Leadership in Collaborative Community Health Partnerships

Jeffrey A. Alexander
Maureen E. Comfort
Bryan J. Weiner
Richard Bogue

This article examines key leadership issues in community health partnerships. We assert that leadership in a partnership is differentiated from that in a traditional, hierarchical organization in that participation is voluntary and egalitarian and often entails cooperation by organizations with different cultures and agendas. Partnership leaders, accordingly, often lack formal control over members and their actions. Using qualitative analysis of 115 site-visit interviews of participants in four partnerships in the Community Care Networks demonstration program, we identify and discuss five themes of collaborative leadership: systems thinking, vision-based leadership, collateral leadership, power sharing, and process-based leadership. We then discuss the multiple challenges that collaborative leadership faces in a community health partnership.

Increasingly, health care policy makers and communities are recognizing that the root causes of poor health in this country lie in such systemic problems as substance abuse, violence, teenage pregnancy, and environmental pollution (Citrin, 1998; Gamm, 1998; Kreuter, 1998). Failure to address these underlying social and public health problems results in an overburdened health care delivery system with reduced ability to effectively allocate resources and

Note: This research was funded through a grant from the Health Research and Educational Trust and the W. K. Kellogg Foundation.
contain costs. To address these systemic issues, many communities are developing community health partnerships that seek to address these difficult, multifaceted problems through innovative forms of multisector collaboration (Bogue and Hall, 1997).

Although many aspects of collaborative community health partnership have received attention from researchers and practitioners (Johnson, Grossman, and Cassidy, 1996; Bazzoli and others, 1997; Bogue, Antia, Harmata, and Hall, 1997; Alexander, Comfort, and Weiner, 1998; Weiner and Alexander, 1998), one that deserves greater emphasis is leadership. In a traditional organization, leadership is typically linked to formal hierarchical position. Formal position supplies both the legitimate authority and the means by which managers and other high-level professionals define the goals and strategies of the organization and influence subordinates and external stakeholders. Leaders can assign goals, hire and fire, allocate responsibilities, and give or withhold monetary incentives or contracts. In a collaborative community health partnership, by contrast, even formally designated leaders have only tenuous authority—and often limited means—with which to set an agenda, initiate projects, allocate resources, and resolve conflict. A growing literature on collaborative leadership, spanning diverse contexts such as cross-functional product development teams and legislative committees, addresses analogous situations in which the leaders possess little formal authority and limited resources (Joyner, 2000; Avery, 1999; Chrislip and Larson, 1996; Ranney and Deck, 1995; Bennis, 1999; Rosenthal, 1998). Yet the collaborative community health partnership possesses distinctive characteristics that call for a type of leadership (and that produce leadership dilemmas) unrecognized or rarely discussed in the collaborative leadership literature.

This article contributes to the literature on nonprofit governance and management by describing the nature of leadership in a collaborative community health partnership as well as offering guidelines for effective leadership in this context. Using qualitative data collected from case study research, we describe salient aspects of leadership in such a partnership that differentiate it from leadership in a more traditional organization, specify the relative advantages and disadvantages of various approaches to partnership leadership, and discuss several key dilemmas in partnership leadership.

Method

In this section, we discuss the study setting and design, data, and analysis plan.

Study Setting

This study was part of a larger investigation into the challenges of governing a collaborative community health partnership (Alexander and
The partnerships in our study participated in the national demonstration of the Community Care Network (CCN) vision (for details, see Bogue and Hall, 1997). Reflecting a systemic, population-based view of health status and its determinants, study partnerships included an array of service delivery organizations and community stakeholders. In addition to hospitals and health systems, partnerships included physician groups, insurers, business alliances, schools, churches, social service agencies, public health departments, local government agencies, and community interest groups.

