Challenges in Cross-Sectoral Partnerships: An Organizational Perspective

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Abstract

The purpose of this paper is to identify challenges to cross-sectoral collaboration based on principals in current organization theory regarding organizational boundaries. The boundary-maintenance function enables organizations to maintain sufficient stability and focus for goal attainment. Organizations periodically adjust their boundaries for tactical and strategic purposes, making participation in cross-sectoral partnerships possible and influencing the manner in which participation will take place. Because collaboration places boundary maintenance at risk, organizations generally appear unlikely to participate except when collaboration is based on loose and terminable linkages and cooperation of a temporary nature. These principles suggest that advocates of cross-sectoral collaboration today risk setting unrealistic goals for such arrangements. Examination of several foundation-funded initiatives illustrates limitations in the ability of organizations to compromise boundary maintenance in the interests of cross-sectoral collaboration.

More optimistically, this paper aims at combining organization theory, evaluation, and action research to produce practical suggestions for promotion of successful cross-sectoral partnerships. Suggestions derived from theory and case studies conducted throughout the United States include: recruiting and empowering leadership committed to cross-sectoral collaboration; ensuring the presence of appropriately mandated, supervised, and paid staff; providing limited access by outsiders to privileged data and decision-making processes, and respecting the integrity of participant organizations’ core commitments and resources. As in the case of foundation-funded initiatives, external forces may prove essential to the initiation and sustainability of cross-sectoral collaboration.

Introduction

To achieve meaningful collaboration, organizations residing in separate sectors must overcome barriers related to organizational boundary maintenance. Any organization thinks first of protecting its own turf. Under normal conditions, organizations maintain boundaries to protect their inner operations. Normal boundary maintenance inhibits formation of the cross-sectoral collaboration many today consider essential for solving to problems facing modern society. In the present context, cross-sectoral partnerships are meant to include associations that transcend divisions between the public, private for-profit, and private non-profit sectors, and, within these sectors, involve stable cooperation among organizations that may historically have ignored or competed against each other. Under the cross-sectoral concept receiving emphasis here, organizations go beyond the tactical collaboration, strategic alliances, and joint ventures familiar in the business and non-profit worlds. The cross-sectoral collaboration concept is intended to include commitment of resources, sharing of decision-making, and commitment to objectives beyond those that benefit any individual participant.

Examination of contemporary organization theory helps explain the reluctance of many organizations to engage in cross-sectoral partnership as here conceived. A ubiquitous imperative toward boundary maintenance breeds general reluctance to participate. Drawing on evaluation of foundation-initiated efforts to foster cross-sectoral collaboration in community health, this
article illustrates challenges and limitations expectable in formation and operation of partnerships. Reluctance to increase the depth of participation is evident even in the presence of nominal commitments and demonstrable need. Examination of the theory and case studies, however, suggests means by which progress can be achieved through realistic expectations and appropriate initiative.

On the most abstract level, cross-sectoral collaboration would appear to prove the richest and most diverse source of options and resources applicable to any given social or policy issue. Politically, cross-sectoral partnerships together enjoy a much wider network for accessing policymakers and policy shapers than any individual component organization. Coalition members possess a wide range of material and human resources that may be formally or informally allocated to the partnership. At their best, it is clear to see why cross-sectoral collaboration has the greatest likelihood of success in areas ranging from the operation of a metropolitan transportation system to water management on remote, publicly-owned rangeland.

Cases studies of large foundation-funded initiatives conducted throughout the United States illustrate both challenges and solutions. Presented below, these case studies include (a) joint efforts by county health departments and community-based organizations in California to promote health, safety, and quality of life in local neighborhoods, (b) a multi-state effort by the American Cancer Society to promote cooperation among public and private agencies in early detection of cancer, and (c) work by the Seattle Housing Authority with private charitable and faith-based organizations reduce isolation, fear, and turnover among residents of public housing.

