Partnerships for Healthier Communities

A study looking at the nature and extent of partnerships between a rural area health service and the local councils in its region

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Funded by:

NSW Institute of Rural Clinical Services and Teaching
NSW HEALTH

Supported by:

GREATER SOUTHERN AREA HEALTH SERVICE
NSW HEALTH

This study was funded by NSW Institute for Rural Clinical Services & Teaching under the Building Rural Research Capacity program.

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Acknowledgements:

- The councils who contributed their time to participate in the study
- Dr Catherine Hawke – for her insightful, encouraging and gentle guidance throughout, particularly when I was drowning in the data
- Emma Webster – for her unfailing ability to be positive and supportive
- Melissa Smead – for developing spreadsheets and entering data

Although I was the principal investigator for the duration of the actual study, a number of people have contributed their ideas and time in formulating the research questions and resultant design.

- Staff at Queanbeyan City Council, Eurobodalla and Upper Lachlan Shire Councils in particular
- Population Health colleagues – who have tirelessly worked with local councils to achieve health outcomes in their local communities and without whose work I would have had no partnerships to research

And last but not least:

- NSW IRCST for funding such a program
- GSAHS for enabling me to participate in the program

Contents

Executive Summary

Background
The achievement of healthy populations challenges health services to look beyond partners who traditionally had responsibility for the provision of health care. Local governments clearly have a key role to play in influencing the overall wellbeing of their communities.

The *Partnerships for Healthier Communities* initiative of Greater Southern Area Health Service (GSAHS) aims to build on existing ways of working with local government, using social planning mechanisms to achieve mutual outcomes for the health of target communities. This initiative aims to create solid partnerships between the key drivers of the broader determinants of health, to enable them to plan jointly and to achieve mutual outcomes for the health of their community.

For area health services the value of partnerships in general are as a mechanism for strategic collaborative work that supports the achievement of cross cutting health outcomes. From a rural health service perspective, there is a clear need for a realistic framework for the establishment and development of workable relationships with local government partners that can survive the challenging rural context and consequently influence the achievement of healthy community and, in the longer term, social determinant outcomes. It is anticipated that findings will be beneficial to both the NSW rural context and the wider sphere.

Objective
The strategic and policy context influencing new approaches in this sphere drives the need to undertake a baseline study to examine the nature and extent of the alliances that currently exist with local government in a rural region, and to determine the essential partnership characteristics that foster healthy community outcomes.

Literature review
The literature review synthesised the available evidence from the literature, policy and strategic documents, surveys and from unpublished papers that provided insight or commentary on partnership work that has been undertaken to address health outcomes, specifically between area health services and local government, where available. The review further aimed to bring together the evidence that describes the critical elements of partnerships that aim to address broader health outcomes

In summarising the findings from the literature review we can conclude that partnerships have both a policy and a practical mandate to address a range of outcomes in the health arena, and are particularly suited to tackling social determinant issues due to their ability to involve stakeholders across the sectors, including communities themselves. local government is clearly an appropriate setting from which to launch this approach.

In considering key characteristics of good partnerships, there is a clear set of ideal components that comprise good partnerships, with a specific set of conditions required for partnerships that address broad health outcomes. It is apparent that no one partnership formation or process fits all. Critical success factors are determined by the needs and reality of the local context, the level of community involvement, and the capacity of partners.

In looking for answers to questions about the nature and extent of partnerships between area health services and local government that address broader health outcomes, the search strategies for the literature review did not uncover any studies that comment specifically on such partnerships within the Australian, rural context. The majority of the literature reviewed reports on studies involving relationships mandated by policy or funding requirements and none involved voluntary partnership arrangements between rural health services and their counterpart councils. There is clearly a gap in the literature in relation to these specific, rural, voluntary partnership formations.

Data collection method
A survey was considered the most appropriate data collection instrument for both ethical and validity reasons to capture a broad range of baseline quantitative and qualitative data. The survey was distributed to the 39 Local Government Areas (LGAs) in the GSAHS region.

The quantitative data collected related to: numbers of partnerships; partnership establishment and activity characteristics; priority issues including the numbers of partnerships that have an explicit focus on social determinants or that adopt a Healthy Communities approach; perceptions of partnership efficacy; indications of organizational support for partnerships; and details about regional or strategic alliances that councils participate in.

The qualitative data collected related to the nature of partnerships including those that specifically addressed social determinants and broader healthy community issues; council willingness to form partnerships; explanations of the benefits and challenges of partnering with GSAHS; suggestions about partnership characteristics and approaches to address broad population level outcomes.

Results
The key findings from both the quantitative and the qualitative data in this study indicate that **partnerships are a key strategy** for councils **irrespective of size or rurality rating**; that the partnerships currently operating in the GSAHS region **reflect evidence from the literature** in relation to critical partnership formation and sustainability factors; that councils do **value and prioritise broader population objectives** in their partnerships; and that councils consider partnerships both **useful in addressing council aims** and effective in **addressing social determinant outcomes**

Partnerships have been a mainly positive experience for councils and encouraged them to continue to work in partnership with GSAHS. Councils value partnerships to achieve broad and specific health outcomes and consider them effective in addressing social determinant aims, irrespective of size of council.

New findings
In comparing the results of this survey with the literature and other surveys, we can conclude that some new findings have been uncovered in relation to:

- Rural councils do participate in partnership work, irrespective of size
- Seeking funds is not the key reason for councils to establish partnerships
- Rural partnerships are more well developed than previously reported
- Smaller councils are just as likely to undertake partnership work
- Rural councils prioritise broader outcomes over health protection outcomes, particularly the smaller ones
- Half of respondent councils have a specific social determinant focus in their partnership work
- Impact of health service restructures on partnership outcomes

These are interesting and beneficial results for practitioners that focus on developing partnerships to address structural determinants of health in rural local government areas.

Conclusions and implications
In reviewing the implications of the key findings from the data, we can conclude that rural health services in NSW should continue to develop and enhance partnerships with the local governments in their region. Partnerships with area health services are valued by councils and support them to achieve their strategic aims.

We can conclude that rural councils do have some understanding about the determinants of health and that working to achieve these outcomes is a clear priority for them in any

partnership work with an area health service. Irrespective of size of council or capacity to form partnerships, these approaches are important to rural councils.

Recommendations for the future

- **Research translation**

Use the findings of the baseline study to develop tools and models that strengthen local government partnership work focused on broad health outcomes, specifically for the rural NSW context. This will be beneficial to area health services in general, and specifically to GSAHS. The findings are also expected to be useful to local government in the emerging policy context in achieving strategic aims in relation to building healthy and sustainable communities.

The findings from this research will be shared with the members of the NSW Strategic Liaison Group which is a network of professionals in NSW working in this partnership sphere.

GSAHS plans to utilise the findings from this study to inform its Working with Local Government Framework. The intention is to develop a strategy that outlines a clear plan of action based on the new evidence to inform and enhance its way of working with partner councils. This process will continue partnership thinking in reporting these findings to all of the councils in the health service region to enable them to integrate relevant findings into their strategic planning. A component of the strategy will be for willing partners to review existing partnerships based on the evidence and determine how best to improve on any aspects to better achieve social determinant outcomes.

