Chapter 2 Theory and Practice of Partnership

Starting with a definition of partnership, a model for partnership is proposed. This model borrows from the determinants of health framework and management and organizational development theories to show 1) requirements of partnership as an organization and the need for partners from multiple sectors, 2) the influence of an organization’s environment on its ability to participate in partnerships, and 3) that partnership as an organizational form must be implemented effectively with results of the partnership process serving as input to the overall health-related goal. Lessons learned from the literature and gaps in the research are then discussed.

2.1 Partnership Definition and Benefits

2.1.1 Partnership Definition

According to the American Heritage Dictionary (1992), a partnership is defined as “a relationship between individuals or groups that is characterized by mutual cooperation
and responsibility, as for the achievement of a specified goal.” The term ‘partnership’ first appeared in business law where it refers to a contract for sharing fairly the profit and loss of a joint business. This concept of a partnership as a fair division of profit and loss has been translated into the organizational development and management fields (Linder, Quill, and Aday 2001).

Based on this, the definition of partnership to be used for this study involves

An organizational form based around a common goal, where participating organizations share benefits and risks, as well as resources and power. The partnership agreement may be formal and in writing or verbal.

In line with much of the partnership literature, ‘collaborate’ is the verb associated with a partnership in this research (Israel, Schulz, Parker, and Becker 1998, NACCHO n.d.).

While ‘partnership’ is currently the term being promoted for health improvement efforts, it is used generically, lacking a definition and model and has, thus led to a wide variety of interpretations of partnership in practice, making it impossible to monitor or judge the partnership process (Linder, Quill, Aday 2001). The term ‘partnership’ will be used throughout this chapter that follows as it is used in the literature; that is, as a generic term that covers a multitude of forms of organizational affiliation.
2.1.2 Partnership Benefits

Organizations generally join together in pursuit of self-interest, which may be shared with or differ from other stakeholders. The partnership must, however, develop a shared purpose, with a common understanding of the problem and the role of each organization in addressing the problem (Wood and Gray 1991). Motivations must be explicit for joining a partnership, allowing for discussion of differences and development of ways to accommodate any differences.

In addition to the increased complexity of health as evidenced in the determinants of health framework, social justice may provide a justification for partnerships. A partnership approach that is collaborative and community centered calls for an explicit interest in benefiting participants. Where citizens of the U.S. have not yet had the political will to enact universal health insurance, improving opportunities for health for all may be the best substitute. In addition, public health policy makers and practitioners view partnerships as a way to build a constituency for public health to ensure a sustained, reliable source of funding for an effective public health system (IOM 2002).

Organizational motivations provide further explanation for the increasing interest in partnerships. While these motivations are not specific to the field of health, they are relevant to any study of organizations. Where motivations between partners are incompatible, many partnerships fail. Interests in partnership involve mutual benefits that range from additional resources, increased credibility, and better understanding and responsiveness to community needs, among others (Kreuter and Lezin 1998). Resource
dependency theory confirms the search for additional resources as a motivation for partnerships, where the decline in federal and state resources, for example, led organizations to look to other organizations (Bardach 1998). Promotion of collaboration by government may stem from a desire for social services providers to do more with less, working within the status quo rather than challenging it (Himmelman 2001). Of note is the possibility that partnerships can be misused by dominant partners to maintain the status quo and simply as a way to garner resources to replace decreasing governmental resources (Rossi Steinberg and Baxter 1998). Participation in a partnership may also allow an organization to participate in an activity that may not be acceptable to its own constituency.

Within the community participation literature, partnerships are viewed as a way to increase program relevance and community empowerment (Kagan and Weissbourd 1994). Changing control and the power structure, these partnerships involve the grassroots in defining issues and in developing and managing solutions (Kaye 2001). Resources such as the internet-based Community Tool Box have been developed to increase the community’s capacity to take on change efforts (Francisco et al 2001). Some of these efforts focus on attempts to increase civic engagement and social capital, which have been on a continual decline over the last several decades as suggested by Robert Putnam’s *Bowling Alone* (2000). The organizational and management literatures offer additional motivations, including increased stability in turbulent times (Emery and
Organizations seek partners to gain comparative advantage in relation to organizations outside the partnership. Mutuality, organizational identity, and organizational change provide a framework for deciding whether to join a partnership. Organizations must judge their tolerance for mutuality (the interdependence of rights and responsibilities of partners) and for organizational identity (willingness to protect organizational identity of partners), as well as recognize that organizational change is required (Brinkerhoff 2002; Bruner and Parachini undated; Brown and Gorg 1997).

Recent increased interaction between organizations reflects a paradigm shift from relying on government to solve societal problems to relying on market forces. This shift has been occurring due to a variety of governmental and political failures stemming, in part, from unresponsiveness to citizens and elected representatives. In pursuit of subsidiarity and privatization, government is devolving responsibility for meeting individual’s needs to the ‘unit of social life’ closest to the individual, with higher levels intervening where capacity is lacking (Brinkerhoff 2002). The nonprofit sector offers an alternative to government because it is viewed by Americans as more trustworthy, efficient, and flexible than the government and thus can provide a bridge between government and the public (Brinkerhoff and Brinkerhoff 2002). These failures in the public sector to provide
comprehensive and compatible services to clients with complex needs help explain increased organizational affiliations (Alter and Hage 1993).

Changes in the health care marketplace also contribute to the increasing call for partnerships. The failure of health care reform in 1993-1994, substitution of untried managed care for reform, increasing health care costs, and increasing numbers of under- and uninsured enforce the public’s and business’ perception that there is a crisis in health and that the search for solutions is urgent (Fonner 1996). The rhetoric around partnerships as a way to increase individual organizational resources and to achieve economies of scale makes partnerships a popular solution.

Taken together, these motivations offer a more complete explanation of why organizations seek to collaborate; however, they do not explain why organizations have problems, once they have decided to collaborate. Institutional theory, discussed below, can be helpful in filling this void as it seeks to explain why organizations adopt the structure and processes they do, which in turn may help explain problems in collaboration.

2.2. Theories Supporting a Partnership Model

The proposed partnership model, discussed below, brings together the determinants of health framework and management and organizational development theories. While not a partnership theory, the determinants of health provide a framework for deciding which
organizations should come together to work toward a specific health improvement goal. Open systems theory describes organizations (the partnership) as social systems to transform resources from the environment into products or services for the environment (improved community health). Institutional theory explains why organizations develop specific structures and processes, depending on the institutional environment that provides them acceptance and credibility.