Both cross-sectoral partnering and collaboration among organizations of all kinds have long been major subjects of interest in the health care and public health industries. For decades, the health services research literature has reported collaborative efforts in areas such as mental health, aged service, AIDS, child abuse services, and trauma care. Networks and collaboratives formed for mutual advantage such as group purchasing and expanded service capacity are also in evidence. Public health agencies have looked to cross-sectoral collaboration, including alliances with community-based organizations and HMOs, to achieve objectives such as disease prevention and chronic disease control. Today’s public health agency is highly dependent on grant money from private and public sector sources, and hence usually eager to build ties with all sectors capable of expanding its economic and political base.

Specialists in health services-related collaboration have reported that certain contingent factors determine the effectiveness of a coalition. These include levels of resources required of the coalition, the ability of the coalition to control internal conflict, and the balance within the local environment between munificence of the resource and prevalence of competition and conflict. Without discounting the importance of these factors, however, the material to follow focuses on boundary maintenance within organizations as a generically significant dimension.

Organizational Boundaries and Strategic Choices

Over the past few decades, students of organizations have concentrated primarily on inter-organizational relationships, paying special attention, for example, to organizational environments and networks. Organizational boundaries, however, have been consistent areas of
concern in organization theory, organizational behavior, and organizational development since the founding of these fields. The perspective provided by boundary maintenance is particularly instructive for understanding the ability of organizations to relate and collaborate with each other.

Boundary maintenance signifies the placement of barriers between people who are in an organization and people who are not. The external manifestations of organizational boundaries occur in a broad range of forms, from patterns of general thinking to massive physical barriers. Members of an organization may develop common language to help them make sense of the organization and its actions, consequently carrying on communication and activities that are closed and invisible to the outside world. Selective recruitment reflects boundary maintenance, as only people with the proper characteristics and qualifications are permitted to cross the boundary. Boundary maintenance is highly visible in the modern form today, as members are required to show formal identification documents to enter an organization’s physical premises or to type an organization-provided sequence of numbers to access portals, channels, and files.

Boundary maintenance has features which are clearly functional for the formal organization. Boundaries help protect business plans and trade secrets. They safeguard the privacy of members and clients. They promote stability of personnel and culture. They contribute to maintenance of required levels of expertise and stable commitments to objectives. Historically, organizations have maintained boundaries in order to protect internal processes considered vital to goal attainment. Without making organizations into closed systems, maintenance of boundaries protects the organization’s core.

Organizational boundaries may be defined simply as demarcations between the organization and its environment. More formally, contemporary organization theory has conceived organizational boundaries the borderlines of the social structure that constitutes an organization. This demarcation has been stated in terms of member self-identify, explicit rules of inclusion, and the extent of the organization’s sphere of influence.

Recent organization theory has expanded the concept of organizational boundaries with useful implications for understanding cross-sectoral collaboration. In one of the best-known formulations, organizational boundaries have been conceived as junctures for decisions about whether to make a product in-house (involving governance tasks) versus buying it from outside (requiring negotiation of market forces). Using this as only a point of departure, Santos and Eisenhardt have identified additional dimensions of organizational boundary dynamics. These authors specify four dimensions, each associated with an area of strategic choice-making by organizations. These are summarized in highly simplified form in Figure 1.

Figure 1. Organizational Boundary Dimensions and Strategic Choices

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Objective</th>
<th>Concern</th>
<th>Strategic Choice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Locus of transaction</td>
<td>Efficiency</td>
<td>Cost</td>
<td>Enhanced product</td>
</tr>
<tr>
<td>Sphere of influence</td>
<td>Power</td>
<td>Autonomy</td>
<td>Greater influence over environment</td>
</tr>
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</tr>
<tr>
<td>Resource portfolio</td>
<td>Competence</td>
<td>Growth</td>
<td>Increased ability to service market or meet social need</td>
</tr>
<tr>
<td>Mind set</td>
<td>Identity</td>
<td>Coherence</td>
<td>Augmented information from environment; objectives shared with broad universe of organizations</td>
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</tbody>
</table>

Each of the dimensions presented in Figure 1 correspond to a set of trade-offs incurred by organizations in changing the scope or nature of their boundaries. For this reason, an organization’s boundary maintenance decision amounts of an exercise in either tactical or strategic choice.