- **Further research**

Use data and findings from the baseline study to develop a second stage to this research to gather in-depth data about the partnerships that have broader social determinant aims and determine whether any evaluation/measurement instruments are being applied that can comment on the efficacy of these partnerships to address community level outcomes. This could lead to the development of appropriate indicators to measure changes in community wellbeing as a result of partnership formation between local government and an area health service, and potentially communities themselves.

Background to study

The achievement of healthy populations challenges health services to look beyond partners who traditionally had responsibility for the provision of health care. Local governments clearly have a key role to play in influencing the overall wellbeing of their communities.

The *Partnerships for Healthier Communities* initiative of Greater Southern Area Health Service (GSAHS) aims to build on existing ways of working with local government, using social planning mechanisms to achieve mutual outcomes for the health of target communities. This initiative aims to create solid partnerships between the key drivers of the broader determinants of health, to enable them to plan jointly and to achieve mutual outcomes for the health of their community.

Why do research in this area?

- **Addressing population level outcomes**

The *Partnerships for Healthier Communities* research project specifically contributes to the growing body of Australian evidence about partnerships between local government and area health services in addressing population health issues. It is anticipated that findings are beneficial to both the NSW rural context and the wider sphere.

- **Strengthening partnerships**

It is further anticipated that results will inform GSAHS approaches to strengthen partnerships with local government and enable partners to work more effectively to build healthier communities in their local region. The findings will be used to develop partnership models and/or tools to enable both agencies to achieve strategic outcomes in relation to the populations in their region: to both support local government in the new strategic planning reform to build healthy and sustainable communities and to assist GSAHS to address some of the broader determinants of health.

- **Rural Context**

The findings from the survey provide information about the nature and extent of partnerships currently operating with local government in a rural setting. The study provides specific information about the GSAHS region while building on the findings from the NSW Health/LGSA survey (LGSA 2005). This survey identified that rural councils were less likely to be involved in broader population health activities; that partnerships were less well developed; and that partnerships involving both health protection and health promotion activities were less common in rural councils.

- **Local government as a setting**

Local councils clearly have a pivotal role in any collaborative approaches to influence healthy community outcomes. Central to the outcome of the study is to strengthen partnership work in rural settings. To do this it is imperative to find out how local governments perceive partnership work and what they might want from partnership development.

Research Design

Research Question(s)

- What is the nature and extent of partnerships between GSAHS and the LGAs in the region?
- Do any of the partnerships specifically focus on broader population level outcomes?

Secondary Questions/assumptions

- Does capacity to form partnerships differ in relation to size of council?
- Do existing partnerships in GSAHS region reflect best practice from the literature?

- Due to criticality of local context, are partnerships that address broader outcomes a priority for councils?

Objectives of study
As this study is intended to be part of a larger research project, a staged approach is adopted.

Stage one involved the collection of baseline quantitative and qualitative data through the dissemination of a survey to the LGAs in the GSAHS region to establish the nature and extent of partnership work currently being undertaken in GSAHS.

Later stages will conduct in-depth interviews with key informants to determine the key components of partnerships that can build capacity to strengthen community wellbeing at a local government level and to look at the partnership factors that have the greatest potential to influence the social determinants of health. A final stage would develop indicators to measure the impact of partnerships on the health of communities

Ethics
The study was approved by the GSAHS HREC in September 2007.

Ethical issues in design
Due to the critical need to ensure research findings are useful to local government as well as GSAHS, input from key staff in various councils was sought at all stages of the research design including the development of study instruments. It is intended to continue this participatory approach in implementing the findings.

What the literature says

Summary
This review synthesises the available evidence from the literature, policy and strategic documents, surveys and from unpublished papers that provide insight or commentary on partnership work that has been undertaken to address health outcomes, specifically between area health services and local government where this literature is available. The review further aims to bring together the evidence that describes the critical elements of partnerships that aim to address broader health outcomes. (*A full literature review is included as Appendix 1).*

A wealth of evidence was gathered that provided valuable findings in relation to aspects of partnership work. This review focuses on the evidence about the rationale for partnerships as an intervention; the key characteristics of a best practice partnership; the partnership factors that are critical to addressing broad health outcomes; the NSW policy context; and a consideration of local government as an important setting for achievement of broader population health outcomes.

Methods
The search for relevant literature published between 1995 and 2007 used the following databases: CINAHL, EMBASE, Ovid MEDLINE (R), PsycINFO, APAIS. The search terms included: partnerships or alliances or collaborations; local government or shire or municipal or authority; and community wellbeing, or healthy communities or social determinants

Results
Combining search terms to determine whether articles existed in the literature that discussed the specific relationship between “partnerships” and “local government” and “social determinants” produced nil results using the above health related databases. Search strategies were then applied to the Oxford Journals Online and Sociological Abstracts

databases. These searches resulted in one or two articles being identified dependent on the search combination used.

Excluding one term from the search combination (eg social determinants) did produce better results, but the majority of the papers did not bring to light findings in relation to the specific question being explored. I concluded that this was a genuine gap in the literature and provided a strong rationale for a study reporting on this specific partnership formation to address broader health outcomes.

Findings from the literature

There was a wealth of literature on partnerships in general. This review concentrates on partnership aspects that increase understanding of the particular relationship issues between local government and area health services. Papers that focus on community or higher level government strategic partnerships were excluded from the review. The evidence that is not included in this review relates to: the myriad of partnership formations that exist; findings that discuss the process versus outcome debate; success factors for partnerships that address outcomes in relation to single health issues, service delivery and systems level alliances; and the recommendations for how we can measure the impact of partnerships on social determinant aspects.

Partnership working is not new. A partnership in its simplest form is defined as collaboration between two groups to work towards a commonly defined aim. Partnership is a term that is frequently used to encourage integration between different spheres of society and different levels of government (Lewis 2004). In the public health arena, partnership approaches are often employed to improve outcomes related to the health and wellbeing of entire communities (Roussos and Fawcett 2000). Partnerships that are formed in the health sphere are often voluntary agreements to work collaboratively on shared health outcomes, rather than focusing on a specific common health promotion goal (Gillies 1997). Lewis (2004) maintains that these voluntary, bottom-up partnerships differ greatly from those that are mandated by government and implemented in a top-down way.

- **Why do we need partnerships?**

The basic framework for partnership work is implicit in the International, Federal and State policy environment in relation to the creation of healthier communities including: the Ottawa Charter (WHO 1986) and the Jakarta and Bangkok declarations; the NSW State Health Plan; the NSW State Plan: and the recent NSW Local Government Reform Program.

Healthy public policy supports the use of partnerships with various characteristics as a key means to implementing a range of strategic planning objectives for health improvement at national, regional and local levels. (Roussos and Fawcett 2000), (El Ansari and Weiss 2006), (Stern and Green 2005), (Gilmore 2001), (Alexander and al 2003), (O,Donnell 2002).

In a review of over 40 health promotion case studies from around the world, Gillies found that partnerships do work in achieving change at both an individual behaviour level and addressing broader outcomes (Gillies 1997). Charlesworth proposes that there is a clear need for an effective mechanism to influence outcomes that address cross cutting social determinant health factors (Charlesworth 2001) and partnerships are a suitable model for this purpose. Partnership working is clearly needed to tackle health inequalities and social exclusion issues and have been identified as a way forward in a series of policy initiatives (Gilmore 2001). Lewis (2004) concurs with this in stating that although partnerships are often not an easy, quick solution to addressing health inequities, they are a necessary component in tackling these.