2.2.1 The Determinants of Health

In the early 1970s, Thomas McKeown used historical epidemiological methods to show that major improvements in health had taken place prior to development of effective medical therapy in England and Wales (McKeown 1978). While focusing on economic development as the primary cause of improvements in health status, the study provoked a discussion regarding the centrality of medical care in keeping people healthy and a broader view of the influences on health (Link and Phelan 2002). The Canadian Minister for National Health and Welfare Marc Lalonde issued ‘New Perspectives on the Health of Canadians’ in 1974, proposing that individuals must accept responsibility for self-preservation, within a broader understanding of human behavior and biology in response to social and physical environments. Examining health within a systems framework brings together the fragmented responsibilities of individuals, government, health professions, and other organizations involved in producing health and makes it possible to identify trade-offs in allocating scarce resources (Lalonde 1974). Unfortunately, the Lalonde report was interpreted to emphasize individual responsibility (Szreter 2002).
The World Health Organization and its members built on this work, ratifying the Ottawa Charter in 1986 in which health promotion was seen as central to enabling people to take control over and improve their health. Only with the later development of a ‘new public health’ were populations emphasized over individuals, along with the social and lifestyle influences on health and the importance of healthy public policy. Healthy public policy ensures that policies for all sectors are reviewed for their potential impact on health. Preventable illness and death indicates a problem in societal priorities and social cohesion (Milio 1985).

The health field model, developed from this tradition, takes a systems approach and posits that genetic endowment interacts with social and physical environments and health care services to determine individual biological and behavioral responses (Evans and Stoddart 1990). The model, depicted in Figure 1, calls for refocusing health improvement efforts to the determinants of health since many diseases have common risk factors. These risk factors affect the population as a whole and include economic and social policies (government taxes, tobacco regulations, income distribution, access to health care, laws regarding gun ownership); institutions (education, labor market, medical care, criminal justice, housing); neighborhoods and communities (environmental exposures, availability of nutritious foods, parks, socioeconomic conditions, and social capital); social relationships (social support and networks, peer behavior); and individual risk factors (Kaplan, Emerson, and Lynch 2000). Recent research has suggested income inequality as a determinant of health (Wilkinson 1999); however, other research points to inequalities in general as a more important risk factor (Deaton 2002). The fact that
personal behavior is constrained by social norms, combined with the fact that a small change over a large population can lead to greater improvements in health status than large changes over a small number of people, means that a population approach targeting risk factors and social norms can be more effective than an individual approach (Rose 1985).

Considering health in terms of the conditions that must be put in place to keep populations healthy clearly identifies public health as a social intervention that involves attention to social, political, and economic issues. Creation of this social value calls for the political will to fund and support a more equitable allocation of resources to enhance health (Szreter 2002 and Reich 2000). Members of the Institute of Medicine study on public health in the 21st century, viewing public health as a public good, agreed that it was influenced by the determinants of health and amenable to a population-health approach (IOM 2002).

A partnership approach calls for changes in the way health issues are addressed. Multiple levels of influence must be considered, along with the multiple sites where populations are found, and the community’s voice to ensure that interventions are tailored to their needs (Sorenson, Emmons, Hunt, and Johnston 1998). Calls for a new approach to public health research argue that epidemiology is no longer sufficient and that the focus of this research must move from the individual to places and structural levels. Area characteristics are more than the sum of their residents because they include geography and the quality of the environment (social cohesiveness, local resources, crime,
socioeconomic status, public services, behavior and culture, and social structure (Yen and Syme 1999).

2.2.2 Partnerships – an Open Systems Perspective

The proposed partnership model is an open systems model that describes a system as a set of interacting elements or sub-systems that make up an integrated whole, forming part of larger systems. Because open systems theory deals with organizations in general and across all sectors, it is applicable to public health and other organizations contributing to health. Open systems theory provides a framework to study partnership as a social system with sub-systems that interact with each other and with the environment (Katz and Kahn 1978). While this research considers all organizations making up a partnership, the discussion that follows will illustrate theory with examples of local governmental public health entities.

The historical roots of open systems theory lie with von Bartolanffy’s general systems theory that describes dynamic, recurring patterns in biological systems. Open systems theory adapted this to the study of organizations, proposing that systems maintain themselves through contact with the environment. An open system is defined as a coalition of shifting interest groups, strongly influenced by environmental factors that develops goals by negotiating its structure, activities, and outcomes. Open systems
Figure 1. HEALTH FIELD MODEL - Determinants of Health
Evans, R.G. and G. L. Stoddart, 1990 “Producing Health, Consuming Health Care,” Social Science and Medicine, 31, 1347-1363
theory argues that organizations are social systems made up of a structuring of events or processes. Social systems are anchored in attitudes, beliefs, and motivations of humans, representing patterns of relationships characterized by variability in objectives that change over time and by control mechanisms to decrease variability of human behavior in the interest of stability (Katz and Kahn 1978). The theory stresses complexity and variability of parts, looseness of connections, amorphous system boundaries, and attention to process, not structure (Scott 1981). Properties of open systems include inputs, transformation processes, and outputs (Katz and Kahn 1978). Inputs represent importation of energy and the influence of the environment on the system. These inputs are transformed into outputs that are returned to and influence the environment. This import and export process represents a cycle of events that decreases the natural tendency of a system toward entropy. Positive and negative feedback loops lead to dynamic homeostasis, where positive feedback allows an organization to respond to changes in the environment and negative feedback serves to correct deviations, opposing change and maintaining stability (Ashmos and Huber 1987). The concept of equifinality allows that a final state can be reached from different initial conditions and by multiple paths. Organizations are controlled through rules, regulations and norms in their environment. Therefore, organizational functioning cannot be understood in isolation since any system is a sub-system of a larger system. Open systems analysis seeks to define the boundaries of a system and
the elements making up the system, their interactions, and the connections between them. Starting with the system of interest, analysis must identify the larger system in which the system of interest is embedded, as well as the sub-systems (Katz and Kahn 1978).

As an organization or social system grows, it must develop five sub-systems that represent differentiation of activities for survival. The interaction of these sub-systems requires integration and ensures that the system is greater than the sum of its parts. Building on Talcott Parsons’ Theory of Action and its four components of a social system (goal attainment, maintenance, integration, and adaptation), Katz and Kahn offered a framework that can be applied to the study of partnership. Organizations must transform inputs into 1) a production or technical sub-system (e.g., health improvement and partnership development activities), 2) boundary spanning structures to facilitate exchanges with external organizations (e.g. the procurement function to obtain materials or the liaison function to maintain relations), 3) maintenance to hold the social structure together by reducing variability (e.g., culture - norms, values, and beliefs), 4) adaptive structures to respond to changing environmental demands (e.g., planning, environmental scan, and feedback systems), and 5) managerial sub-systems (e.g., control, coordination, directing, regulatory mechanisms, and authority structure) (Katz and Kahn 1978). As part of the adaptive sub-system, a negative feedback loop involves goal-oriented behavior and acts
through self-correction to maintain equilibrium and stability in a changing environment. A positive feedback loop leads to instability and to change for organizational survival (Katz and Kahn 1978).