The *locus of transaction* dimension, for example, involves the “make or buy” decision highlighted in classic formulations of boundary-related decisions by organizations. Less familiar is the *sphere of influence* dimension, in which an organization may choose to enlarge its boundaries for the purpose of enticing other organizations to work with it on a political, social, or business agenda. In making such a choice, however, the initiating organization risks losing autonomy due to the need to accommodate the partners’ own commitments and obligations. This recalls the familiar downside of co-optation, in which the co-opting organization is forced to accommodate the co-opted one, and thus loses autonomy.

The *resource portfolio* dimension involves a strategic decision to grow in competence for the purpose of better servicing a market or community’s needs. Growth according to this dimension may be the most relevant to formation of cross-sector collaboration, as organizations seek to expand into areas of clearly greater scope than has been traditional for them. Strategic risks, however, include abandonment or at least vitiation of prior commitments, core capacities, and customary protection of internal procedures or prerogatives.

Just as in the first three dimensions, the final, or *mind set* dimension, opens perceptions and consciousness within the organization to outside stimuli. All things being equal, these are favorable for an organization. However, it is important to remember that organizations are driven by human consciousness. Changes in mind set, then, can reduce the organization’s ability to maintain personal identification with the organization and internal solidarity, both arguably essential resources for organizational functioning.

It is important to understand that organizations periodically make decisions regarding their boundaries based on internally defined need and opportunity presented by the environment. At any time, an organization may choose to enhance, reduce, or expand its boundaries according to any of the dimensions specified in Figure 1. Moreover, organizations may simultaneously make
boundary changes of diverse types, expanding some boundaries, contracting others, and leaving still others unchanged.

The framework summarized in Figure 1 suggests that highly dynamic and contingent factors related to boundary maintenance help determine an organization’s likelihood of participating in cross-sectoral collaboration and the magnitude of the organization’s actual participation. This view of organizational boundaries does not suggest a general openness to intensive collaboration, cross-sectoral or otherwise. While the dynamics of organizational boundary-changing suggest the possibility of collaborative scenarios, they in no way suggest a general predisposition to collaboration in any significant depth. This interpretation raises issues for researchers and practitioners that include:

(1) What accomplishments should realistically be expected to result from cross-sectoral collaboration efforts?

(2) What dynamics occur in organizational boundary maintenance when cross-sectoral collaboration is envisioned, initiated, or enacted?

Question (2) is particularly important in anticipating development of guidelines for successful development of future cross-sector collaboration.

**Expectations of Collaboration**

To help determine what accomplishments may realistically be expected from cross-sectoral collaboration it is useful to examine the expectations sponsors and evaluators have stated or implied. Collaboration among organizations is itself non-problematical. Routine collaboration among organizations can be seen in the normal politics of coalition formation. In this fashion, industrial corporations, insurance companies, and labor federations may jointly support a health care-related measure in Congress. Individual organizations and industries may join other coalitions in the next political round, finding themselves, for example, on opposing sides in a trade issue. Joint ventures in business are common. For temporary and special purposes, cross-sectoral activity involving for-profits, non-profits, and government agencies abound.

But both practitioner and research-oriented discourse has placed increasing emphasis on durable, multi-purpose collaboration and set high expectations for achievement by cross-sectoral partnerships. Private foundations have made the cross-sectoral collaboration a criterion if not an objective for grantmaking for decades. Expectations regarding the potential for establishment of cross-sectoral collaboration and the outcomes it might achieve are visible in the commitments sought by foundations from grantees and the criteria for success asserted by program evaluators.

The Community Care Network (CCN), a large, nationwide intervention funded by the W.K. Kellogg and the Duke Endowment in the late 1990s, may represent the most intense and extensive effort to promote the durable, multi-purpose form of collaboration as a way to solve intractable social problems. CCN provided grant funding for twenty-five intersectoral partnerships throughout the United States. Each partnership included an average of 10 organizational collaborators per grantee site, including private health care providers, public
health departments, local government, human service agencies, educational institutions, health plans, managed care organizations, and business coalitions.