- **Partnership characteristics**

Although it is often difficult to distinguish between different types of partnerships there is an agreed set of components that comprise such relationships. An essential list for a basic partnership would include: agreement on a common goal and commitment to achieving that

goal; the existence of trust; equal ownership and sharing of power and responsibilities; sustainability; addressing resource aspects; and understanding of agency differences. (Charlesworth 2001) (Stern and Green 2005) (Walker and Adam 2001) (Alexander et al 2003) (Dowling 2004).

- **Characteristics of partnerships that address broader health outcomes**

There is a multitude of approaches to the promotion of health through partnership initiatives and those that are explicitly targeting population health outcomes have a further set of key ingredients for achieving success. These additional aspects include: presence of more than two partners that come from a variety of sectors; consideration of local context; leadership; relationships; mechanisms for community involvement at all levels; enduring mechanisms for decision making and planning; policy development element; diverse approaches to health promotion; a framework that enshrines social capital; and sustainability focus that copes with change in a shifting policy context. (Gillies 1997, Alexander J.A. et al, 2003, Small et al 2004, Charlesworth 2001, Evans and Killoran, 2000, Glendinning 2001, Dowling 2004).)

- **Local government as a setting**

Local governments traditionally have a long standing association with public health and a great deal to do with the broader health of the communities in their geographical region (DHS Victoria, 2001). The World Health Organisation's Healthy Cities/communities movement was established in 1986 to provide a framework for implementation of the priority action areas of the Ottawa Charter in local municipal settings.

Local government has a key role to play in addressing cross cutting issues in having influence on initiatives that promote the social, environmental and economic wellbeing of their communities (Charlesworth 2001) (DOH, UK, 1998). In a paper presented to the WHO Global Conference in Health Promotion in Bangkok in 2005, Jackson et al described the effectiveness of the Ottawa Charter strategies and made suggestions for future emphasis when implementing these. Central to the effectiveness of any intervention, was a focus on key cross-cutting actions. Local municipalities are a crucial setting where comprehensive strategies that involve multiple action and partnerships can occur at various levels.

- **NSW Policy context**

It is worthwhile to summarise the key aspects of the changing policy context in NSW that have an influence on questions being explored in this review in relation to partnerships between local government and area health services. In September 2002 the NSW State Government announced its Local Government Reform Program (LGRP), which aims to ensure "healthy and sustainable" local councils that are accountable and responsive to their communities. The government continued this reform process and in recognition that capacity for strategic planning is critical to sustainability, developed the Integrated Planning and Reporting Project and issued a discussion paper. The findings of this research indicated a number of factors in relation to achieving strategic planning objectives that are pertinent to consider in the implementation of partnership initiatives between local government and area health services.

- **Difficulties with partnerships**

Partnerships are not easy. They do produce benefits but the process of forming and maintaining partnerships is invariably problematic and can pose challenges. They take time and resources (Lewis 2004) and require hurdles to be straddled in the agreement of the common goal (Pampling et al 2000); in the development of trust (Audit Commission 1998); in managing agency differences (Pampling et al 2000) (Charlesworth 2001); and maintaining stability in a constantly changing policy and political climate (Evans and Killoran 2000) (Charlesworth 2001) and in counteracting partnership fatigue (Pampling et al 2000). There is ample evidence in the literature that indicates that partnerships between local governments and health services are particularly fraught with difficulty (Glendinning 2001). Local government level partnerships in the UK provide an example of the challenges created in meeting government funding and policy requirements that are constrained by community

capacity to participate effectively within timeframes (Lewis 2004). Partnerships do promise much in providing a platform from which to tackle broader health issues but the difficulties they have to overcome are considerable (Lewis 2004).

Discussion

In summarising the findings in this literature review we can conclude that partnerships have both a policy and a practical mandate to address a range of outcomes in the health arena, and are particularly suited to tackling social determinant issues due to their ability to involve stakeholders across the sectors, including communities themselves. Local government is clearly an appropriate setting from which to launch this approach.

In considering key characteristics of good partnerships, it is apparent that no one partnership formation or process fits all. Although there is an indication that there are core aspects that are commonly agreed upon, each of these characteristics may be removed and considered independently. Stern suggests (2005) that the features of a partnership are embedded in participants' expectations. I would add that these characteristics are further determined by the needs and reality of the local context and concur with Charlesworth (2001) when she argues that partnership arrangements are interwoven with their local contexts and that they have a critical influence on how the partnership operates. The fact that we have a variety of partnerships at different stages and with varied make-up within the GSAHS region is perhaps reflective of both the evidence and the changing needs and diverse local contexts within which they operate.

The key findings in Gillies (1997) review in relation to broader outcomes point to both the importance of the involvement of community in any partnership work and the significance of social capital constructs in addressing broader outcomes. This is clearly a limitation of the research that will be undertaken in GSAHS as this focuses solely on partnerships between an area health service and local governments, many of which do not expressly include community participation or the building of social capital in their approach. Although the make-up of the partnerships that are currently operating in GSAHS do not appear to fit the composition that is implied by the evidence, it is clearly worth investigating these types of partnerships.

Gillies (1997) stresses that there are no simple solutions or single approaches in the use of partnerships as a strategy to achieve health changes. There is ample evidence that highlights the difficulties in harnessing trust, time, resources, commitment, sustainability, and in resolving relationship difficulties to form effective partnerships. Charlesworth (2001) contends that what is noticeable in her research findings is that the same problems and mistakes continue to occur in partnership working. I would argue that these are perhaps not mistakes but an inherent and critical part of the process and agree with Pampling et al (2000) who argue that the partnership process itself is a strategy for future work and builds trust, clarifies differences, refines common goals and so on.

Given that there are numerous examples to show that difficulties exist in forming and maintaining partnerships, it must be asked why agencies continue to use this approach to progress their objectives? I would argue that it is important to have evidence that demonstrates satisfactory results for the local context to justify these challenges. Within the context of this study, it is anticipated that outcomes should be satisfactory to both partners - area health services and local government.

Conclusions

In looking for answers to questions about the nature and extent of partnerships between area health services and local governments that address broader health outcomes, the search strategies for the literature review did not uncover any studies that comment specifically on such partnerships within the Australian, rural context. The majority of the literature reviewed reports on studies involving relationships mandated by policy or funding requirements and none involved voluntary partnership arrangements between rural health services and their

counterpart councils. There is clearly a gap in the literature in relation to these specific, rural, voluntary partnership formations.

As partnership arrangements can be shaped in a number of ways, it is valuable to gather evidence about how rural partnerships are configured, and whether they have the critical components evidenced in the literature for addressing broader health outcomes, or whether they have a different set of characteristics. It is not only theory that is needed but more appropriate ways of exploring the pluses and minuses of partnership work (Lewis 2004).This could inform the development of a partnership model that is flexible enough to fit the changing policy and political context for rural councils and health services.

There is a further gap in the evidence about whether this type of partnership can have any influence in the long-term on the health of rural communities. Given that local context is key to the success of partnerships that address community level outcomes, there is clearly a gap in the evidence that can inform such partnership work in the Australian rural context. It would be pertinent to examine existing partnership work that is specifically focused on social determinant and healthy community objectives.