Defining the system by identifying the boundaries between the system and its environment is often arbitrary, depending on the person studying the system (Scott 1981). Indicators for boundary identification include interaction rates, types of activities, spatial and temporal characteristics, and the degree of influence. Boundaries are defined in functional, not geographic, terms to include organizations producing similar products and services and critical exchange partners, sources of funding, regulatory groups, professional and trade associations and other sources of normative influence. Nonlocal and local connections, as well as cultural and political influences, are considered for inclusion in the system (Scott 1981).

This framework is useful in describing the component sub-systems of partnership that are required for effective functioning. The utility of the open systems approach is that importance placed on the environment calls for scanning for changes and bridging boundaries and interdependencies. The open systems approach allows identification and elimination of potential dysfunctions (Morgan 1996). The explanatory power of open systems theory is however limited, given that it provides a framework to describe and classify organizations within their environments (Ashmos and Huber 1987). Open systems theory views organizations only as physical entities, ignoring the importance of meaning in any human system (Flood 1999). Inattention
to interactions among interest groups or stakeholders also limits its usefulness (Harrison and Shiron 1999). For this, an expansion of open systems theory is required.

2.2.3 Partnerships – An Institutional Perspective

Institutional theory builds on the open systems perspective by adding that the environment is not only a stock of resources and technical information, but also a supplier of legitimacy and meaning (Thompson 1967). Early institutional theory argued that organizations reflect rules and structures in their external environments, rather than result from internal, rational decision making processes. Organizations take on patterns of functioning and of meaning systems from those organizations in their environment that influence them, providing them legitimacy and stability where they accommodate the requirements of these influences. Organizations are thus more about the process of organizing than about the structure of organization (Weick 1979). The environment is a source of information and a stock of resources. Most institutional research focuses on why organizations are structured as they are and on the isomorphism between organizations that this process produces. Additionally, the theory provides some understanding of why organizations are interested in collaboration because it can help organizations adjust more efficiently and effectively to increasing complexity (Hatch 1997). An organization’s structural complexity increases as the environment becomes more complex. With increases in uncertainty,
organizations increase their formalization and control processes. Increasing complexity and uncertainty leads organizations to become more interdependent, looking for ways to coordinate (Scott 1981).

The institutional model consists of four elements: 1) macro processes within power and social structures (the nation-state, professions, culture, and the economy) affect or control development of the environment of organizing; 2) the institutional environment is made up of a set of organizations with identities, structures, and activities that influence a particular organization; 3) causal connections (or types of pressure) between institutional elements and organizational identity, structure, and activities; 4) sources of influence on organizations (e.g., public regulation by nation state, scientific or professional norms and guidelines) (Meyer 1994). Within institutional theory, two types of organization exist—technical and institutional. In technical organizations, success depends on outputs and profit. In institutional organizations, on the other hand, success depends on acceptance of society’s norms and values (Powell and DiMaggio 1991). Understanding an organization’s ability to participate in a community health partnership through an examination of these elements is an important part of this research.

2.2.3.1 Macro Influences

Social order is created through a shared conception of a situation and determination of one’s identity within it. Society is sustained by rewards of the economic system
(incentives) and maintained through norms, codes, and political structure (laws) (Ashmos and Huber 1987). This wider societal environment—the nation-state, culture, the professions, and the economy—thus shapes the environment of organizing. These societal and cultural demands lead to specific roles for organizations to play.

As a public good, public health is a government responsibility, in cooperation with others that influence health. Economic, political, and social priorities create tensions in public support for public health, including between individual rights and community responsibility and between the biomedical and public health communities. Lacking political will and public interest, past public health programs often failed (IOM 2002).

While local public health entities have been assigned a role to play in organizing the community and in implementing partnerships (IOM 1998; IOM 2002), their ability to do so may be circumscribed by their role in society. In spite of major contributions to health, public health is viewed by the public as less urgent and visible than medical care and thus, has been relegated well behind medical care in terms of priorities. Lack of visibility in allocating scarce resources in the political process, combined with traditional American values for minimal government and low taxes, has resulted in an often marginalized local public health presence at the mercy of changing community values. In addition, public health is often confused with health care for the poor, where market failures placed pressures on public health agencies to
compensate for a health care system that excluded the poor (Brown and Gorg 1997). This secondary position places public health at a disadvantage in coming together as equals in partnership with medical care, for example.

The nature of American society that celebrates individual rights makes it difficult to define collective responsibility for public goods such as public health. Public health is similar to the mental health field, where societal goals have not reached a consensus, resulting in diverse technical definitions of public health and little or no vertical or horizontal integration (Scott and Meyer 1983). Because of this, public health suffers a continual crisis of legitimacy.

2.2.3.2 The Institutional Environment

Organizations are immersed in the environment that constitutes their identity, structure, and activities. They gain acceptance and credibility, or social legitimacy, by ensuring that their values are congruent with wider societal values represented by institutions or supraorganizational patterns of organized social life in the macro environment. Institutional actors exert power in order to gain from the status quo through socialization, professionalization, state regulation, requirements for trust, and imitation under uncertain knowledge. The institutional environment determines an organization’s domain (sphere of activity), form (structure and processes), and criteria for evaluation through socialization and state or judiciary requirements (Powell and Dimaggio 1991).
2.2.3.3 Forms of Pressure

In addition to identifying influences in the institutional environment, it is important to determine how the institutional environment exerts pressure on organizations. Influence can be exercised through structural, process, or outcome controls that are coercive (state regulation), normative (implicit professional norms), or mimetic (imitation under uncertain knowledge). Structural controls focus on the impact on organizational effectiveness of the adequacy of facilities and qualifications of personnel, for example. Process controls focus on activities through assessment of the degree of conformity with performance standards. Outcome controls focus on achievement of specific objectives. Organizations in highly developed institutional sectors such as education and mental health have interlevel controls on structural measures, including accreditation, certification, and licensure. Organizations with centralized, fragmented, or federalized decision making emphasize process controls. Institutional organizations move the focus from outcomes to human relations where appropriateness of form and social fitness is more important than what they produce (Meyer and Rowan 1991).