Each partnership was expected to pursue objectives requiring vigorous collaborative efforts, such as:

- Improving the health status of the community as a whole, not only those receiving direct service from health care providers in the coalition;
- Developing a seamless continuum of care, ensuring that patient navigation and treatment corresponded to the patient’s needs rather than the structure or mechanics of the health care organization or system;
- Management through fixed resources, for example, under a global budget or capitated payments;
- Maintaining accountability to the local community.

Reflecting the expectations of the CCN sponsors, evaluators formulated an extended set of indicators and scales to measure attainment of the above objectives. In addition to being evaluation tools, these measures reflect sponsors expectations of what cross-sectoral partnerships might accomplish.

Expectations regarding the CCN-funded partnerships are visible in a field typology, or template that CCN evaluators used to provide formative feedback to grantees during site visits. This typology specified a series of stages according to which it was hoped that the partnerships would develop. Each stage involved a greater level of collaboration, new tasks, and emergent challenges as required for moving farther along the collaboration spectrum. Figure 2, below, specifies features of these stages.

**Figure 2. Community Care Networks (CCN) Partnership Development Stages**

<table>
<thead>
<tr>
<th>Stage</th>
<th>Structure, Process, and Functioning</th>
<th>Desired Outcomes</th>
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</table>
| Emergence | ● Establish initial governance structure  
● Clarify individual partner interests  
● Report and exchange information  
● Define purpose of collaboration  
● Recruit necessary partners                                          | ● Case management and patient navigation  
● Collaborative provision of services  
● Consolidation of administrative services  
● Joint purchasing |
<p>| Transition| ● Build capacity for                                                                                   |                  |</p>
<table>
<thead>
<tr>
<th>Maturity</th>
<th>Critical Crossroads</th>
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</thead>
<tbody>
<tr>
<td>Focus on big picture rather than operational details</td>
<td>Balance individual and collective interests</td>
</tr>
<tr>
<td>Initiate action rather than react</td>
<td>Balance autonomy and authority</td>
</tr>
<tr>
<td>Increase diversity</td>
<td>Manage membership and leadership transitions</td>
</tr>
<tr>
<td>Deepen involvement in governance</td>
<td>Establish future structure and composition</td>
</tr>
<tr>
<td>Implement measurement system</td>
<td>Address “wicked” problems</td>
</tr>
<tr>
<td>Monitor program and partnership performance</td>
<td>Create equitable distribution of benefits</td>
</tr>
<tr>
<td></td>
<td>Institutionalize partnership</td>
</tr>
</tbody>
</table>

As suggested in Figure 2, each successive stage of CCN partnership development was expected to reflect move in the direction of fuller partnership and closer collaboration. Most elementary was the *emergence* stage, in which each partner was expected to focus strategy and decision-making on internal issues but to systematically explore more intense future collaboration. The *transition* stage concentrated on consolidation of internal and external ties. Concrete interventions were to have been concentrated in stages labeled *maturity* and *critical crossroads*. During these advanced stages, expected outcomes were to have included several developments widely believed among health policy specialists to improved health and cost savings. Examples
of these are summarized in Figure 2 and include hoped-for developments such as elimination of redundant resources, joint offering of services, and predominance of capitated contracting.

Thinking about structure, process, and hoped-for outcomes in CCN has strong implications for transformation of organizational boundaries. Established information-related boundaries are called into question as early as the emergence phase. The later stages imply significant adjustment of organizational boundaries, in areas such as governance, hiring, purchasing, and business modeling. Organizations that previously functioned as entirely separate entities would seem to require boundaries that overlapped in areas related to power, competence, and self-identify.

Similar observations regarding sponsor expectations can be made through examination of evaluation indicators applied to the California Wellness Foundation (TCWF)-sponsored Health Improvement Initiative (HII). Funded at $20 million for five years in the late 1990s, HII supported nine “Health Partnerships” to create and carry out four-year health improvement plans. The principal goal of HII was on generating sustainable, community-level systems changes that would ultimately lead to improvements in community health. TCWF hoped that the Health Partnerships would bring together key community stakeholders to develop and implement plans for achieving “population health,” broadly defined to include improvement in social, economic, and cultural determinants of health as well as actual health status of community residents themselves.