Study partnerships held a common, overarching vision, which emphasized (1) community accountability; (2) improvement in the health status of the community as a whole; (3) a seamless continuum of care, with mechanisms that facilitate service delivery at the appropriate time and setting according to individual need; and (4) management within limited resources. Partnership activities included measuring and tracking community health status, providing multifaceted services to defined populations, developing community problem-solving capacity, and evaluating and communicating progress in improving community health and achieving systems change.

As with other collaborative community health partnerships, those we studied possessed several features distinguishing them from traditional service delivery organizations, advocacy organizations, and special-interest groups:

- They are based on voluntary collaboration rather than hierarchical control.
- They reflect multiple sectors of business, education, health, and human service delivery.
- They take a comprehensive approach to improving community health status that focuses on education, prevention, early detection, and seamless delivery of health and human services.
- They consist of partnering organizations committing varying levels of resources and effort to the partnership; the degree of overlap between their own institutional goals and activities and those of the partnership as a whole also vary significantly.
- They combine two types of network: a local coalition of public and private stakeholders focusing on public health and community planning, and a service delivery network seeking to provide and coordinate jointly a continuum of services (Bazzoli and others, 1997).
- They exist primarily to benefit the community, although they must also create value for the partnering organizations.

Study Design

We adopted a multiple holistic case study design (Yin, 1984) and selected cases through a two-stage process. First, we screened a pool
of twenty-five CCN partnerships using three criteria. To examine the most broadly applicable results, partnerships had to have a relatively balanced mix of public and private sector organizations. To draw from the best possible data set of experiences and knowledge, they had to have been ongoing at least three years prior to 1997. Finally, to gather information that would be most representative of the experience of all twenty-five CCN partnerships, they had to exhibit a relatively balanced profile of activities on the four dimensions of the overarching vision described earlier.

We then selected four partnerships from the remaining pool based on two theoretically chosen criteria: urban or rural location, and managed care penetration (details available from the authors). By applying these criteria, we sought to investigate how these relatively enduring attributes of partnership context affect partnership governance. In this study, however, we emphasize common themes and dilemmas rather than differences across cases.

Data
We conducted semistructured, face-to-face interviews at the four case study sites in 1997, 1998, and 1999, typically with ten to fourteen key informants. These informants represented a broad cross section of each partnership and included governing body representatives as well as general members. Each interview lasted approximately one hour and was recorded in full by the investigators. A total of 115 individual interviews were transcribed word for word and prepared for computerized text search using QSR NUD*IST 4.0 software.

Analysis Plan
Our analysis strategy consisted of three steps. In the first step, we used an iterative Q-sort process to develop a conceptual map of the construct of partnership leadership. This resulted in eight mutually exclusive groups of terms associated with leadership, ordered by the strength of concordance across the individual Q-sorts of research team members.

In the second step, we used the four most concordant groups of terms to conduct text searches with NUD*IST on all 115 interview transcripts simultaneously. Three team members then independently reviewed the search results, employing a number of strategies to examine what the informants said about leadership. Essentially, each engaged in a naturalistic form of inquiry that involved repeatedly reviewing the data in search of themes or concepts that reflect experiences and understandings common to many informants. This process yielded a consolidated scheme of emergent categories and concepts that could be organized under ten broad questions related to the nature, structure, and functioning of partnership leadership (Lofland and Lofland, 1995). In the final step, the team used the consolidated scheme in a further round of text searches, generating
reports that linked all coded text associated with a given question. Each team member then examined each report, identified key leadership themes, and wrote a memo fully describing and explaining each theme (Lofland and Lofland, 1995).

Results

The procedures just described yielded five short memos of one to three pages describing five leadership themes that seemed distinctive to the collaborative community health partnership compared to the traditional organization: systems thinking, vision-based leadership, collateral leadership, power sharing, and process-based leadership. The conceptual relationships among these themes are displayed schematically in Figure 1. This conceptualization suggests a mutually reinforcing relationship between system thinking and vision-based leadership on the one hand, and between power sharing and collateral leadership on the other. The mechanism by which these four themes are translated into action in a partnership is expressed in the fifth theme, process-based leadership.