Influences can be either horizontal (local) or vertical (nonlocal). Horizontal linkages are informal and tend toward integration and maintenance functions. Vertical linkages to state, regional, and national systems are hierarchically arranged and impose tighter restrictions than horizontal ones. American communities are increasingly defined by domination by these vertical influences (Warren 1967).
The nature of the association (mandated or voluntary) can affect the partnership outcome (Alter and Hage 1993). The type of external pressure determines the amount of autonomy an organization enjoys (Powell and DiMaggio 1991; Alter and Hage 1993). Mandated partnerships reduce organizational autonomy and remove facilitating conditions such as redistribution of power and the ability to influence the contextual environment through policy change (Gray 1985). Systems are non-hierarchical and self-regulating; organizations, on the other hand, are hierarchical. This dichotomy creates a potential conflict between the community health partnership and individual partners. Individual partners must accommodate this difference by making fundamental changes within their organizations to support partner goals. This is difficult where outside control decreases the ability to adjust to changing needs and to innovate (Alter and Hage 1993).

Organizations in the institutional environment can act as barriers to moving from a focus on medical care to prevention. The determinants of health are linked to political, social, economic, and cultural realities where politicians, business, medical and academic communities have vested interests to maintain the status quo, along with those who benefit from the current distribution of resources. For example, in the battle against tobacco, the tobacco industry stands to lose and religious and conservative groups fight against abortion and reproductive health education for adolescents (Moodie, Psane, and de Casellarnau 2000).
2.2.3.4 Sources of Pressure

Sources of technological, economic, social, and cultural demands on organizations include professional norms, regulations and rules, public opinion, laws, government agency requirements and interest groups (Scott 1981). Funding sources represent another source for organizations that do not produce goods and services for economic profit (Gans and Horton 1975).

Primarily an institutional type of organization, the success of public health depends on confidence and stability achieved by accepting and repeating rules imposed by the institutional environment, which includes all the sources of pressure mentioned above. With no strong central control or societal consensus, the collective good of health is highly sensitive to its environment through regulation and social construction (Scott and Meyer 1983). Lacking a visible commodity and a clear definition of public health labor or resources, public health practitioners, interested in increasing public health legitimacy, are currently developing credentialing of public health, which would bestow legitimacy through conformity with professional norms (http://www.phppo.cdc.gov/nphpsp/, n.d.; Scott and Meyer 1994).

Funding organizations influence the ability of public health entities to manage their resources by stipulating eligibility and reporting requirements. A major funder, the federal government lacks implementation authority at the local level and therefore exerts influence mainly through detailed administrative controls and other categorical program requirements. These controls, however, are not uniform and are misaligned,
coming from the multiple agencies and levels of government that have responsibility for public health (IOM 2002). Categorical grants have produced fragmented programs and organizations, increasing organizational complexity with each program having its own rules of eligibility and accounting (Alter and Hage 1993). Problems of legitimacy and organizational functioning have also led to crisis, inconsistency, and failure to meet the real problem (Scott and Meyer 1994). Attempts to overcome these problems have met with limited success. The National Environmental Performance Partnership System (NEPPS) was designed in 1995 to strengthen the relationship between public health and environmental agencies by increasing flexibility and autonomy for states and limiting federal oversight. However, a GAO review in 1999 found that the program had experienced limited success due to statutory requirements still in place and reluctance by EPA regulators to reduce oversight without having agreed performance measures in place (GAO 1999).

Limited funding, fragmented services, and dependency on categorical resources act as disincentives and limit the ability of public health entities to function effectively to provide services and programs that are relevant to their local communities (Davis and Lederberg 2000; Gostin and Hodges 2002). Multiple sources of financial resources mean that public health entities have multiple influences from local general funds or special taxes (34%); state subsidies, including federal pass-through funds (40%); and federal grants (6%). Additional resources come from fee-based services, grants, and permit and license fees. Other influences include state public health structures, local government, and specific historical and political contexts (NACCHO 1995).
Public health capacities and programs resulted from a mix of crisis, legislation, and a lack of resources, resulting from special interests including legislators and oversight by multiple Congressional committees (IOM 2002). Institutional influences and this ad hoc approach resulted in insufficient infrastructure (skills, communication systems), high staff turnover, poor pay, competition between sectors, reactive planning, lack of uniformity between information systems, and lack of political skills (Davis and Lederberg 2000). The size of the problem is so enormous that, instead of restructuring the fragmented system, policy makers are recommending a coordinating structure for the multiple agencies that contribute to the public’s health. In addition to removing outdated incentives, health policy makers need to create incentives to facilitate partnership (IOM 2002).

2.2.4 Beyond Institutional Theory

Early institutional theorists argued that organizations change only in response to external environmental requirements. Organizations can however act rationally to resist environmental influences or to negotiate among dissimilar regulations from multiple levels of government agencies, for example (Powell and Dimaggio 1991). Institutional theory is limited to explaining why single organizations adopt their structures and processes, while not addressing the interrelationships between organizations. This research seeks to understand how the structures and processes of individual organizations act as facilitators and impediments to partnership.
development and how they can be explained by the institutional environment and social legitimacy of participating organizations.

Impediments to partnership can be personal (e.g., vested interests, fear of loss of autonomy, individualism), structural (e.g., data systems, proprietary ownership, incentives) or environmental (Hodges, Nesman, and Nernandes 1998). An understanding of these problems can facilitate identification of changes required to duplicate facilitators or reduce impediments imposed by the institutional environment. Where changes are not possible to reduce impediments, alternative strategies to partnership can be sought.

Just as changes in institutional rules create incentives for organizations to change patterns of behavior (Alter and Hage 1993), failure to remove institutional rules may act as a disincentive for change. Institutional rules and resulting organizational processes and structures, put in place before new demands for community partnerships, create impediments to partnership development. While partnerships are promoted by the federal government, laws remain in place, which forbid monopoly action in general, for example. These laws may need revision or some organizations seeking to form partnerships may find themselves the subject of antitrust litigation. Another example of a barrier to partnership involves fragmented services offered by local public health entities, required by the nature of categorical grants from the federal government. In addition, new incentives may be required to facilitate development of partnerships (IOM 2002).
2.3 Partnership Model for Community Health Improvement

With the above definition of partnership and theory guiding this study, a model for examining partnerships as a strategy for improving public health and ultimately, community health, can be developed. This research, however, focuses solely on the partnership development process (the shaded portion of the model depicted in Figure 2). A community health system or partnership results when health is viewed within the perspective of the determinants of health framework, also a systems model.

Partnerships are a means to an end, where the overall goal shapes who participates and how. For the purposes of this study, the goal is stated as improved community health; however, within that, specific objectives relating to improved public health services will be identified from the work at each study site. The proposed partnership model in summary uses the determinants of health framework discussed earlier to define the factors that shape health and the organizations working on those factors to come together in a community health partnership. Open systems theory views organizations as mechanisms dependent on their environments for inputs that then are transformed into outputs that are returned to the environment (Katz and Kahn 1978). In the case of this research with the partnership as the unit of analysis, multiple organizations contribute resources for partnership development and improved community health. These resources are used in activities (transformation process) to produce an effective partnership, which serves as input to the health improvement process. A feedback loop from the partnership development process back to the
partners ensures that information is provided continually to improve the process, as well as to track environmental changes.