As ultimately agreed upon by TCWF and program evaluators, systems change in HII was defined operationally to include activities in four areas:

- Service Integration—providing comprehensive, coordinated services that respond to the needs of community residents;
- Policy Development—developing and implementing new policies that promote population health;
- Finance/Budget Reform—changing the process by which local funding decisions are made to more closely link budgets to outcomes (results-based budgeting); and
- Data Integration—increasing the extent to which data are organized and shared across agencies.

Like those seen in the CCN, outcomes hoped for in HII suggested challenges to organizational boundaries. As indicators of success, program evaluators sought evidence of collaboration in forms such as strong governance structure; sharing of data; efforts to obtain resources for the collaborative per se; and, development of collaborative plans to provide direct service and to change the system by which services were delivered. In a manner similar to CCN, a rating scale applied to HII partnerships illustrates the extent to which TCWF and program evaluators believed collaboration might progress. A scale developed by the evaluation team, for example, included potential levels of change in service integration as follows:
None: All providers operate independently

**Limited coordination among care/service providers**: Referrals occur, but it remains difficult for clients to move between agencies/services; little provision in place for continuity of care/services.

**Systematic coordination among care/service providers takes place**: A referral system is in place, but some barriers exist in client access to information and movement between agencies/services. Some provisions for continuity of care/services exist.

**Extensive coordination among care/service providers**: A seamless referral process exists, without barriers to client movement between agencies/services; clients and providers have ready access to information about all available services.

As in the CCN, cross-sectoral partners funded by HII were presented with the expectation that they would develop into entities quite different from traditional boundary-enclosed organizations. The concept of a “seamless web” implies that boundaries among organizations, or between types of organizations, would have become insignificant for some important purposes. The notion of sharing information among collaborating organizations sounds similarly problematical. Even between organizations that have not traditionally competed, strong organizational barriers restricting access by outsiders to market, patient, and cost data are ubiquitous. The first message of organization theory for the cross-sectoral collaboration, then, addresses limitations in the ability of individual entities to share resources and merge functions. The persistence of boundary maintenance in most organizations suggests that sponsor and evaluator expectations regarding depth of collaboration are often unrealistically ambitious.

**Implementation, Forms of Collaboration, and Assertion of Boundaries**

Data collected for evaluation of the CCN and HII interventions illustrate the degree to which boundary maintenance may limit collaboration. Evaluation data on three additional initiatives, described below, illustrate a range of ways in which organizations involved in cross-sectoral collaboration address boundary maintenance issues. All three examples comprised programs with mandates for cross-sectoral collaboration. Organizations limit their depth of collaboration through boundary maintenance. But certain forms of boundary maintenance may also enable collaboration to take place.

**The California Endowment: Partnership for the Public’s Health (PPH)**

Launched in the early 2000s by the California Endowment (TCE), the PPH aimed at fostering multi-sectoral collaboratives throughout the State of California. It was hoped that resulting collaborative arrangements would combine public and private sector resources to strengthen communities and prevent disease. The initiative placed special emphasis on establishing linkages between county public health departments and community-based organizations. Many in the public health community believe that significant isolation prevails between health departments and the communities they serve. This is said to reduce the value of services that health departments provide to the public. Under conditions of isolation, for example, health departments may have a poor understanding of issues facing the community, and local
organizations concerned with health may be unable to benefit from the resources of the health departments such as technical expertise and health data bases.

PPH provided technical and financial resources to 39 community partnerships in 14 local health department jurisdictions. These resources were provided with the intention of promoting community and health department capacity building. Collaboration between county health departments, community-based organizations, and a number of different types of entities was expected to promote community-level policy and systems change, eventually improving population health.

A majority of partnerships formed under PPH were agency collaboratives as opposed to more resident-driven groups or single agencies. There were six community groups that could be classified as purely "grassroots" or resident-driven; and nine where there was a mix of resident and agency involvement. The nine remaining community groups were dominated by a single agency or program.