Theme One: Systems Thinking

The systems-thinking theme embraces three essential qualities of partnership leadership. First, systems thinking means taking a population-based view of health. Effective partnership leaders supplement the disease-based medical model with a wellness-based social model that stresses the social, economic, cultural, and environmental determinants of health (Proenca, 1998; Shortell, 1996). Further, the leaders focus on the structural drivers of health status that operate subtly yet pervasively at the community level (for example, clean air, strong families, safe streets). This often reveals that the highest-leverage strategies for altering the underlying causes of poor community health are the least obvious and typically require broad-based collaboration. Such a perspective is therefore crucial for identifying the need for collaborative action, specifying targets, and developing the partnership's strategy. Because a systems perspective can be hard to grasp and maintain, however, the partnership leaders must constantly push members to think in terms of higher-order

Figure 1. Key Leadership Themes

- Systems Thinking
- Vision-Based Leadership
- Collateral Leadership
- Power Sharing
- Process-Based Leadership

Five leadership themes seem distinctive: systems thinking, vision-based leadership, collateral leadership, power sharing, and process-based leadership.
cause and prevention, rather than symptom and quick fix. As one interview participant noted:

You know it’s really easy to attack problems that you can deal with at a tertiary level because they’re real, they’re there. But if you want to lower these more nebulous morbidity indicators, [then] people have a lot harder time discussing what they want to do. So they drop back into [saying], ‘Well, how are we going to attack cancer? Well, let’s set up an organization through the tumor registry and get everybody that’s got cancer together and that will be our grant. We’ll provide them information on therapy and interventions and all that.’ I said, ‘That’s not primary prevention. That doesn’t do anything with the prevalence or incidence of the disease.’

Second, systems thinking means developing a sound working knowledge of how a community’s formal and informal organizational systems interrelate and affect community health. By definition, community health improvement requires collaboration among the community’s formal organizational systems (health and human services, education, public health, civic organizations) and informal organizational systems (neighborhoods, ethnic groups, families). Effective partnership leaders have a deep, intuitive sense of how the community works. Further, they demonstrate willingness to work with, and learn from, individuals and organizations from across the community.

Third, systems thinking means staying focused on the big picture. Effective partnership leaders look beyond the narrow interests of their own organization or constituency, even beyond the interests of the partnership itself, and focus primarily on the needs and priorities of the community as a whole. Such a perspective embraces all aspects of a community and is not centered on any one of them. Interview participants acknowledged the difficulty of attaining such a big-picture perspective, yet they emphasized its importance. As one put it: “People desire in some ways to represent, and therefore advocate, for their constituency . . . understanding the needs of the constituency with which you are most familiar and matching that with what you hear and see for the whole system . . . . [Looking at the ‘big picture’] doesn’t necessarily come naturally, and it’s in every aspect of the work. Being able to do that is what moves people from advocates to leaders in a more powerful and deeper way.”

Theme Two: Vision-Based Leadership

Through systems thinking, leaders create a framework for action. Through vision, they communicate the framework compellingly, mobilize resources, and guide action toward long-term aims. In a collaborative partnership, vision is leadership’s most powerful medium, not just its message. A partnership depends on voluntary
Participation, as well as a limited budget. Partnership leaders enjoy few of the means for regulating participation available to organizational leaders (formal authority, monetary rewards, administrative penalties, and the like). Vision therefore becomes an important basis of influence as leaders work to align partnership members and promote collaboration.

A well-conceived vision consists of a core ideology and an envisioned future (Collins and Porras, 1996). Core ideology defines what the partnership stands for (core values) and why the partnership exists (core purpose). It creates an identity that transcends the identities of individuals and organizations, the legal form or structures, and the partnership's activities. An envisioned future defines what the partnership aspires to become, achieve, and create. It specifies a compelling long-term goal that serves as a unifying, focused reason for collective effort and vividly describes what it will be like to achieve the goal.