Before moving on to a more detailed discussion of the model, it is important to note that varying levels of affiliation, or ways organizations work together, exist on a continuum with full integration at one end and complete independence at the other end. Between these two extremes, other types of affiliation represent steps toward more formal affiliation. While presented as a linear process, partnership is not linear since it represents a dynamic process that builds on previous steps or forms of affiliation. As such, it moves back and forth between the steps, depending on current needs or opportunities. The model represents but one strategy among many to improve community health.

A more detailed discussion of the partnership model depicted in the shaded portion of Figure 2 is set out below. The discussion will be organized around elements of the model; that is, the transformation process, the environmental analysis, and effectiveness characteristics of collaboration.
2.3.1 The Transformation Process

The transformation process involves multiple partners contributing resources that are transformed into outputs or services for improved health.

2.3.1.1 Partners

The determinants of health framework argues that health is created through the interaction of multiple factors (i.e., the physical and social environments, lifestyle,
Organizations that deal with the factors relevant to the actual health goal sought must therefore be included in the partnership. Work of the different levels—federal, state, and local—that influence health must be coordinated within this model. Potential partners include organizations that work on economic and social policies, social relationships, and individual risk factors within institutions, neighborhoods, and communities (Kaplan, Emerson, and Lynch 2000). Other stakeholders include those who support an initiative, those who could sabotage the initiative, those who could be involved in implementation and those who have the power to influence implementation (Eden 1996).

Partners are selected according to their comparative advantage or what they as an organization offer the partnership. Government finds its comparative advantage in the fact that it is a major part of the institutional environment and controls many resources (Brinkerhoff 2002). As such, government can provide authorization to carry out some activities, legitimacy, and incentives for participation (Plough 2001). For non-profits, comparative advantage stems from their ability to play a social mobilization role to increase local ownership, as well as from their flexibility, responsiveness, and innovation (Brinkerhoff 2002). If an entity is to take on the convener role for partnerships, it must have an ability to induce stakeholders to join; legitimacy among stakeholders; unbiased approach to problem; ability to facilitate collaboration; and an ability to identify stakeholders with legitimacy (Wood and Gray 1991).
Much of the research on community health partnerships has focused on the community as a partner. As with the term partnership, a definition is required for the extent of participation that is appropriate (Krieger et al 2002), depending on whether change or the status quo is the goal. Community participation involves political and social dynamics in the community; connections between these processes that shape the context must be made explicit (Schulz, Parker, Israel, Allen, Decarle, Lockett 2002). Questions of who represents the community, competition among groups, and differences in values, language and culture therefore become important (Israel et al 1998). However, there are limits to using grassroots strategies exclusively, since most problems result from wider societal influences; stakeholders from the multiple levels are therefore required (Himmelman 1996).

A community health partnership is part of multiple, larger systems making up the institutional environment (regulatory structures, government agencies, legal system, professions, interest groups, public opinion), and the macro environment (culture, social sector, laws, politics, economy, technology and the physical environment). The arrows going between the community health partnership and the institutional and environmental systems indicate that they influence each other. Partner organizations are situated within the institutional and macro environments, as well as within the community health partnership in Figure 2.
The first step, therefore, in this research involves identifying the health goal sought and the organizations actually participating in the partnership, as well as those organizations that are indicated by the determinants of health.

2.3.1.2 Resources

Community health partnerships receive resources from their members that they in turn transform into partnership development activities, as well as health producing activities. One resource—knowledge/technology—helps explain why organizations seek partners, reflecting an increasing understanding of the complexity of health (Lalonde 1974). Before the partnership can contribute effectively to the health improvement process, partners need to identify and make available all resources required to match the goal sought.

Institutional theory informs the model by calling for an examination of social legitimacy, a resource gained by an organization adopting society’s values and practices (Powell and DiMaggio 1991). An understanding of how social legitimacy was gained by each partner organization is important to determine each partner’s ability to participate.
2.3.1.3 Development of Organizational Sub-systems

The model then suggests two separate transformation processes, one for the partnership itself and one for the health improvement effort. The partnership transformation process involves activities to achieve the stated goal of an effective partnership. People come together to produce goods or services. Resources from the environment are required, along with markets for products. As these activities are differentiated, a need to integrate these activities through management functions arises. As people start leaving the organization, management develops incentives and a culture to reduce variation, holding people together. Finally, feedback is required to adjust performance and to scan the environment to identify the need for change. In terms of a partnership, these activities include environmental assessment; identification and recruitment of partners; planning and resource acquisition; establishment of partnership structure, sub-systems, processes, incentives, and procedures; and monitoring for feedback to improve the process. These activities make up the five sub-systems required for partnership to become institutionalized and effective as follows (Ashmos and Huber 1987; Katz and Kahn 1978)

Adaptive mechanisms to allow the organization to identify the need for change for survival, including a plan and mechanisms to scan the environment for opportunities and threats and track progress for internal improvements. Continual assessment is required since change in one element affects other elements
Need for feasibility analysis for form of affiliation to identify pre-existing facilitators and impediments (Wood and Gray 1991).

Boundary spanning staff who interact with the external world to ensure access to resources and to maintain good relations.

Maintenance a common culture of shared norms and values to reduce variation/conflict within the social structure (the partnership).

Management an integrative mechanism, along with procedures and processes to control and facilitate work. New forms of leadership are required to deal with shared responsibilities and reconcile differences. The importance of managing “across organization boundaries has been argued to be almost as significant as knowing how to manage within organizations (Huxham and Vangen 2000).

Production activities to improve community health and to develop the partnership. In addition to developing the sub-systems discussed previously, production activities in terms of the partnership strategy include the operations of the partnership, as well as support to a management board.

The institutionalized partnership represents the output of the partnership development process, which serves as an input to the community health improvement process. An arrow from the partnership development process back to the partner organizations
indicates that there are reciprocal influences between the partners and the partnership. Formal feedback from the partnership development process and results is provided through ongoing information systems through the adaptive sub-system mentioned above to improve management decisions and operations. In terms of the partnership development process, this feedback indicates the need for individual organizational restructuring of responsibilities and relationships to accommodate the needs of the partnership (Bruner and Parachini undated; Brown and Gorg 1997). Given the variable nature of partnerships, information systems must be designed flexibly to provide data to improve management of resources (Parente 2001). Where resources and activities contributing to the partnership development process have been clearly defined from the beginning, managers are able to identify problems and gaps that can then be addressed (Scheirer 1994). Monitoring is also required to track changes in the environment that demand an organizational response for survival.

