers, the authority, the resources, and the power to coerce – prove anathema to authentic cooperation. It was evident that different skills and practices are needed to facilitate collaboration, and that many organizations, both public and not, are often bereft of these capacities necessitating a partner with these capacities to be part of the process. CPAC and PHSA, for instance, have defined these as core competencies for themselves. The cases suggest that effective governance in these complex, multi-stakeholder environments is less about authority, answers, or coercion than it is about developing the capacity to help stakeholders help themselves. The not insignificant benefit to the public partner is a greatly enhanced reputation as trusted broker, convener, facilitator and collaborator.
5. **Attention to the "Last Mile"**
   One of the inherent weaknesses of the traditional, centralized approaches of governments is what we might refer to as the "last mile" problem: a) getting policy into practice, and b) getting quality intervention feedback to inform further policy or program innovation. The cases not only underscore the need to address this issue, but they also highlight the need to work inclusively with local stakeholders as a response. The cases illustrate that the involvement of local stakeholders in the processes of co-design and co-development is essential in order to find locally relevant solutions and to avoid top-down approaches driven by researchers and policy makers working at a distance. In particular, success depends on engaging those most affected, such as front line service providers and citizens, reinforcing the notion of a holacratic exercise in co-governance.
6. **Measuring Performance**
   Informants expressed a growing interest in exploring new methods to determine the impact of investments made in knowledge sharing,

collaboration and their ongoing impact on public issues. Their sense of the importance of learning as you go, experimentation, and satisfying the information needs of multiple stakeholders suggests an evaluation focus that needs to be more developmental than the more typical form of formative or summative evaluation.

We began this paper with a suggestion that "Destination 2020" wasn't going far enough. The cases we have described not only suggest that the principles of Blueprint 2020 aren't just idealism: but that they are already being realized – at least in some areas of Canada's public health system. Public agencies are opening up, developing their own complex networks of stakeholders and through them governments are reaching out to partner with citizens and other social organizations to take advantage of their knowledge, resources, commitments and power to make change.

The cases also illustrate that orchestrating a multi-faceted community perspective is doable and can generate a willingness to work both across government and across communities to affect a whole-of-government response. They are also suggestive of a need to find ways in which technology can be used to facilitate 'conversations with everyone' and in which the very institutions of government can become an inducement to broader cooperation and collaboration. And they also make clear the need to develop collaboration skills and practices as core internal competencies.

Finally as Alberta's Wellness Strategy reminds us, "This conversation will help us get there. This is a journey worth travelling – to imagine a world better than this one and then create it. Are we up to it?"[33] Reflecting on this, one wonders whether Canadian governments other than Alberta are similarly up to co-creating a different world?

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[1] ____.*Destination 2020*, Government of Canada, May 2014: 6 [Accessed at: http://www.clerk.gc.ca/local_grfx/d2020/Destination2020-eng.pdf].

[2] *Ibid*. pg.33

[3] *Ibid*.

[4] *Ibid*.

[5] Christopher Wilson. 2014. "Re-Imaging Government", *www.optimumonline.ca*, 44(3): 1-41; Gilles Paquet. 2014.*Unusual Suspects. Ottawa, ON:* Invenire Books.

[6] Ruth Hubbard and Gilles Paquet. 2007.*Gomery's Blinders and Canadian Federalism*. Ottawa, ON: University of Ottawa Press, p. 100.

[7] Nik Nanos. 2012. "Canadians Rate Highly the Issues Close to their Day-to-Day Lives," *Policy Options*, August.

[8] Quoted in, Dylan Love. 2014. "A Conversation With Linus Torvalds, Who Built The World's Most Robust Operating System And Gave It Away For Free," *The Business Insider*, June 7 [Accessed at: http://www.businessinsider.com/linus-torvalds-qa-2014-6#ixzz34cksJobN].

[9] Sometimes KDE is also referred to as knowledge management, knowledge exchange as well as knowledge mobilization.

[10] Canadian Institute of Actuaries, http://www.cia-ica.ca/docs/default-source/2013/213075e.pdf.

[11] David McLean, Dan Williams, Sonia Lamont and Hans Krueger. 2013.*Community-Based Prevention: Reducing the Risk of Cancer and Chronic Disease.* Toronto, ON: University of Toronto Press; Canadian Institute of Actuaries, http://www.cia-ica.ca/docs/default-source/2013/213075e.pdf.

[12] Jason Gale and John Lauerman. 2014. "How the World's Top Health Body Allowed Ebola to Spiral Out of Control," *Bloomberg News*, October 17 [Accessed at: http://www.bloomberg.com/news/2014-10-16/who-response-to-ebola-outbreak-foundered-on-bureaucracy.html].

[13] *Ibid*.

[14] Defined as a comprehensive practice for structuring, governing, and running an organization that replaces today's top-down, leadership driven, predict-and-control processes by a distributing authority within and among self-organized teams.

[15] http://holacracy.org/how-it-works.

[16] Based on an interview with Lee Fairclough, former Vice-President of Strategy, Knowledge Management and Delivery at the Canadian Partnership Against Cancer, February 2014. Ms. Fairclough contributed to the organization's startup and is passionate about working with partners to determine how pan-Canadian actions to advance cancer control can have a measurable impact for Canadians.

[17] Claude Rocan. 2011. "The Voluntary Sector in Public Health, www.optimumonline.ca, 41(4), [Accessed at: http://www.optimumonline.ca/article.phtml?id=400].

[18] Michael J. Prince. 2006. "A Cancer Control Strategy and Deliberative Federalism: Modernizing Health Care and Democratizing Intergovernmental Relations," *Canadian Public Administration,* 49 (NULL): 471.

[19] Claude Rocan, *op. cit.*

[20] ____. 2006.*The Canadian Strategy for Cancer Control.* Canadian Partnership Against Cancer Corporation, p. 4.

[21] ____. 2014.*Cancer Screening Overview*, National Cancer Institute, April 4 [Accessed at: http://www.cancer.gov/cancertopics/pdq/screening/overview/HealthProfessional/page1].

[22] Claude Rocan, *op. cit*.

[23] Michael J. Prince, *op. cit*., p. 468.

[24] Based on an interview with Lydia Drasic, Executive Director, BC CDC Operations & Chronic Disease Prevention.

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[28] Dave Rodney and James Talbot. 2014. *Alberta's Strategic Approach to Wellness: Health for All ... Wellness for Life*. Government of Alberta: Alberta Health, March, p. 4 [Accessed at: http://www.health.alberta.ca/documents/Strategic-Approach-Wellness-2013.pdf].

[29] *Ibid*., p. 22.

[30] *Ibid*., p. 5.

[31] *Ibid*., p. 14.

[32] See also Katherine W. Phillips. 2014. "How Diversity Makes Us Smarter," *Scientific American*, 311(4).

[33] Rodney, Dave and James Talbot, *op. cit.* pg 5