In one partnership, for example, leaders designed a process to help members identify the common values among their multiple, sometimes competing, interests. The eight values they discovered helped define the partnership and reminded members of their commonalities when conflict arose. These partners also clarified their core purpose, to build problem-solving capacity, which helped in sorting through requests for services and funding opportunities. Finally, a yearlong assessment helped leaders identify a compelling long-term goal: every child in the community will enter school ready to learn. This goal tapped members’ passion and promoted alignment of their diverse assets with a shared, global outcome.

A partnership often faces difficulty deciding which paths to pursue and which not to pursue, particularly when a systems perspective expands the possibilities for action. Leaders use a well-conceived vision as the criterion against which to judge the suitability of a proposed course of action, because it clearly represents that which is central and enduring to the partnership. Indeed, informants praised leaders who could articulate the vision with passion and consistently remind “[us] what it is that fundamentally binds us.” Otherwise, “partnerships may drift or even founder.”

Finally, an effective leader uses vision to gain the support of two critical stakeholder groups. First, leaders communicate the partnership's vision to partnering organizations. This is challenging since a partnership often operates below the radar screen of organizational managers and board members. A respondent stated that “one of the challenges comes from my need to communicate pretty clearly on the values and advantages of participating in this partnership. . . . [My organization] knows there needs to be a return on the time investment that I’m making.” Effective partnership leaders help the leaders of the member organizations see how the partnership helps their own entity achieve its own mission and goals, which is the key to sustained commitment.
Second, an effective leader uses the vision as a basis of connection to the dreams and aspirations of the broader community, and thereby as a means to garner its support. Unless leaders can articulate the partnership’s values, purpose, and goals in terms compelling to the community, people may view the partnership with cynicism or even suspicion. As one informant noted: “There is a lot of diversity [in our community] . . . But there are some important values that are shared by everyone and it was important—even to the most practical-minded business people and city-manager people—to communicate to the community at large and whoever is interested in us from outside our county what it is that fundamentally binds us. And that is our values.”

Theme Three: Collateral Leadership

Despite growing interest in empowerment, leadership in most organizations continues to be the prerogative of a small group of managers or senior professionals holding formal positions of authority. A partnership, in contrast, relies on a broader base of leadership. Informants frequently pointed out that no single individual or group furnished leadership. One observed: “There is a core group of individuals who have significant influence in the [partnership] and I would say, in some cases, that core is made up of formal leaders. And the less formal leadership groups are really, as I see it, the idea generators. It’s their role to keep the organizations [at the] cutting edge.” In describing this aspect of partnership leadership, we chose the term collateral leadership rather than, say, “distributed leadership” because it accurately reflects our observation that broad-based leadership supports, but does not substitute for, the leadership exercised by formally designated partnership leaders. Collateral leadership emerges from three principal sources: partnership staff, organizational representatives, and advocates for a particular community segment.

Staff leaders can bring to the partnership a fresh perspective and knowledge of trends; they can generate enthusiasm and creativity and keep members engaged and on task. They are also often charged with communicating to the partnership’s formal leadership. In the words of one informant, partnership staff “provide an awful lot of informal leadership that guides and shapes things [that] the full [partnership] board responds to and the executive committee responds to. . . . I think their leadership is crucial.” The staff leadership role often resides in partnering organizations, while some partnerships have their own dedicated, paid staff. Others, however, have no staff, sometimes by design. Some informants reported fearing that formal, full-time staff would reduce participation and the sense of ownership for the partner organizations and other members of the community.

As an expert and advocate on specific issues, a situational leader plays an important role in shaping the partnership’s direction and activity. By definition, however, situational leadership is narrowly focused on specific issues or activities. As such, the leadership
exercised by a particular partnership member is likely to shift over time depending on the relevance of the issues to that individual’s home organization or community segment. For example, a member who represents a community clinic may exert considerable leadership on issues concerning access to primary care but play only a supporting role in fundraising.