Recommendations from the Literature Review

Area health services and local governments alike have committed time and resources to building relationships with each other although they may not faithfully reflect "best practice" partnerships. Does this imply that these relationships are inconsequential and therefore fruitless to pursue in current economically constrained circumstances? Does it make it more difficult to measure any success? GSAHS initiatives are attempting to evaluate joint working between a rural area health service and the local governments in its region and expect to contribute to the evidence base by being informed of the particular challenges and benefits of this type of alliance. It is uncertain whether these relationships are doomed to fail or are perhaps a pragmatic approach for wielding outcomes within changing policy, political and economic environments. It is imperative that we find this out.

1. Undertake research to examine partnership arrangements

Research needs to be undertaken that examines the types of partnerships that currently exist between a rural area health service and the local councils in its region and to determine if any specifically focus on broader health outcomes.

This study is a **beneficial second stage** to both the NSW Survey and the SWSAHS consultations to document the specific activity being undertaken in GSAHS and **to contribute to the knowledge gap** in relation to partnerships between a rural area health service and the local councils in its region.

2. Develop appropriate models for partnership work to address healthy community outcomes

Many area health services, including GSAHS, have provided data, information and planning expertise in their collaborative work to address social determinant factors with local governments in their region. This sharing of expertise admittedly has been sporadic and inconsistent but there is clearly an opportunity for area health services to be more deliberate and cooperative in working with our local government partners to achieve healthy and sustainable communities.

The development of appropriate models that are evidenced from research that is conducted with local councils could establish the basis from which to plan regionally to address broader, upstream determinants of health.

Study Method

A survey was considered the most appropriate data collection instrument for both ethical and validity reasons. A survey would capture a broad range of baseline information; balance participation burden with extent of qualitative and quantitative data collected; address sampling bias to strengthen findings; balance bias with richness of data; and be achievable within time and resource constraints.

Answering the research questions
The quantitative data collected related to: numbers of partnerships; partnership establishment and activity characteristics; priority issues including the numbers of partnerships that have an explicit focus on social determinants or that adopt a Healthy Communities approach; perceptions of partnership efficacy; indications of organizational support for partnerships; and details about regional or strategic alliances that councils participate in.

The qualitative data collected related to the nature of partnerships including those that specifically addressed social determinants and broader healthy community issues; council willingness to form partnerships; explanations of the benefits and challenges of partnering with GSAHS; suggestions about partnership characteristics and approaches to address broad population level outcomes.

Sampling
There are 39 Councils in the GSAHS region. The types of councils that are located in this region similarly reflect the range of councils to be found in other Australian rural regions.

The Australian Classification of Local Governments (ACLG) categorises Local Governments across Australia using the population, the population density and the proportion of the population that is classified as urban for the council. According to the ACLG classification (DLG 2006), GSAHS has eight Urban Regional councils (five of medium size, three small) and 31 Rural Agricultural councils (seven very large, 10 large, 11 medium, three small).

The sampling procedures were purposeful and the survey was disseminated to all 39 councils. As there exists a mixture of types in GSAHS that reflect the characteristics of all non-metropolitan councils, comparisons can be made with other rural councils at state, national and international levels. Although the small sample group does limit the generalisability of findings in the wider sphere, there is value in generating this baseline data that can inform broader research on the rural context and is at the same time beneficial to a specific rural health service.

It was expected that responses could be stratified into the two main sub-groups of Urban Regional and Rural Agricultural to capture any variations in partnership aspects that could be explained by size of council. This will be useful in extracting findings that inform the rural context.

Data Collection
Pre-test findings
A pilot survey was pre-tested with three councils (large and small) and with a number of key GSAHS staff with expertise in the field. A number of useful suggestions were made and the survey was revised where appropriate. The revisions included: rewording to clarify expected responses; opportunity to provide explanation about a less effective as well as an effective partnership; explanation of key terms on the instruction sheet.

A letter of invitation, a study information sheet, a survey instruction sheet and the survey tool were distributed to the General Managers of the local governments in the region *(Attached as Appendix 2*). The Managers were encouraged to get together senior staff that had knowledge of any partnership work to provide input to the survey as a group.

In an attempt to address the bias factors inherent in concluding that the sample group is representative of the whole, the researcher made a follow up phone call to councils that did not return either a completed or blank survey by the deadline. Many of these councils indicated they would still like to participate in the survey and some did then respond.

Data Analysis
The data generated from the surveys was entered on excel spreadsheets. Quantitative data analysis was initially tabulated and then augmented with the use of pivot tables to enable sub-grouping of data in relation to inquiry themes. No statistical measures that are ordinarily applied to quantitative data were computed due to the low volume of responses.

The survey format was developed to both seek answers to the initial research question(s) and to enable comparisons with findings from the literature in relation to partnership characteristics. The qualitative data was thus examined and coded using the inquiry framework of the survey questions. The descriptive sections of the surveys were further analysed and coded to support the quantitative data findings and to extract emerging themes that sit outside the initial line of inquiry. Excel tables of the codes were constructed to enable multi-layered examination of qualitative themes to enrich the scope of the thematic analysis.

Results

Response rate
Of the 39 LGAs that received the survey, 22 (56%) returned their surveys, three of which were returned blank. This is an actual response rate of 50% (n=19). Five out of eight larger (Urban Regional) councils responded and 14 out of 31 smaller (Rural Agricultural) councils responded. Larger indicates a regional town which is predominantly urban in nature with a maximum population of 70,000. Smaller indicates a rural town with a maximum population of 20,000. Larger councils are identified as Urban, and smaller councils are identified as Rural in data tables and charts throughout this report.

(Table showing survey response rates to each question is provided as Appendix 3.)

Partnerships in General

Partnership extent
Councils were asked to indicate the number of partnership type relationships that they currently have with GSAHS. In the information sheet provided to councils, an explanation was given of what is meant by a partnership in the context of this study.

Responses show that (68%) of respondent councils (n=19) have at least one partnership with the area health service. Of the 13 respondents that have partnerships, 10 of these partnerships belong to smaller councils. Ten out of 14 respondent smaller councils and three out of five respondent larger councils have partnerships.

Six of the 19 respondent councils have no partnerships currently although some indicated they have had partnerships previously with GSAHS and provided responses in relation to these in the survey.

Only two councils have six or more partnerships and as these were larger councils this is likely to be a reflection of their capacity to develop a range of relationships. To verify this assumption, the data of those that have between one and five partnerships was analysed further in relation to sub category of size of council. This showed that the respondent councils that have two or more partnerships (n=9) included both large and smaller councils.

Purpose of general partnerships
Councils were asked to indicate the purpose of partnerships that they had developed with GSAHS. More than one category could be selected.