This research examined these sub-systems within the partnerships studied to determine whether and to what extent they existed and to identify the factors that facilitated or impeded their development. Adapting the work on stages of development of partnership from the organizational literature (Butterfoss, Goodman, and Wandersman 1993); the stages of development used in this analysis included

- Rudimentary – Little evidence, if any, is available of elements of a sub-system
- Formative – Elements are being designed and resources are obtained, where required
- Implementation/Maintenance – Elements are formally established and operational
- Institutionalization – Sub-system is ongoing and sustainable

Understanding the stage of development of each element and of the overall partnership allows appropriate strategies for that stage to be adopted.

2.3.2 The Influence of the Macro and Institutional Environments

Institutional theory serves in the model to highlight important environmental influences that are often overlooked in partnership efforts and that may provide insights into problems encountered in forming or implementing partnerships. The adaptive sub-system discussed above provides a mechanism for an organization to scan the environment, tracking the need for change, as well as to provide information on progress toward achieving a stated goal. Research on environmental influences focused on

1) the macro environment – made up of economic, political, and cultural institutions, as well as the physical environment and technology, influences the specific roles that organizations adopt in the institutional environment.

2) the institutional environment - shaped by the macro environment and made up of interest groups, professions, public opinion, government agencies, laws and courts, regulatory agencies, and funding agencies relevant to a specific organization, exerts influence through
3) pressures, including coercive (state regulation), normative (professional norms, requirements of trust), and mimetic (desire to be like others, imitation under uncertain conditions) pressures on

4) specific organizations that reflect patterns from the institutional environment in order to gain resources and legitimacy (Powell and DiMaggio 1991; Meyer 1994).

While the macro environment is generally constant within a given society, the institutional environment of an organization varies depending on its function and local and non-local influences. Institutional theory therefore focuses on the relationships between these influences and the structure, processes, and activities of an organization. Starting with organizational problems, the analysis attempted to identify those problems that represent responses to demands from organizations in the institutional environment, as well as influences exerted by the macro environment. The research also sought evidence of change attempted by each organization in response to requirements of increased interdependence stemming form working with others and of efforts to work with organizations in the institutional environment to remove impediments. This feedback loop allows organizations to develop strategies in response to opportunities and threats from the environment and to enhance internal activities (Child and Faulkner 1998).

Institutional theory traditionally has been used to explain why single organizations adopt the structures and processes that they do (Scott 1981). Some of the impediments encountered in partnership development are assumed to be due to the institutionalization process of individual partners that are now at odds with new
demands for partnership. Extending institutional theory to explain how structures and processes of organizations affect their ability to work with other partners permits identification of the sources and kinds of institutional pressures that may be responsible for problems. A clearer understanding of these pressures may provide clues about the kinds of change required.

2.3.3 The Effectiveness Characteristics of Collaboration

In line with the argument that the strategy of partnership has to be implemented effectively, criteria are available to characterize the extent of the collaboration between organizations, as well as of the degree of value added by organizations working together (the partnership strategy), instead of working alone, to achieve a goal. These include formalization, intensity, reciprocity, and standardization, which in turn contribute to institutionalization of the partnership. Each characteristic can be described according to its strength along an effectiveness continuum, with weak and strong at either end of the continuum. Each characteristic is described as follows

- Formalization – recognized officially (social legitimacy gained; resources received)
- Intensity – frequency of interactions, match between partners, resources, and goals, and internal partner support
- Reciprocity – degree of mutual exchange of resources and decision-making
• Standardization - administrative rules and regulations; coordinating body;
degree to which linking procedures are specified (Hudson 1987).

These characteristics represent the value that must be created for individual
organizations to justify their participation (Cropper 1996).

2.4 Study Assumptions

Institutional theory provides a framework that explains the structures and processes,
adopted by single organizations to gain social legitimacy. An important assumption
of this research involves expanding institutional theory to study multiple
organizations making up a partnership. The proposed model assumes that
institutional theory provides an understanding of structures and processes of partner
organizations that may later impede partnership development, where the old
environmental requirements no longer meet the new demands of partnership.

Early institutional theory assumed that organizations change only passively in
reaction to environmental demands. This research, however, adopts tenets of new
institutionalism and assumes that rational decision making within organizations is
possible and that changes are required in either the institutional environment and/or
within partner organizations to remove these impediments.

The proposed partnership model assumes that two separate processes are required in
community health partnerships—one for partnership development and one for
improved community health. Partnerships cannot contribute effectively to improved health without this dual approach.

The research approach is a deductive one, bringing open systems and institutional theories to the study of community health partnerships. As an organizational form, community health partnerships are assumed to be amenable to analysis based on these theories. Because the past study of these partnerships has not been supported by theory and empirical evidence, qualitative research methods are appropriate to better understand partnership within its context, where explanatory variables exist (Yin 1994).

2.5 The Practice of Health and Social Services Partnerships – Evidence from the Literature

The term ‘partnership’ in the health and social services literature incorporates a wide variety of types of organizational affiliations, including cooperation, integration, and collaboration, among others. A major barrier to early efforts at examining organizational affiliation within health and social service programs involved the general lack of attention to evaluation until the Government Performance and Results Act in 1993. Early efforts were limited to review of project reports to identify facilitators and impediments to some form of organizational affiliation. More recent efforts attempted to develop evaluation models addressing complex health conditions through multi-sectoral coalitions. An important feature of these models is the
examination of community participation or the community as a partner in a health intervention.

The literature on partnership has been described as normative, with partnership seen as an end in itself (increased equity); as a public relations exercise; and as a means to an end (the how to literature) (Brinkerhoff 2002). A review of this work will help focus development of research protocols ensuring that the research methodology builds on this experience.

2.5.1 Early Efforts at Organizational Affiliation

From the 1970s, the Department of Health, Education, and Welfare (HEW) began documenting the experience of social service projects with service integration. Service integration, defined as a process in which multiple service providers are linked to provide better coordinated services to individuals and families (Gans and Horton 1975), is germane to this discussion since it and partnership represent different levels of organizational affiliation. A review of 30 social service project reports identified important facilitators and impediments to service integration. Principle impediments included categorical funding and the fragmented policies, procedures, and organization of HEW and of service providers. Facilitators involved support from the sociopolitical environment and organizational leaders, shared objectives, incentives, and lack of fear of loss of control (Gans and Horton 1975).
A series of federal government reviews through the 1970s and 1980s pointed to additional constraints to service integration. These constraints included organizational structure based on specialists (as opposed to generalists); service integration not seen as a priority goal; different strategies required for different environments; and lack of financial resources for system reform efforts (USDHHS 1991). In 1993 the National Performance Review addressed the problems of categorical grants and differing program rules and regulations in developing partnerships. Recommendations centered on suspending or eliminating regulations that interfered with program objectives, simplifying financial and compliance procedures, and actively promoting collaboration between the federal, state, and local governments (National Performance Review 1993). Even where block grants (defined as grants for services and programs in broad areas, giving states and localities broad discretion on specifics, as long as related to goal of programs) replaced categorical grants, Congress placed numerous restrictions on the use of block grants (GAO 1992). Categorical grants remain a problem today. One of the recommendations of the recent study on public health by the Institute of Medicine focuses on the need to consolidate categorical grants to increase flexibility at the local level (IOM 2002).