An advocate for a particular community segment may also exert collateral leadership. As with representatives of the partnering organizations, a formal or informal advocate often focuses on specific issues, in this case on the basis of the interests of a certain community segment. This leader promotes two-way communication between the partnership and community members and helps build support for the partnership by translating the vision and goals into terms that are meaningful to a particular community segment. The leader also helps the partnership obtain input about health needs and assets from a broad spectrum of the community, including those who are economically disadvantaged or politically disenfranchised, ensuring that initiatives are more consistent with the community’s realities. Commenting on the collateral leadership contributed by a formal or informal advocate, one interview participant remarked: “It’s important for us to have at the table with us people who can talk from lots of different places in our county, whether that be from a racially diverse group or a socioeconomic [group] that is different than the person next to them. We have an obligation to think of all the kinds of people that we are trying to serve.”

Our research suggests that collateral leadership is integral to the community health partnership. It responds to three distinctive features of partnership: the complexity of the task of community health improvement; the diversity of the interests, needs, and assets of members; and the unavoidable time constraints on voluntary collaboration. Collateral leadership offers several advantages. First, it complements the systemic, visionary leadership exercised by formal leaders, lending both operational leadership of specific activities and direct contact with external stakeholders from the various community segments.

Second, a single individual or small group can rarely give adequate time and attention to all three partnership features (task complexity, diversity, and time constraints). This is especially true when formal leaders serve voluntarily and face competing demands on their time. Thus collateral leadership reduces the burden placed on the time that a formal partnership leader has available. Similarly, no individual or organization can adequately represent the broad spectrum of interests a community health partnership seeks to coordinate. Hence collateral leadership reduces the burden on any one person for perspective.

Finally, collateral leadership enables a partnership to tap into diverse skills and resources. Formal leaders may be highly skilled in efficient decision making and moving discussion quickly to closure. Staff leaders may be experienced in consensus building and
ensuring that all parties have a chance to exercise voice. Advocate leaders may be skillful in protecting and advancing perspectives that are at risk of going unheard. If people bring complementary leadership skills to the table, the partnership is stronger.

Despite these advantages, significant problems can result if formal leadership and collateral leadership are out of balance. For example, with formal leaders exercising little or no influence over partnership strategy, the interests of partnership staff, a bloc of organizations, or advocates for a particular community segment may unduly influence the partnership. Conversely, if the partnership enjoys strong formal leadership but little collateral leadership, the partnership may lose the broad base of participation needed to address community health issues. As one interview participant observed, “If the board is simply going off once a year and deciding what we are going to do, we are going to lose some people that are out there... [that] really make the organization go.” Striking an effective balance between formal and collateral leadership is a major challenge, and a critical success factor, for any collaborative community health partnership.

Theme Four: Power Sharing

As with systems thinking and vision-based leadership, collateral leadership and power sharing go hand in hand. Indeed, power sharing may be the most important mechanism through which formal partnership leaders can build the broad base of leadership that multisector collaboration requires. In many respects, the collaborative community health partnership operates as a virtual organization. It often lacks formal legal status; occupies no physical space of its own; relies heavily on financial contributions from partnering organizations; and accomplishes the bulk of its work through the donated time and effort of partnering organization employees, community groups, and concerned citizens. By sharing power to set priorities, allocate resources, and evaluate performance, partnership leaders foster a sense of joint ownership and collective responsibility, from which collateral leadership emerges.

Sharing power may be the most difficult personal challenge for the partnership leader. In the home organization, the individual may occupy a position of considerable formal authority and responsibility. Wielding power feels both familiar and natural. Sharing power does not. As one interview participant observed, “A lot of times people in [traditional] institutions are a little bit leery about letting the people run the show because [somehow] there is this... fear or threat that people are going to do something radical and reckless.” To some extent, concerns about sharing power arise from the fact that in many cases partnership members have not worked together previously and thus do not know much about each other’s intentions,
competence, and reliability. However, even absent these concerns, the leader of a traditional organization still finds that sharing power does not come easily. One interview participant commented: “It’s an issue of skill-building and training, from the top all the way down. . . . People need to understand how to share power and how to share responsibility and decision making, as well as learn how to step into a role that they may not have been accustomed to [having] in the past.”