Table 1: Council description of purpose of partnerships held with GSAHS

Purpose	Number of responses (n=14)		
	Rural	Urban	Total
Response to Council business plan objective	4	3	7
General collaborative working	8	4	12
Shared planning objectives	3	2	5
Response to an identified health or community concern	9	3	12
To seek funding	4	1	5
Government or Legislative requirement	1	1	2
Other	2	-	2

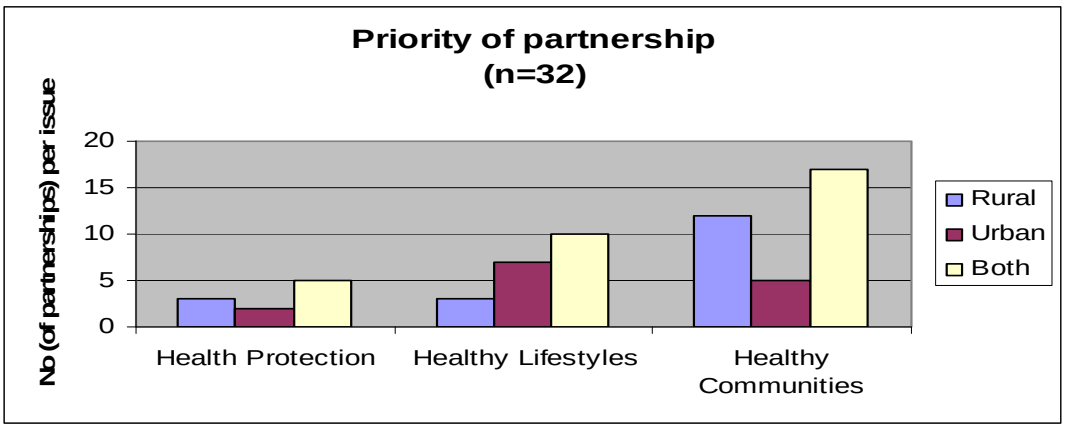
Note**:** 5 respondents did not complete this section.

Priority approach for general partnerships
Councils were asked to give the number of partnerships held that focused on particular priorities:

- Health Protection (eg Needle Syringe Program activities);
- Healthy Lifestyles (eg increasing physical activity options); and
- Healthy Communities (eg specifically using an approach that addresses the social factors of health eg working on transport, social disadvantage issues).

Of the 13 councils that responded to this question, a total of 32 partnerships were specified. Of these 32 partnerships, 17 focused on a healthy communities approach, 10 focused on healthy lifestyles, and five on health protection, showing that 27 out of 32 partnerships are focused on broader aims. Of the 27 partnerships that have this broad focus, 15 belong to smaller councils and 12 to larger councils.

Graph 1: Number of partnerships that focus on key priorities



Partnerships as a strategy
Councils were asked if their organizations were supportive of partnership work in general and to provide details of how this was expressed in agency practice.

Sixteen of the 19 respondent councils replied yes, one responded no, and two did not complete this section.

Two key themes emerged from these qualitative responses shows that: councils consider the area health service as a key stakeholder to be included in consultations and planning for actions that address community well being; and partnerships are a common approach to use resources effectively to achieve council strategic planning objectives.

Specific partnerships described

Nature of partnerships
Councils were asked to provide two examples of partnerships (preferably those focusing on social determinants) that they had with GSAHS. They were asked to describe one that they considered to be **more** effective and one that they considered to be **less** effective. Fifteen councils described at least one partnership example, six of these did not analyse a second, less effective partnership.

Four of the six respondent councils that had indicated that they do not currently have any partnerships with GSAHS, did not complete any part of this section.

The responses to the following section(s) were provided for each of the type of partnership analysed. The data has been aggregated here to enable more meaningful analysis. Due to time and resource constraints, a simple first-level representation is generally provided. The following data has not been analysed in depth to enable a range of comparisons between for eg rural and urban regional councils; less effective and more effective partnerships; respondent council partnership characteristics and evidenced partnership factors from the literature.

Councils were asked to describe the nature of the partnership. This was provided in a comment section and was analysed as described in the qualitative data analysis section.

Of the partnerships described (n=24), details of 15 more and nine less effective examples were given.

Councils responded that approaches to address specific issues and to undertake interagency work were used in both more and less effective partnerships.

More effective partnerships were described as concentrating on:
- response to specific issues
- targeted service provision
- interagency approaches that specifically address broader determinants of health.
- social planning activity

Less effective partnerships were described as concentrating on:
- interagency work
- response to a specific issue

Partnership establishment
Councils were asked to indicate the activities undertaken to establish partnerships. More than one category could be selected.

Table 2: Partnership establishment activities

Activities undertaken	Number of responses (n=24)
Identified members or key stakeholders	15
Defined roles and responsibilities of members	9
Defined common goal or aim to work towards	16
Defined components to share in partnership eg resources, data etc	11
Budget/resources allocation to set up partnership	5
Budget/resources allocation to progress partnership aims	6
Considered the building of trust as a key aspect to partnership	11
Time allowed for partnership to develop	5
Agreed a plan of action	10
Signed formal agreement such as MOU exists	5
Informal agreement exists	12
Involvement of community members	11
Other	2

Actions commonly undertaken to establish partnerships for respondent councils reflect partnership formation activity evidenced in the literature. In particular identifying key members; agreeing common goal; resource sharing; involving community; the existence of some level of agreement; and the building of trust are key characteristics identified for a "best practice" partnership as described in the literature.

Partnership Implementation

Councils were asked to indicate the activities undertaken in the course of the partnership. More than one category could be selected.

Table 3: Partnership implementation activities

Implementation activities undertaken	Number of responses (n=24)
Information sharing eg datasets, previous strategic plans	14
Planning activities such as facilities planning or working on social plan	12
Project implementation	13
Evaluation of achievements	12
Joint community consultations	6
Interagency meetings	12
Health or Social Impact Assessment	5
Sought funding	10
Other	2

Actions commonly undertaken to implement partnerships for respondent councils reflect partnership activity evidenced in the literature. In particular: sharing of resources and information; joint planning and implementation; and evaluation of achievements are key activities described in the literature.

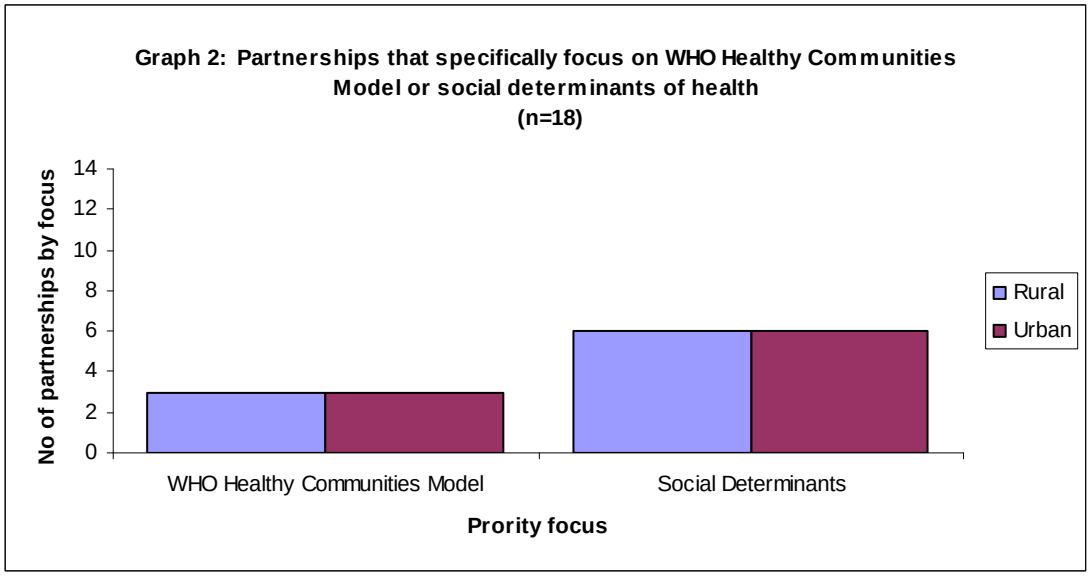
Partnership formation

Councils were asked to state who initiated the partnership. Of the 24 partnerships described: 12 were initiated by both; five by Council; five by GSAHS; and two councils were unsure.