The depth of collaboration ideally envisioned by sponsors and evaluators may have occurred in some of the PPH-funded jurisdictions. A partnership in San Joaquin County, California, for example, was reported to increase access to and use of each partner’s resources (staff and materials), develop a clear governance structures, improve trust, engage in joint programmatic activities, and developed a sustainability plan. Generally, collaboration in smaller, more ethnically homogeneous communities was more complete than elsewhere.

Detailed data collected by the PPH evaluation team on partnership development identified some definitely positive and negative factors in partnership-building. On the negative side, observers reported that the “bureaucratic” nature of health departments made it difficult for them to exercise full participation. “Bureaucratic” in this sense meant an unwillingness to depart from agency procedures, rules, and mandates. Communication challenges, both external and internal, were held responsible for an inability of partners to develop in-depth relationships. Residents were often unengaged in the activities of the collaborative. These observations constitute evidence that boundary maintenance remained strong, particularly in the case of the health departments.

Health departments, however, did engage in actions interpretable as modification of boundaries in a manner that made at least limited collaboration possible. Some health departments formed community advisory boards, in effect inviting outsiders in. Others health departments appointed liaison personnel specifically to coordinate health department thinking and actions with priorities of the outside community. This hiring and deployment extended the organization’s boundaries outward.

The American Cancer Society/Department of Public Health Retreats

Consistent with its commitment to reduce disparities in early detection of breast cancer, the American Cancer Society (ACS) has forged collaborative relationships with state-level health departments throughout the United States. After several years of such activity, it became apparent that many involved in the collaborative activities did not share sufficiently explicit goals, clearly-defined roles, shared expectations, or formal systems of coordination. ACS attempted to establish more effective collaboration through a series of retreats in several states.
Actual format of the retreats was set by state health departments and varied across states. Retreats in some states were more heavily dependent on professional facilitation; others utilized a discussion toolkit; still others made use of detailed agendas, prior surveys of attendees, and memos addressing policy issues.

As in the PPH, interview data collected for evaluation purposes demonstrated that some value had been obtained from the retreat model. In some states, interview subjects reported improved understanding of their counterparts in other agencies. Groundwork was established for new information channels, improving the ability of personnel from ACS and state health departments to efficiently initiate conversation and requests for data as needs arose.

More negative information, however, emerged from interviews of other retreat participants. In some states, interview subjects reported that individuals empowered to make decisions for the health department were not present. Other interviews indicated that peer-to-peer communication was difficult because individuals at the appropriate levels were not included in key working groups. During some retreats, participants seemed unwilling to fully address sensitive issues. ACS retreat participants in New Hampshire, for example, commented that department of health officials were afraid of change and “didn’t want to play.” Interview subjects in New York State reported reluctance to raise and deal with issues crucial to some participants. One interviewee used terms such as “walking on eggshells” to express the degree of caution he had sensed.

Despite relaxation of boundaries apparent in some of the retreat locations, the process appeared inconsistent across venues. Failure to send people with sufficient authority to discuss or agree upon policy directions or solutions may be viewed as reinforcement of boundaries. The same appears true of an unwillingness to discuss sensitive issues. In both instances, the health departments did not permit entry of outsiders into their authority structure or communication channels.

The Mutual Partnerships Coalition (MPC)

The MPC, funded in the 1990s by the W.K. Kellogg Foundation, constitutes a final case study. Substantively, MPC aimed at reducing isolation of inner city-dwelling elders living in Seattle, Washington. A group of community-based workers was assigned to locate elders at risk of isolation and to help them create a network of social ties. Significant among potential social ties were one-to-one matches involving elders, either with peers in the same age group or with youths. As in the two preceding cases, evaluators obtained evidence to suggest that the community of inner-city elders benefited from the program.