2.5.2 Recent Studies of Organizational Affiliation

A review of service integration efforts in 1993 reflected the growing understanding of the multi-sectoral nature of health interventions, calling for a holistic approach and
for the use of theory to understand the process. Stressing the political nature of organizational change, the review points to the need to develop powerful constituencies for change. Some assumptions about service integration were identified as barriers to integration. For example, ‘expert’ service providers assume they bring the solution to the community with little or no consultation. Further areas of concern included lack of an institutional memory for the process of service integration; poorly defined problems and interventions, making measurement impossible; and the disconnect between the intent of service integration to increase system efficiency and the resulting preservation of the status quo. Problems enumerated in the Gans and Horton review of 1975 still remained in 1993, including categorical grants, crisis orientation, and federal dominance (Kagan and Neville 1993).

Four dimensions are involved in service integration; that is, service delivery, program linkages, policy management, and organizational structure. Dealing only with service delivery and program linkages leaves the status quo in place, while dealing with policy management and organizational structure issues recognizes the need for change. Those involved in integration efforts mainly supported the status quo and the existing power base, thus ensuring failure for integration efforts. Success is more likely where a clear goal of the level of affiliation sought is established, the four dimensions framework is used to study the effort, and training, technical assistance, and funds for integration efforts are available (Kagan and Neville 1993).
While these efforts at service integration set the stage for public-private partnerships, results were limited for partnership development because they maintained unequal relationships. Funders failed to share planning decisions below the national level and maintained restrictions on administering agencies’ use of funds, personnel, and accountability (Kagan and Neville 1993). This remains true in many cases today because funding is usually short term and maintains existing power relations. Collaboration is initiated by foundations, government, academia, organizations such as the United Way, or corporations, who continue to control resources that are provided for community-based organizations to take on increased responsibilities and to do more with less. Funders maintain control, while the community acts in an advisory capacity (Himmelman 2001).

Researchers have worked to develop an evaluation model for local coalitions dealing with multi-sectoral health objectives. The community is seen as the key partner and community participation and empowerment are stressed. According to this model, strategies for each stage of partnership development—formation, implementation and institutionalization—must be appropriate (Butterfoss, Goodman, and Wandersman 1993; Fawcett et al 1997). During the formation stage, a lead agency brings together participants who develop needs assessments and plans. During implementation, the focus turns to programs and activities, as well as to maintenance and routinization of structures and processes. Programs and activities continue during the institutionalization phase without external funding and other organizations adopt
these programs as their own. This model recognizes the importance of the context, including socioeconomic variables, politics, and demographics, among many others (Wandersman et al 1996). These authors call for qualitative case studies to deepen our understanding of how the environment influences the ability of the partnership to function.

Building on this work, the New York Academy of Medicine undertook research to understand the concept of partnership synergy. Tools were developed to understand how partnership functioning leads to partnership effectiveness as measured by partnership synergy (extent to which perspectives, resources, and skills of participants contribute to and strengthen the partnership). Determinants of synergy revolve around resources, partner characteristics, relationships among partners, and the external environment (Lasker, Weiss, and Miller 2001). The research resulted in self-administered questionnaires, with three versions for partnership coordinators, individual partners, and organizational partners (CACSH 2000/2001). These questionnaires can be used to determine whether advantages of a partnership approach are present, to identify the factors that contribute to successful partnership, and to undertake evaluations of partnership to improve their management. Because the research is quantitative, a deeper understanding of the reasons behind some of the results is limited.

Two reviews of the literature on partnerships as a strategy for improving community health both conclude that most justification for collaboration has been based on
conventional wisdom, rather than on empirical evidence. An important finding in the first review covering 68 studies focused on the importance of paying attention to the pre-formation stage to improve the chance of survival of the effort (Kreuter and Lezin 1998). A second review of 34 studies concluded that community partnerships are more likely to lead to individual behavior and to systems change than to changes in health status. The review enumerated limitations in studying the effect of partnerships on health outcomes. These involved the difficulty in generalizing from the studies, the difficulty in establishing a relationship between an exposure to an intervention (the partnership) and the outcome (improvement in health); the mismatch between timeframes for partnership studies (short time period) and partnership (long time period); and lack of tested logic models or theories of action. Challenges in partnership work involve community participation, collaborating across professional fields, sharing risks, resources, and responsibilities, dealing with conflict, and maintaining adequate resources and continuity of leadership. The review concluded with recommendations similar to the ‘wisdom’ literature, starting with establishing clear objectives and changes sought and conditions for success early on in the process (Roussos and Fawcett 2000). Many of the studies under review adopted a medical model and a quantitative approach, looking for cause and effect or dose-response relationships. This fidelity to the scientific method and to the assumption that the universe has an underlying order is itself a barrier to the study of partnerships, a social phenomenon. The only way to understand their functioning is through qualitative research methods, where it is more important to ask if partnerships are
going in the right direction (Berkowitz 2001). More recent studies continue to offer advice in terms of strong leadership and good governance for effective partnerships (Shortell et al 2002). Criticism of this anecdotal, wisdom literature points to the inadequacy of these generic conclusions for building partnerships specific to the needs of a community (Spitz and Ritter 2002).

A third review of the partnership literature focused on community-based research, where a collaborative approach was used. Challenges involved trust; unequal power and control; different cultures leading to differences in priorities, values, language, and task versus process orientation; and defining what and who represents the community. Facilitators included jointly developed operating norms, goals, and objectives; democratic leadership; a community organizer; support staff; prior working relationships; and involvement of key community members. Broader social, political, economic, institutional, and cultural barriers involved competing organizational demands on staff time; expectations of funding institutions; political and social dynamics in the community; and deterrents to change (Israel, Schulz, Parker, and Becker 1998).

Using institutional theory explicitly, researchers studied AIDS projects in Dallas, Miami, and Atlanta aimed at developing a coordinated, comprehensive system of community-based services through a designated local lead agency and case management. Project efforts were limited to case management because the political will was lacking for broader structural or operational changes. Inter-organizational
relations were based on confidence and good faith, as expected for institutional organizations. Results of this study pointed to the need to study the local environment before deciding on the form of organizational affiliation to determine the degree of resource dependency, the influence of professional networks, and the extent of pre-existing polarization or consensus (Dill 1994).