Partnerships that focus on broad health outcomes

Councils were asked to indicate whether the example partnerships described adopted the World Health Organisation Healthy Communities model and/or aimed to specifically address the social determinants of health. An information sheet was provided to councils which included an explanation of these terms *(See appendix 2).*

Eighteen of the 24 case study partnerships focused on broad outcomes, and half of the partnerships described have a specific social determinant focus. This includes a spread across both larger and smaller councils and more and less effective examples (although more of the partnerships described as effective had a broader focus (13 out of 18)).



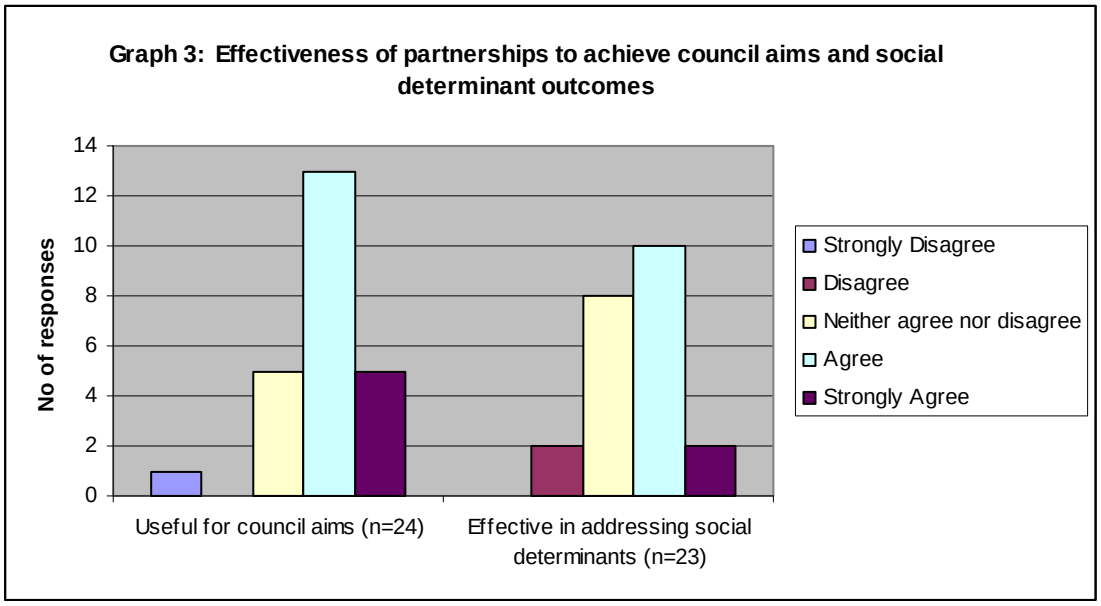
Councils were asked to describe the partnership examples that had a specific World Health Organisation (WHO) Healthy Communities or social determinant approach.

The partnerships (both effective and less effective) that were described as having a social determinant and/or healthy community focus embraced both single issue and sizeable projects that addressed structural factors.

Partnerships that were formed to respond to **specific issues** include actions aimed at increasing communication and participation at varying levels – agency, community, individual. This enabled councils to target all aspects of an issue across economic, geographic, social and physical factors to increase access to services and reduce barriers to participation and achieve shared objectives.

Partnerships that were formed to **address social determinant factors** include interagency and high level collaborative approaches to engage key stakeholders to address broad health agenda objectives. This often included the establishment of formal structures such as a Healthy Communities group or the utilisation of social and community planning mechanisms to put into action initiatives that address the social determinants of health in relation to identified community wellbeing objectives. Some partnerships had a specific focus on addressing structural factors such as employment, education, poverty, stress, transport, etc that impact on a range of health issues such as fluoridation, food security, aged care, youth health, sexual health and general wellbeing at a community level.

Partnership efficacy
Councils were asked to indicate to what extent they agreed with statements in relation to how useful the selected partnership was in achieving council aims and how effective it was in addressing social determinants.



Of the 24 partnerships rated in this question, 18 councils stated some level of agreement that the partnership was useful in achieving council aims.

Of the 23 partnerships rated in this question (one respondent did not complete this part), 12 councils stated some level of agreement that the partnership was effective in addressing social determinant aims.

Council experience of partnering with GSAHS

Councils were asked if the experience with the selected partnership examples had encouraged them to continue to work in partnership with GSAHS. Twelve councils responded yes, two responded no, seven did not complete this question (possibly because this question came at the end of the second partnership example, which some councils did not complete).

Councils were asked to ask to provide details of what **continuing to work in partnerships with GSAHS** might mean.

Those in favour of continued partnership work with GSAHS indicated that: information sharing and access to networks was key: that shared visions and common goals are beneficial to both parties; that partnerships benefited community outcomes; that the capacity and commitment of GSAHS staff was a factor in continuing to form partnerships; relationships and motivation are key to partnership success; and that partnership sustainability is linked to identification and contribution of capacity of each partner.

Councils were asked to comment on reasons for **not wishing to pursue partnerships with GSAHS**.

Those councils not in favour of continued partnership work with GSAHS indicated that: partnerships need to be clearly defined and focused on outcomes and that resource issues hinder partnership outcomes. Resources include: an understanding of the benefits of

partnerships and a commitment to working towards outcomes (especially for clinical staff); and staffing hours allocated to this work including time to attend partnership meetings.

Benefits of partnership with GSAHS
Councils were asked to describe the benefits and value of working with GSAHS.

There was general agreement between respondent councils that partnering enabled: the sharing of resources to address common goals; the achievement of outcomes at the community level, enabled access to professional networks and expertise; increased understanding of agency perspectives; and increased the capacity to achieve sustainability.

Challenges of partnerships with GSAHS
Councils were asked to describe the challenges of working in partnership with GSAHS.

Key themes emerged were in relation to the impact of health service restructure, resourcing partnerships and agency differences. There was general agreement between respondent councils that GSAHS as a large organization and experiencing ongoing restructures had a negative impact on critical aspects of partnerships including: staff turnover affecting relationship maintenance and progress of objectives; release of staff to participate in partnership meetings due to workload and time constraints; sustainability and attainment of long term objectives. Other issues described included general lack of funding and resources for both organizations, but particularly for councils to participate in larger initiatives. In relation to agency differences, councils stated that: there is disparity between the sectors; that GSAHS is larger, more complex and dynamic than councils; and that GSAHS does not seem to be willing to work with smaller communities.

Achieving change through partnership

Critical partnership factors to achieve changes at a community level
Councils were asked to describe, from their perspective, what the critical partnership components are that should exist to achieve changes at a community level.

Responses fell into three key themes: key aspects for establishing partnerships; implementing and maintaining good partnerships; and clear consultation processes to involve community.