With time and experience, the partnership leader learns that power is not a fixed quantity and that power sharing does not resemble a zero-sum game. The leader rediscovers a paradox long asserted by management scholars: that leadership increases its control by giving up some of its authority (see Tannenbaum, 1966). Sharing power creates a sense of shared ownership and mutual accountability that empowers not only partnership members but also leaders. If power is exercised mutually rather than unilaterally, the total amount of control in the system increases, as does the system’s effectiveness. However, the members must view power sharing as an authentic move on the part of leadership. As one interview participant described a leader considered highly effective: “She understands working with communities in a very deep way and really [understands] the difference between partnering with communities to further our agenda versus working with communities and responding either to their [agenda] or our shared agenda. [She understands] the difference between those and how easy it is to think you’re doing one thing but really be doing the other thing. It’s her ability to understand that [difference] and [to] point that out that makes her a leader.”

Theme Five: Process-Based Leadership

The final theme, process-based leadership, cuts across the others and speaks to how the substantive and structural aspects of leadership are translated into action. In the partnership context, how a leader pursues a goal is frequently as important as achieving the goal itself. Because a partnership leader cannot rely on the formal structure and authority that facilitate action in other organizations, he or she depends heavily on interpersonal skills, which encourage input and participation, and on effective communication mechanisms, which assure wide and multidirectional diffusion of information.

Respondents most frequently judged “the ability to listen” to be one of the top five attributes of partnership leadership. One interviewee, in fact, opined that the “first five are listening.” A partnership often intentionally brings together organizations with differing and complementary skills, knowledge, and experience. Listening carefully precedes deep understanding of other organizations’ and the community’s perspectives, needs, and visions for the future. A good leader initiates communication and gives others an opportunity to be heard, both inside the partnership and out. Inside the partnership,
good leaders solicit input and feedback from other members. Externally, they seek out dialogue with a variety of government, business, nonprofit, and community leaders to whom the partnership is potentially relevant. Finally, listening implies commitment to use people's input. Leaders who appear to listen but never incorporate input substantively quickly lose credibility.

Attention listening and access are a key part of interpersonal effort to keep members motivated and engaged. Respondents accorded similar importance to respect and appreciation. Partnership members, like their leaders, have numerous competing demands on their time and energy, including their primary jobs. If a leader consistently recognizes the time, effort, and skills that a member contributes, the member feels motivated to contribute more. One interviewee noted that “there's not a meeting we go to that people aren't praised for the work that they do, and thanked for what they do.” Our data also suggest that the effective leader takes a nonjudgmental approach when dealing with partners. Conveying genuine respect for the views of all members, regardless of their affiliation or power, reinforces the principles of inclusion and common purpose and can in turn elevate respect for leadership. For example, in one fairly strident exchange with a vocal member of an underrepresented group, a steering committee chair acknowledged and sincerely expressed concern for the member's position. In return, rather than forcing the issue, the minority member suggested that the two continue their discussion after the formal meeting, so as not to disrupt the planned agenda. This dynamic of respect, though sometimes subtle, can powerfully shape the outcome.

Partnership participants value leaders who are forthright and direct in their communication. An effective leader addresses issues head on instead of denying or trying to minimize them. Direct communication means that partnership members can get accurate information firsthand, rather than relying on secondhand sources that may, despite the best of intentions, be distorted. One respondent was impressed when, after an important board discussion, a partnership leader personally contacted the providers involved in the issue, heading off potential rumors. Ineffective communication skills, by contrast, can obviate other positive attributes the leader may have. In one partnership, a committee leader stepped down because, despite being aligned with the partnership vision, poor communication skills exacerbated conflict with others.