Implementation issues arose in MPC due to a mandate for intersectoral collaboration from the sponsoring foundation. Ultimately, five separate agencies received funding under the MPC grant and actively participated in the initiative. Comprising a highly cross-sectoral collaboration, MPC-affiliated organizations included the Group Health Cooperative of Puget Sound (a consumer-governed HMO), the Seattle Housing Authority (a city agency), Senior Services of Seattle/King County (a private, charitable organization), and the Central Area Motivation Project/Rights of Passage Experience (CAMP/ROPE), a free-standing grant-funded organization offering youth programs.
Although ground-level activity by MPC was intense throughout the project, most organizations consistently maintained their boundaries. Evidence suggests that this arrangement was functional in view of the MPC’s objectives and structure. Although partners were committed to promoting sustainability of the initiative, no obligation for contribution of significant assets outside the grant budget was presumed. An operating unit for MPC under the jurisdiction of GHC came closest to an outside organization making active strategic decisions in the area of boundary maintenance. The MPC Director, who was formally an employee of the Group Health Cooperative of Puget Sound, sought ways to concentrate initiative within his hands. Ultimately, the Director was fired for working too closely with a competing health care provider organization. The boundary of Group Health Cooperative of Puget Sound was not to be open in a manner that allowed its resources to be used for the benefit of a business rival.

Discussion

Despite high expectations expressed by sponsors, the phenomenon of organizational boundary maintenance may be expected to limit the depth of cross-sectoral collaboration. All things being equal, organizations may be expected to protect their boundaries. It is the nature of formal organizations to restrict access to sensitive information, personnel, and material resources via jealously guarded organizational boundaries. Evaluation data from a number of interventions suggests that cross-sectoral collaboration does not produce the “seamless web” envisaged by advocates. Rather, organizations judiciously adjust their boundaries to enable them to engage in limited collaboration, seldom if ever requiring that the organization’s objectives, values, or supervisory structure undergo revision.

Organization theory suggests that boundaries in organizations, although they typically limit collaboration, can take forms that accommodate the need of the organization to participate in some collaborative effort. In the instances cited above, public health agencies developed advisory boards that provided access by outsiders to internal communication channels. In this fashion, relaxation of a boundary made it possible for the organizations represented by the board members to identify common concerns and plan collaborative actions with the health departments. However, it is important to remember that this form of boundary relaxation is highly limited and easily rescinded. Outreach personnel and community coordinators hired by health departments, for example, seem to vanish from agency payrolls upon expiration of external funding.

Inferences from organization theory and evaluation research should not be seen as consistently negative. From an action research point of view, the descriptions presented above should help establish guidelines for promoting successful cross-sectoral collaboration in the future. It should of course be emphasized that material presented here is restricted to initiatives launched by private foundations concerned with improving community health. But three key propositions deserve to be tested in the broader context of cross-sectoral collaboration.

First, the preceding discussion implies that cross-sectoral collaboration must be supported, if not actually initiated, by forces outside the set of organizations expected to collaborate in any given policy area or geographical location. Organizational boundaries keep resources from exiting the organization. Revision in the commitments and self-identity of members of organizations too is
normally limited. Thus, initiative must come from outside. Well-funded private foundations served this function in the cases cited in this paper. In other instances, a powerful government agency, business group, or community organization may play the required role.

Second, no cross-sectoral collaboration may be expected to sustain itself and achieve significant results if it must do so by drawing on the core resources of its member organizations. Organizational boundaries may be flexible, but their ultimate function is to protect the organization’s core: its classified files, budgets, historical commitments, and member identification and loyalty. Collaboration must take place through resources with which individual organizations ultimately consider dispensable.

Third, effective cross-sectoral collaboration requires definite human resource inputs. Much has been written about the importance of leadership for organizational change. Without disputing this, it is important to emphasize the necessity of support personnel explicitly charged with managing relationships among partners: seeing that meetings are scheduled and conducted, taking and disseminating minutes; following up on requests for information and formulation of collaborative actions. Looking again to the question of leadership, an incipient collaborative might turn to an individual outside the structure of any participating organization as the lead change agent. A free-lance change agent will most likely lack the parochial commitments found among employees of organizations potentially involved in an upcoming cross-sectoral collaboration.

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