In establishing partnerships, councils mentioned the following factors for success:
common goals; clearly identified stakeholders; trust; mutual respect for partner roles; co-operation; regular and clear and honest communication; transparency of information; acknowledging value of relationship building; motivation and relationship; and identifying capacity of partners.

In implementing and maintaining partnerships, councils stressed: commitment to the partnership and to achieving goals; allocating resources including funding; having decision makers in partnership; effective planning including a clear plan of action; focused on outcomes; outcomes realistic and achievable; evaluation and reporting of activities.

In relation to community participation, councils emphasized: adopting a consultative approach; involving community; partnerships as role modeling for community on how to work together; and committing to service delivery levels – not raising expectations and then removing them (as a result of restructuring).

Addressing the social determinants of health
Councils were asked to describe how councils and GSAHS can best work together to address wider and often more complex issues such as the social determinants of health.

Although the responses to this question showed a reiteration of similar themes as provided in the response about critical factors to achieve community level outcomes, some reflect a clear understanding of the structural determinants of health and how area health services and local government can work more strategically together.

These included: working closer together on common issues; a consultative and planned approach (with formal agreements); building the capacity and scope of member organisations to more effectively target community outcomes; enduring meeting cycles; appropriate level of resource allocation; delegate decision making power at partnership level; representation on key strategic meeting cycles; harnessing the involvement of health advisory groups; pooling resources by participating in strategic alliance structures such as Regional Organisation of Councils (ROC); workforce development factors such as training for both council and health staff; funding council positions for co-ordinators; and accountability mechanisms.

Limitations of findings

Clearly the small sample size, the resultant response rate and the low numbers in the stratified council size groups, limits any statistical weight that might shore up the reliability of the findings. Further to this, it can be assumed that those councils that did respond are mainly supportive of partnership approaches which may bias the results and inevitably have an influence on the validity of the data.

Bias aspects have been balanced in one aspect with the use of a survey that provided anonymity as an opportunity to encourage councils that might not favour partnership approaches to participate.

The self-report data in relation to questions asked about partnerships that focus on broader issues is problematic in attempting to interpret responses from councils that have varying levels of knowledge and understanding of health determinant factors. Attempts to minimize validity measure problems were made by providing explanations of terms and contextual information in lay terms that did not overuse health jargon.

In an attempt to balance bias issues in relation to the sample being representative of the whole, the researcher made a follow up phone call to councils that did not return either a completed or blank survey by the deadline. Many of these councils indicated they would still like to participate in the survey and some did then respond. Of the 17 that did not respond, the researcher has evidence of varying levels of partnership activity with the area health service in 10 of these, some of which are very well developed. Due to the ethical aspect of identification it is not appropriate to substantiate this here. However, despite response rates being low, in filtering the findings of this study alongside reasonable assumptions about non-respondent characteristics from researcher knowledge, it is feasible to conclude that we have a flavour of what exists in one rural, health service region that can be generalised to a broader context.

Discussion

It is evident that respondent councils endorse partnerships as a strategy, both in general and to some degree specifically with the area health service. With reference to partnering with GSAHS, the data indicates a medium to reasonable level of satisfaction with partnership history. **The level of satisfaction with previous or existing partnership experience is sufficient enough to encourage councils to want to continue working with the health service.** This bodes well for future partnership work when coupled with other findings from the survey data.

The data that signifies partnership establishment and implementation activities appears to throw a different light on the supposition that partnerships are often entered into (particularly

by rural councils) to attract funds to offset cost-shifting issues as a result of councils being expected to achieve broad population health outcomes. NSW/Health LGSA (LGSA 2005) survey found that councils stated access to financial and staff resources were a prerequisite to building capacity in non-mandated areas such as health promotion work. Although further analysis needs to be undertaken to verify this, it does seem that **if we compare the results in the current survey concerning purpose and priorities of partnerships, we see that new facts have been uncovered that differ from existing evidence**.

In relation to partnership establishment, the findings of this survey differ to the results of the NSW Health/LGSA study (LGSA 2005) which found that rural council partnerships were less well developed. Although the measurement variables are different, it is still reasonable to conclude that **the rural partnerships described in this study are well developed as they emulate 'best practice' characteristics from the evidence.**

The additional comments provided by respondent councils indicate positive experiences in relation to the more effective partnerships, and mainly negative experiences compared with the less effective one. In considering these responses with reference to the literature, it is noticeable that the more effective partnerships do reflect key elements of a good partnership, namely: agreement on a common goal and commitment to achieving it; a level of trust appears to be evident; and partnerships address both partner and community aims. Equally, the less effective ones indicate that key elements of a good partnership are lacking, namely: not focused on outcomes; roles not defined; common goal not agreed; trust seems to be missing; communication issues. Overall, disagreement ratings in relation to partnership efficacy for both council aims and social determinant outcomes were insignificant. **The levels of agreement in relation to efficacy generally and the low levels of disagreement are noteworthy and support other findings in this study that councils do look upon partnerships favourably, particularly to address strategic objectives.**

Although response rates for smaller councils was less than larger ones overall, more partnership activity described in the survey is undertaken by smaller councils. Further to this the level of partnership activity in ratio to response rate is higher for smaller councils as over two thirds of respondent smaller councils in GSAHS region have some kind of partnership currently with the health service. The higher levels of partnership activity for smaller councils contradicts data from the LGSA (LGSA 2005) survey that states that smaller councils are less likely to participate in partnership activity than larger and metropolitan councils. **This would seem to negate a conjecture about capacity to form partnerships being relative to size of council. This is an encouraging finding and clearly worthy of further examination.**

It is evident from the data that respondent **Councils do value partnerships to achieve broad and specific health outcomes.** Respondent councils prioritise Healthy Communities and Lifestyle (health promotion) outcomes over health protection in their partnerships, and this is particularly true for the more rural councils.

The findings of this survey differ to the results of the LGSA study (LGSA 2005) and the National Public Health Partnership Report (NPHP) (2002). The LGSA survey found that although partnerships in health promotion and protection are common across all council classifications, partnerships focusing on health protection were more likely to be embarked on and were more developed. The NPHP report found that most of the public health regulatory functions are primarily related to health protection. The LGSA study also found that rural councils were less likely to be involved in health promotion and /or broader population health activities generally; and that partnerships between area health services and rural councils involving both health protection and health promotion activities were less common. Although the participants in the GSAHS study were asked to report on voluntary partnerships that would exclude many of the mandated health protection collaborative work analysed in the LGSA study, it is still significant that for the councils in this study, partnerships are a key strategy to achieve broader health outcomes. Of the councils that participated in this study classified as Urban Regional, they are either medium or small and

therefore considered more rural than the Urban Regional Large groupings in the Local Government study, which would support the new finding that rural councils are involved in broader population health activities.