Partnership leadership must attend to process strategically, particularly when designing communication channels. The diversity and scope of many partnerships can make this task difficult and render the options to choose from complex, but attention to three key elements can help. First, communication channels must foster broad diffusion of information. The central role of vision requires that partnership mission, purpose, and goals be widely disseminated within the partnership. Further, the diffuse nature of collateral leadership necessitates that many people have access to information that
tradi
tationally might have been limited to a small cadre of formal leaders. Without communication channels and mechanisms that support these information needs, the partnership is hobbled.

Second, channels must permit communication flow in multiple directions. This includes not only up and down but also horizontally, and even in some cases diagonally, between levels of staff in the several organizations. Without such flexibility and reduction in intermediaries, much of the value-added of the partnership form is lost.

Third, they must respect and allow for the diverse needs of the variety of organizations and communities that make up the partnership. Not all types of communication mechanism work equally well when partners have differing communication styles. Groups may have sharply diverging expectations of the timing and extent of communication, what types of information should be conveyed, and even the language or jargon employed. Partnership leaders must be able to appropriately structure communication to bridge these cultural gaps. This may require redundant channels, multiple forums, or novel media. Some partnerships have experimented with using electronic communications, conducting broad-based community surveys or feedback meetings, and even simply having partner organizations host board meetings on rotation. The aim is to ensure that communication occurs through a variety of mechanisms that, in combination, meet the communication needs of all parties.

**Leadership Dilemmas in a Partnership**

In this section, we review several frequently mentioned challenges that leaders confront as they move their partnership forward. These issues were typically expressed in terms of the constraints, tradeoffs, and inherent conflicts that partnership leaders face.

**Continuity Versus Change in Partnership Leadership**

A partnership faces a paradoxical need for both continuity and change in leadership. Continuity in leadership over time brings the stability necessary to progress on long-term goals. Because leadership is the primary repository and chief communicator of the vision, the partnership risks losing the integrity of the vision when leadership changes. Even natural changes in leadership, such as succession, can disrupt partnership momentum. Several respondents noted that their partnership experienced a serious setback or delay when a key leader left the partnership. Although continuity is valuable, so is occasional infusion of new leadership. Some respondents complained that lack of new leadership in their partnership resulted in an absence of fresh ideas, new energy, and vision. Partnership start-up in particular can entail Herculean contributions of time, effort, and enthusiasm from leaders, and respondents across all partnerships mentioned leader, staff, and partner burnout as a serious concern. Under these circumstances, a partnership may inevitably require a low-level but
constant flow of new leadership to regenerate and even maintain its focus and vigor.

The challenge is to strike an appropriate balance of continuity and change. In some cases, a high rate of turnover among situational leaders may infuse new energy and ideas that the partnership needs without the detrimental effects that turnover in formally designated leadership might bring. However, even an outright loss of key leadership can be positive if it motivates others to step up into a new role, or if it serves as a wake-up call to acknowledge areas for partnership improvement. One respondent recalled the departure of an important staff leader constructive in hindsight: “It took a jolt of some sort to cause us to refocus... we needed a recasting.” Such opportunity to reassess strategy, goals, and activities can be critical to keeping the partnership fresh and moving in the appropriate direction.

Leadership Development

Partnerships have addressed the need for a ready supply of new leadership by paying conscious attention to leadership development, whether in the partnership, within partner organizations, or out in the community. Respondents spoke of the paucity of individuals coming up through the institutional and community ranks who were well prepared to take on a leadership role in the partnership context. Promising staff members narrowly grounded in a technical domain may not appreciate the complex web of community relationships within which the institution is embedded. In the community, concerned citizens, though active in health-related issues, perhaps never think of themselves as community leaders. Current leadership is in a unique position to identify potential leaders, invite their participation, and support and mentor them as they take on an auxiliary leadership role.