One research effort that examined the effect of collaboration on performance of the core public health functions in local health departments involved public health officials in North Carolina. Responding to a mailed questionnaire, based on self-assessed Likert scales for partnership performance and a combined 4-point score to measure performance of the core public health functions, interviewees revealed that interactions between public health departments and city/county government, boards of health, community members, citizens’ groups, and hospitals explained the greatest amount of variance in performance of the core public health functions (Lovelace 2000). In addition to the cross sectional nature of the study and the subjective self-report measures, lessons learned were limited due to the quantitative nature of the study.

2.5.3 Research on Partnership Projects

National efforts to promote partnerships were described in Chapter 1. The discussion that follows will present results from recent evaluation activities.
Turning Point, a joint W. K. Kellogg and the Robert Wood Johnson Foundations project at the state and local levels, aimed to bring about systems change by bringing together disparate and fragmented elements of public health activities in local communities. Types of affiliation in the different Turning Point sites ranged from informal contacts to interagency agreements. An overview paper set out problems in public health systems identified in the various Turning Point efforts, including differences in cultural perspectives, inefficient bureaucracies, competition for limited resources, fragmented delivery systems stemming from uncoordinated and categorical federal funding. In addition to lessons similar to those in the wisdom literature, other lessons involved the importance of addressing issues of power and control and of including the community, insufficiency of volunteer efforts, the need for a balance between quick wins and long-term efforts, and the need for systems and capacity building for the partnership itself (Rhein et al 2001)

Recognizing the important influences on public health, Turning Point national and local support offices at the University of Washington and the National Association of County and City Health Officials, respectively, developed a variety of guides to help public health entities recognize and deal with these influences. For example, since legislatures, courts, and administrative agencies influence norms for health behavior and the social conditions to be healthy, a model public health law was developed (Cohen and Swift 1993). Working papers produced for Turning Point participants included issues such as performance measurement (Lichiello 1999) and governance structures (Plough 2001). Turnover of officials, short timeframe of government
budgets, reorganization efforts of staff and programs, government skepticism of community health governance, and community distrust of government all presented challenges to government involvement in partnerships.

Within Turning Point, state and local participants worked to identify elements of the public health infrastructure that needed strengthening and ways to accomplish this. State level Turning Point partnerships encountered bureaucratic and political barriers, as well as low productivity and control issues by government agencies. The most productive partnerships were at the local level, although engaging the community in these efforts proved difficult (Bella 2001). An important policy implication of this work pointed to the need to expand public health in terms of constituencies and perspectives. Turning Point efforts resulted in broadened participation in and ownership of public health, as well as systems thinking both at the state and local levels and from a determinants of health approach. Efforts moved from needs assessment to action projects, creating a synergistic effect by leveraging the resources of a broad membership to affect policy and organizational change. Other policy implications pointed to the need for explicit support for community priorities for public health, for new public health skills involving communication and facilitation, and for federal agencies to integrate their efforts with the state and local levels (Baxter 2002). One local Turning Point project in New York City examined implications of their experience for their local health department, especially the importance of developing infrastructure to support community work. In pursuit of this goal, the local health department established a Division of Community Health
Works to provide technical assistance and staff to developing local partnerships (Cagan, Hubinsky, Goodman, Deitcher, and Cohen 2001). In another Turning Point project, the Multnomah County (Oregon) Health Department worked to design a public-private integrated health information system. Their experience pointed to the difficulty in engaging the private sector; the substantial effort required to organize community support; and the secondary nature of partnership work to the organization’s own work. The work also raised the issue of cooperation versus regulation in obtaining private sector data (Multnomah County Health Department 1999).

Results from the Community Care Network (CCN) evaluations are becoming available. An early effort involved development of a framework drawn from the social sciences to explain motivation for participation in partnerships. Study results revealed that organizations, mainly in the private sector, are willing to work together on activities that do not disrupt existing power and control, where they stand to gain prestige and visibility, and where client volume stands to increase (Bazzoli et al 1997).

Evaluation work resulted in a conceptual framework for assessing partnerships involving governance and management. Dimensions of the framework included the context and the problem addressed; partnership composition and degree of diversity; resources; coordination and integration; accountability; centrality; and alignment. The framework provided advice for each dimension, stressing the importance of
aligning elements of the partnership with the external environment, as well as the form of the partnership with agreed goals (Mitchell and Shortell 2000). Another effort offered a typology of CCN models based on the degree of formalization of the affiliation. Ranging from a centralized action model—the most formal—to a foundation model—where there is no real partnership, pros and cons for each model focused on issues of control, degree of influence, and on the ability to remain focused (Hasnain-Wynia, Margolin, and Bazzoli 2001).

Much of this work on CCNs pointed to the limited results realized by these efforts. Researchers posited that this may be due to the short-time frame allowed for a long-term effort and to management challenges (Shortell et al 2002 and Hasnain-Wynia, Margolin, and Bazolli 2001), too narrow a focus to have a population impact, and lack of a common, well-defined vision (Shortell et al 2002). Important elements involve paying attention to a changing context, focusing on vision and outcomes, and of paying attention to nurturing the partnership while working to improve community health. Political issues and efficiency and effectiveness issues must be considered (Zukovski and Shortell 2001). Disincentives for health services managers to participate in partnerships included antitrust legislation and multi-state health plans that have no physical community (Weiner, Alexander, and Zuckerman 2000). Where there was success in CCNs, six characteristics were present; that is, an ability to manage size and diversity; an ability to attract leadership; an ability to maintain focus; an ability to manage and resolve conflict; an ability to recognize and deal with
lifecycles; and an ability to patch (ability to reposition according to changing needs) (Shortell et al 2002).

An evaluation of a research partnership in Detroit confirmed the importance of balancing development of the partnership process with community health activities, in addition to paying attention to the stage of development of the partnership (Lantz, Viruell-Fuentes, Israel, Softley, and Guzman 2001). Barriers were identified as the time-consuming nature of organizational structure development; conflict between a participatory approach and the reward structures within partner organizations; and partnership duties as one among many duties of partner representatives. Deterrents to change stemmed from inequitable power and resources, a history of discrimination, expert models, and a scientific paradigm. Building on existing infrastructure and processes, trust, committed leadership, previous collaborative history, and well-respected members who have in-depth knowledge of the local area all facilitated partnership development (Israel et al 1998).

This review of the literature on health and social services partnerships and the proposed community health partnership model provide the basis for designing a qualitative case study methodology, the subject of Chapter 3.