In examining the qualitative data in this study, it must be noted that as some councils did not provide information on a second, less effective partnership it is likely that they had only one partnership example to describe. The fact that not all respondents gave examples of both kinds of partnership may throw further light on an examination of whether capacity to form partnerships is relative to size of council. This qualitative data was analysed further by size of council to determine whether this had any relationship on number of partnerships described. Respondents who described only one partnership did include both larger (urban regional) and smaller (rural agricultural), however no medium or small rural agricultural council described a less effective partnership. **There is not enough consistent results here to make any firm conclusions about size of council impacting on ability to form and maintain partnerships.**

When considering the results about the extent of partnerships that focus on broader health outcomes, we see another encouraging result for the research questions posed. **Fifty percent of councils who responded to this survey reported having a specific social determinant focus**. As the spread of partnership activity on broader population level outcomes (75%) is across smaller and larger councils and is incorporated in different types of partnerships, we can surmise key points from these results. Although caution must be maintained when making any broad statements about the extent and efficacy of partnership work undertaken by rural councils that focuses on social determinant outcomes, **it is possible to generalize some conclusions from this study to the wider sphere.**

An unexpected result (for the researcher) surfaced when examining the data in relation to who initiates partnerships. Councils maintain that achieving health outcomes is not their core business but this data indicates that councils initiate partnerships as often as GSAHS does. If we consider this result along with other findings in this survey about purpose and priority focus for partnerships, we start to see that **councils do lean towards this approach to achieve healthy community outcomes.**

In considering the descriptive data about the nature of partnership examples described, it is **worth noting is that the more effective partnerships described do appear to be focusing on broader health outcomes generally, whereas the less effective ones described are mainly focused on single issue objectives**. There is clearly not enough data here to make any firm conclusions but it would be valuable to undertake case studies with targeted councils to examine this assertion further.

These are interesting and encouraging results for practitioners that focus on developing partnerships to address structural determinants of health in rural local government areas.

Key findings of study

The data in this study provides a myriad of answers to the questions raised in relation to what is the nature and extent of partnership work between local government and GSAHS in this region and whether any of the partnerships specifically focus on broader population level outcomes. The data also provides answers to the secondary questioning about capacity to form partnerships in relation to size of council; whether existing partnerships in GSAHS region reflect best practice from literature; and whether partnerships that address broader outcomes are a priority for councils, based on an assumption that local government must prioritise its constituents which inevitably narrows the scope of any broader focus.

The key findings from both the quantitative and the qualitative data in this study indicate that **partnerships are a key strategy** for councils **irrespective of size or rurality rating**; that the partnerships currently operating in the GSAHS region **reflect evidence from the**

literature in relation to critical partnership formation and sustainability factors; that councils do **value and prioritise broader population objectives** in their partnerships; and that councils consider partnerships both **useful in addressing council aims** and effective in **addressing social determinant outcomes**.

Partnerships as a key strategy for councils

It is evident from this study that councils clearly endorse partnerships as the majority have at least one with GSAHS and further state that they are supportive of partnerships in general. Both small and larger councils have more than one partnership currently, and those that focus on broad outcomes and social determinants are also spread across differently sized councils. Councils initiate partnerships as frequently as GSAHS. The quantitative data indicates that partnerships are useful in achieving council aims which is strengthened with the qualitative finding that suggests that partnerships are a common approach to using resources effectively to achieve council strategic planning objectives. Partnerships have been a mainly positive experience for councils and encouraged them to continue to work in partnership with GSAHS as they consider the area health service a key stakeholder to be included in consultations and planning for actions that address community well being.

Links to the literature

The benefits to be gained from partnering with an area health service for councils reflect many of the factors identified in 'good' partnerships in the literature. These include: the sharing of resources to address common goals; the achievement of outcomes at a community level; access to professional networks and expertise; increased understanding of agency perspectives; and increased capacity to achieve sustainability. The challenges of working in partnership with an area health service partly reflect the literature in relation to resourcing partnerships and addressing agency differences. However the impact of health service restructures on partnership outcomes appears to be a new finding.

Actions commonly undertaken to establish and implement partnerships as indicated in both the qualitative and quantitative data in this study, reflect partnership characteristics and formation activity evidenced in the literature.

In describing the factors that encouraged councils to continue to work in partnership with GSAHS, councils echo critical success factors expressed in the literature. Namely, that information sharing and access to networks is key: that a shared vision is beneficial to both parties; that partnerships benefit community outcomes; and that the capacity and commitment of partners is a factor in continuing to form partnerships.

In describing the factors that discouraged councils to work in partnership with GSAHS, councils confirm that if success factors expressed in the literature are lacking in the partnership then partnership outcomes are hindered. Councils stated that the partnerships in question were not clearly defined; didn't focus on outcomes and suffered resource issues.

Achieving broader aims

Councils do value partnerships to achieve broad and specific health outcomes and consider them effective in addressing social determinant aims, irrespective of category of council. In this study councils show that they prioritise healthy communities and lifestyle results over health protection outcomes in their partnerships. The critical partnerships factors to address health outcomes at the community level and the suggestions for collaborative approaches to addressing structural determinants of health as described by the councils in this study reflect findings from the literature.

Specifically, the partnership factors to achieve changes at a community level described in this study but strengthened from the literature include: having common goals; trust; commitment to partnership and to the allocation of resources; involving decision makers in the partnership; addressing communication factors; effective planning; focusing on

outcomes; adopting a consultative approach; involving community; and evaluation of activities.

The key ideas for achieving social determinant outcomes as described in this study that are bolstered by findings from the literature include: a planned approach (with formal agreements); building the capacity of member organizations; enduring meeting cycles; resource allocation; representation on key interagency groups; harnessing the involvement of health advisory groups and strategic alliance structures such as Regional Organisation of Councils (ROC); and involving the community in decision making.

It is the intention of the researcher to undertake in-depth analysis and a further review of the literature review at a future date. For example the comparison of the responses of different sized councils and emerging qualitative themes could be studied to determine whether the qualitative data contributed to the assumptions about size of council affecting partnership capacity, and whether there is an even spread of social determinant health literacy across smaller and larger councils.

Conclusion and Recommendations

In reviewing the implications of the key findings from the data, we can conclude that rural health services in NSW should continue to develop and enhance partnerships with the local governments in their region. Partnerships with area health services are valued by councils and support them to achieve their strategic aims.

We can conclude that rural councils do have some understanding about the determinants of health and that working to achieve these outcomes is a clear priority for them in any partnership work with an area health service. Irrespective of size of council or capacity to form partnerships, these approaches are important to rural councils.

Recommendations for the future

- **Research translation**

Use the findings of the baseline to develop tools and models that strengthen local government partnership work focused on broad health outcomes, specifically for the rural NSW context. This will be beneficial to area health services in general, and specifically to GSAHS. The findings are also expected to be useful to local government in the emerging policy context in achieving strategic aims in relation to building healthy and sustainable communities.

The findings from this research will be shared with the members of the NSW Strategic Liaison Group which is a network of professionals in NSW working in this partnership sphere.

GSAHS plans to utilise the findings from this study to inform its *Working with Local Government Framework*. The intention is to develop a strategy that outlines a clear plan of action based on the new evidence to inform and enhance its way of working with partner councils. This process will continue partnership thinking in reporting these findings to all of the councils in the health service region to enable them to integrate relevant findings into their strategic planning. A component of the strategy will be for willing partners to review existing partnerships based on the evidence and determine how best to improve on any aspects to better achieve social determinant outcomes.

- **Further research**

Use data and findings from the baseline study to develop a second stage to this research to gather in-depth data about the partnerships that have broader social determinant aims and determine whether any evaluation/measurement instruments are being applied that can comment on the efficacy of these partnerships to address community level outcomes. This

could lead to the development of appropriate indicators to measure changes in community wellbeing as a result of partnership formation between local government and an area health service, and potentially communities themselves.

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