Within partner organizations, partnership leadership development can often be accomplished within the framework of existing staff development and evaluation efforts. Some organizations, for example, have integrated collaborative competencies into routine performance evaluation. In the community, partnerships have identified potential leaders through tracking participation in partnership-sponsored community events or noting who is active in issues such as welfare rights or housing. This is an opportunity to observe people in action and get a sense of their capability. Some partnerships have made identification and fostering of potential leaders a part of the job description for paid staff. Others have hired community members thus identified into paid partnership or initiative staff positions, such as community health worker or organizer, to accelerate their development.

Partnership leadership may also have to devote more effort toward orienting potential leaders to the partnership’s purpose. Existing community leaders may need to be sold on why they should devote their scarce, sought-after time to this particular effort. Other
potential leaders may be firmly committed to the issues but need a concrete invitation, coaching, or encouragement to participate in a leadership role. Partnerships may balk at the sometimes substantial commitment of time and effort required to develop potential leaders, but they may find that it is part of the territory of collaboration, particularly collaboration with communities.

**Power and Participation**

The partnerships we studied used two distinct power-sharing strategies. Partnerships embracing a norm of equality among members valued leadership neutrality; they selected individuals with few organizational ties, little vested interest, or no outside agenda to hold leadership positions. Partnerships employing a norm of equity tied leadership selection more or less directly to the level of resources contributed to the partnership or to the centrality of the organization in the community.

Neutral leadership fosters equal voice and representation among all partners, regardless of differences in resources, power, and size, and reduces perceived threat by ensuring that no one actor or perspective dominates. Neutral leadership is expected to ensure that leadership does not favor a particular constituency over the best interests of the collective. If trust is low, as when partners are new, or when there is a history of hostile interaction, neutral leadership can be seen as a way of leveling the playing field or preempting a potential turf battle. However, if committed and visionary individuals are excluded from leadership simply because of organizational or sectoral affiliation, the partnership may miss out on a valuable source of energy, creativity, and experience. Further, the desire for neutrality may at times be a symptom of democratic paralysis, or unwillingness to make difficult but necessary decisions to move the partnership forward.

An equity-based approach to leadership assumes that the views of all partnership members are respected in decisions, but that influence is tied to the organization's financial support of the partnership or its importance in the community. Equity-based power sharing may afford efficient decision making and focused direction for the partnership. In a community health partnership context, however, where there is often wide discrepancy in resource contributions to the partnership, this approach risks alienating smaller or poorer partners.

An equity approach to leadership presupposes that a strong foundation of trust and honesty exists between leaders and members of the partnership. Partners of lesser power quickly feel disenfranchised or threatened unless they know that their views are respected and they can be assured that partnership leaders will not abuse their position or show decided preference for the views of a particular partner. Equity leadership must therefore provide a mechanism for input into partnership deliberation and decision making, such as a broad-based governing body, for those members who are not part of the leadership core.
Conclusion

Taken as a whole, the themes identified in our research suggest that leadership in public-private health partnerships requires a different set of orientations and skills from that of leadership in a traditional hierarchical organization. The voluntary nature of a partnership, its diverse membership, and the complex and sometimes ambiguous nature of partnership goals create particular challenges for this type of organization. The most effective leadership under these conditions recognizes the need for appropriate balance—between power sharing and control, between process and results, between continuity and change, and between interpersonal trust and formalized procedures. The ability of partnership leaders to walk a fine line often distinguishes truly effective leadership from mere management.

JEFFREY A. ALEXANDER is Richard Carl Jelinek Professor of Health Management and Policy in the School of Public Health, University of Michigan; faculty associate at the Survey Research Center, Institute for Social Research; and research scientist at the VA Health Services Research and Development Center.

MAUREEN E. COMFORT is a doctoral candidate in health services organization and policy at the University of Michigan.

BRYAN J. WEINER is assistant professor in the Department of Health Policy and Administration at the University of North Carolina at Chapel Hill.

RICHARD BOGUE taught communication and health policy at universities in the United States and Mexico and led many programs on community-responsive health system improvement for the American Hospital Association; he now consults with governing boards and community partnerships to evaluate and improve their performance.

References


